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SASKATCHEWAN POPULATION HEALTH AND EVALUATION RESEARCH UNIT

Understanding Cross-Jurisdictional Partnerships and Decision-Making in Northern Saskatchewan

NHS
Northern Health Strategy

Final Evaluation Report

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Prepared by:

Dr. Chad Nilson

Dr. Bonnie Jeffery

Colleen Hamilton

Rural Health

Healthy
Children

Northern and
Aboriginal Health

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LIST OF ABBREVIATIONS

AHA	Athabasca Health Authority
CDNAP	Chronic Disease Network and Access Program
FNIH	First Nations and Inuit Health (Health Canada)
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
MHATAC	Mental Health and Addictions Technical Advisory Committee
MLTC	Meadow Lake Tribal Council
MOU	Memorandum of Understanding
NCCC	Northern Chronic Care Coalition
NHLWG	Northern Health Leadership Working Group
NHS	Northern Health Strategy
NHSTSC	Northern Health Sector Training Sub-Committee
NHSWG	Northern Health Strategy Working Group
NITHA	Northern Inter-tribal Health Authority
NMS	Northern Medical Services
NOHWG	Northern Oral Health Working Group
PAGC	Prince Albert Grand Council
PBCN	Peter Ballantyne Cree Nation
PHU	Population Health Unit
PIHTAC	Perinatal and Infant Health Technical Advisory Committee
SPHERU	Saskatchewan Population Health and Evaluation Research Unit
TAC	Technical Advisory Committee

EXECUTIVE SUMMARY

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In December of 2008 the evaluation team—including representatives from the Northern Health Strategy (NHS) and Saskatchewan Population Health and Evaluation Research Unit (SPHERU)—met to discuss a review of the Northern Health Strategy's ongoing efforts to foster a cross-jurisdictional decision making process in the healthcare services provided to northern people in Saskatchewan. The Northern Health Leadership Working Group (NHLWG) and the Northern Health Strategy Working Group (NHSWG) are two major components of this process that this particular review examines. Receiving action recommendations directly from the latter of these two components are seven different Technical Advisory Committees (TACs). These committees are responsible for advancing initiatives in the areas of chronic disease management, mental health and addictions, oral health, perinatal and infant health, human resources, emergency preparedness and community development. Of these seven, the first five were chosen by NHS to be included in this evaluation.

The overall purpose of this review is twofold: (a) to evaluate the progress made toward the ongoing effective multi-jurisdictional partnerships and decision-making processes; and (b) to evaluate progress in specific areas of work undertaken by the NHS Technical Advisory Committees. To satisfy the needs of this review, considerable attention is given to 5 main evaluation objectives:

- Identify and describe the process used to promote cross-jurisdictional partnerships among partners of the NHSWG.

- Identify and assess aspects of the cross-jurisdictional partnerships that are working successfully; as well as those aspects that are challenging.

- Identify and assess the cross-jurisdictional decision-making process.

- Document the ongoing partnership development and progress towards the specific activities identified for the TACs.

- Provide an assessment of the change in health service delivery in selected areas of the project.

Northern Health Strategy: Building on the Momentum

The most recent task of the NHSWG was to continue the efforts it has made in previous years with new funding from the integration envelope of Health Canada's Aboriginal Health Transition Fund. The funded project was titled *Northern Health Strategy: Building on the Momentum*. This project serves as the main focal point of this evaluation report.

According to the project funding proposal, the overall objective of the NHS is to "work cooperatively and collaboratively to improve the health status of all Northern residents. The

NHS will continue to focus its efforts on activities which result in better integrated and adapted services that improve access to quality programs and services in the North"[1]. Several other objectives also guide the NHSWG in its most recent undertakings:

- Better adapted and integrated health services that improve access to quality programs and services throughout northern Saskatchewan.

- Improved health status of residents of northern Saskatchewan.

- Improved care and quality of life for residents living with chronic disease.

- Improved access to dental services for residents.

- Increased access to mental health and addictions services.

- Increase awareness of value of breastfeeding and number of women doing so.

- Integrated northern e-health strategy developed.

- Health and social indicators for First Nations developed to monitor progress.

- Improved recruitment and retention of health care providers.

- Increased health promotion, access to health care, health provider education.

- Develop and implement a health human resources planning model for northern Saskatchewan.

- Increased information sharing, collaboration and strategic planning among CEOs and senior executives of the NHSWG.

- Capacity building within the Northern Health Leadership Working Group (NHLWG) and the Northern Leadership Forum (NLF) participants as they come together to learn more about health issues and work on solutions such as creating healthy public policy.

By reaching these objectives, the NHSWG aims to produce four main outcomes through its *Building on the Momentum* project[2]:

a) An ongoing effective multi-jurisdictional decision-making process.

b) Specific service program improvements in priority sectors (increased access to dental services for northern residents; multi-party healthcare training program for northerners; increase in breastfeeding).

c) Analysis and advocacy to effectively address inter-jurisdictional issues and common services issues that are not currently known but which can be expected to arise;

d) Supporting and promoting related projects where smaller groups of partners are taking the lead.

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[1] Northern Health Strategy. (undated). Northern Health Strategy: Building the Momentum. An *Aboriginal Health Transition Fund Integration Project Proposal,* submitted by Northern Health Strategy.
   [2] Ibid.

In continuing its efforts to improve equal access to healthcare among northerners, the NHS and its various components work to build cross-jurisdictional partnerships and foster cooperative decision-making within those relationships.

In autumn of 2009, the NHS issued an internal report which outlined the future aspirations of the organizations. Within that report, four broad themes were used to summarize the future directions of the NHS. These include (a) support progressive health service programs and services; (b) develop quality improvement; (c) build capacity and (d) improve coordination, communication and advocacy.

Evaluation Questions

The following questions guided the evaluation plan. Each question is addressed specifically within the findings section of this final report; however references to these questions are also made throughout other sections of the report.

1) How are cross-jurisdictional partnerships being promoted?

2) Where are cross-jurisdictional partnerships forming?

3) What are some of the successes and challenges concerning cross-jurisdictional partnerships?

4) How are decisions made within this cross-jurisdictional process?

5) How are cross-jurisdictional relations being enforced?

6) How is information and knowledge shared within these partnerships?

7) How is information from various components of the NHS being shared with northern communities?

8) What direction should cross-jurisdictional partnerships and decision-making be headed in the long-term? Short-term?

9) Are the partnerships formed through the NHS sustainable?

10) What process do the TACs use to communicate, make decisions, and accomplish their objectives?

11) What progress are the TACs making towards accomplishing their goals and objectives?

12) What impact have the TACs made on the delivery of healthcare in the North?

Methodology

The main objectives of this review are addressed through data collected from interviews, focus groups, observation and documents. In total, 888 documents were reviewed, 36 respondents were interviewed, 3 meetings were observed and 2 focus groups were facilitated—one with members of the Northern Chronic Care Coalition (NCCC) and one with members of the Perinatal and Infant Health Technical Advisory Committee (PIHTAC). Respondents interviewed for this evaluation came from the NHLF, NHLWG, NHSWG, NCCC, PIHTAC, Northern Oral Health Working Group (NOHWG), Northern Health Sector Training Sub-committee (NHSTSC) and Mental Health and Addictions Technical Advisory Committee (MHATAC).

Data Analysis

Northern Leadership Forum

Data collected on the NLF indicate the NHS is a strong advocate for northern communities. Findings also suggest that the NHS is effective at bringing northern communities together to work on initiatives and has been successful in encouraging communities to work with the existing resources within their community to build better capacity to address important issues. Closing commentary offered by one interview respondent was that the NHS should continue with what it already does: "the NHS needs to be used as a vehicle to face the many issues in the North. It needs to keep being an agency that pulls all the other agencies together to work on issues. It is a well-respected organization".

Northern Health Leadership Working Group

Interviews with members of the Northern Health Leadership Working Group suggest that there are numerous partnerships throughout the North that bridge cross-jurisdictional boundaries. The opportunity of forming a cross-jurisdictional partnership brings benefits to participants in terms of information-sharing, collaboration and the rewards that come with collectively solving a shared problem.

Once partnerships are formed, the effectiveness of those cross-jurisdictional relations depends upon parity among group members in terms of commitment to the partnership, contributions to the partnership and a common understanding of roles and expectations of participants to the partnership process.

Decision-making within partnerships requires common understandings of a given problem, effective communication and proper information. Barriers to decision-making vary considerably and can stem sources that are internal as well as external to the partnership.

Once decisions are made within the NHS, information is communicated to a wide audience through a number of modes. Success of the ensuing implementation process is dependent upon each partner carrying out their part in the initiative.

Observations of a NHLWG meeting, as well as closing comments during interviews with working group members, indicate that the NHS should be sustained. The ultimate success of too many cross-jurisdictional partnerships and their collective decision-making processes is dependent upon the Northern Health Strategy and the facilitating role it plays in these processes. Most importantly, the NHS serves as a central venue of communication among care providers. Due to a lack of continuity in the leadership of communities and health care agencies in the North, a continuous means to communicate with other health care providers is critical.

Northern Health Strategy Working Group

Respondents from the Northern Health Strategy Working Group pointed out significant cross-jurisdictional partnerships in the North. Effective and meaningful cross-jurisdictional partnerships are propelled by mutual respect and trust, clear role expectations, and a shared understanding of problems and their solutions. According to several respondents, the uniqueness of Northern Saskatchewan provides a natural environment for partnership formation. To several, cross-jurisdictional partnerships are a practical necessity considering the many barriers to health care in the North. Interview data reveal that the processes of partnership formation are not easy. There are many hurdles a partnership must pass before it becomes both sustainable and effective.

Decision-making within the NHSWG, like most other entities of the NHS, is consensus-based. Interview participants were quite detailed in their descriptions of the determinants of successful and unsuccessful attempts at cross-jurisdictional decision-making. One key component is proper communications. Another is a shared perspective of the goals of the decisions as well as the benefits that may flow to each partner agency.

As for the process of implementation, concessions within the decision-making process may be required. This will allow for a sharing of responsibilities and resources that is much needed in the partnership process.

Closing dialogue of respondents from the NHSWG suggest that the NHS should move forward with a greater effort to convince provincial and federal governments of two things. The first is that the various successes of the NHS merits further changes to the status quo health care system. The second is that funding should be extended because the NHS is working. The NHS is creating cross-jurisdictional partnerships and fostering effective

decision-making that is reducing barriers to health care delivery and improving access to services for people living in the North.

Northern Chronic Care Coalition

The role that technical advisory committees themselves play in cross-jurisdictional partnership formation and cooperative decision-making is effective. As described by members of the NCCC, the work of the TACs is clearly a catalyst of networking and knowledge transfer that has a positive impact on health care in the North. Within the area of chronic disease, considerable efforts have been made to improve client understanding of patient self-management and care provider use of clinical guidelines in both the management and prevention of chronic disease.

The main outcomes of the Northern Chronic Care Coalition are difficult to quantify. However as NCCC members admit, the long term gains of the NCCC are sure to come if these processes of communication, information sharing and agency networking continue.

Data provide a preliminary measure of NCCC progress more than they do change in health care delivery. Most importantly however, they serve as a measure of the extent to which the NCCC has helped foster the cross-jurisdictional partnerships and decision-making opportunities that lead to improved access to quality care for people living in the North.

Northern Oral Health Working Group

The Northern Oral Health Working Group has had multiple successes and considerable partner involvement. Decision-making within the committee was helped by the fact most group members not only shared the same vision for a committee goal, but identified the same means to achieve that goal. Of the main activities undertaken by the Northern Oral Health Working Group, provisions of ongoing professional training, networking and knowledge on best practices have had a positive impact on health care professionals. These include positive changes to services provided for pre-school children, and general services provided by dental therapists across the North. Of course the most significant triumph of this TAC has been the expansion of regular access to a dentist for adults in various parts of the North.

Northern Health Sector Training Subcommittee

The NHSTSC, which serves as the NHS human resources TAC, has solid internal relations that have been supported by past work opportunities of the membership. Barriers to the decision-making process are posed by jurisdictional matters that produce differences in job pay across the same profession. Another restraint to decision-making is the lack of

autonomy some members have to make their own decisions while the matter is on the table. Progress of the human resources TAC is marked by awareness that has been raised collectively by multiple groups. Awareness of issues within health human resources is possible because of the large mutual effort to include all of the relevant stakeholders in the North. The biggest feat of the sub-committee is its movement towards establishing a multi-year multi-partner agreement that brings training to the North which also happens to be relevant to the North.

Mental Health and Addictions Technical Advisory Committee

Interviews with members of the MHATAC reveal there to be some longstanding disparities between ideology, preferred practices, and even vision. For quite some time members of the TAC found it difficult to move forward because of the divide within not only their committee but their profession. Strong leadership shown by the NHS coordinator and TAC coordinator helped break down some of the internal barriers to change so that committee members could work together more effectively. The major output of this committee has been the Northern Saskatchewan Suicide Forum; which according to some respondents was a must-do event not only in terms of client need but agency expectation. Many different types of barriers have thwarted the progress of the MHATAC. Some are internal while others stem from the systemic rigidity of the provincial, federal and regional health entities that carefully preserve the status quo in the delivery of mental health and addictions services.

Perinatal and Infant Health Technical Advisory Committee

Data collected on the PIHTAC reveal significant value in the progress achieved by this group. The multiple opportunities for training and knowledge sharing have benefited both health care providers in the North and South. Breaking down some of the barriers faced by new/expecting mothers both before and after delivery is important. Much of the work done by this TAC—according to participants—contributes to the dissolve of these barriers. Of course, as admitted by participants of the focus group and respondents to the interviews, considerable work still needs to be done. Finding a way to improve meeting attendance, attract continuous membership, secure sustainable funding and give committee members more decision making autonomy will definitely help advance the progress of this TAC.

Findings

The findings of this review process indicate that cross-jurisdictional partnerships are formed in northern Saskatchewan because of a shared need among healthcare providers to reduce barriers of equitable access to quality health care for all northerners. Barriers identified in this research include distance, language, culture, economy, capacity and knowledge. The largest barrier is the many administrative hurdles presented by jurisdictional differences among healthcare providers. Assisting in the process of partnership formation—and subsequently barrier removal—are the facilitating efforts of the Northern Health Strategy and its various components.

Decision-making within such partnerships is often possible because of a mutual understanding of the problem and preferred solutions. While most decision-making within NHS partnerships is consensus-based, cooperative efforts are often thwarted by misinterpreted role expectations, a lack of decision-making autonomy among partner representatives and variation in the stages in which each partner agency is at concerning its own deliberation of a given issue or initiative.

The combined progress of all five TACs explored in this review can be marked by three main developments: (a) levels of raised awareness; (b) increased specialization and knowledge transfer; and (c) networking in areas where there was next to none previously. While many of the TACs share similar experiences in their endeavours, each has also experienced its own unique set of successes and challenges. The main impact of the TAC process has been expanded service capacity of care providers in the North. Training sessions, knowledge transfer and networking have all been used as tools to increase the quality of care that patients receive from their caregivers in the North.

Recommendations

Based on findings presented in the report, the following recommendations to the Northern Health Strategy are proposed:

a) ***Reduce travel barriers to working group and committee meetings by hosting them in the North.*** As identified through interviews and observation, many participants of the NHS have heavy workloads at their home agency. Selecting a northern meeting location may help some participants find time in their schedule to attend NHS meetings.

b) ***Improve role definition processes within the TACs.*** Findings of this report reveal that several TAC members were not clear of the role they were to play in the committee. Furthermore, confusion and conflict has occurred when committee or working group leaders place expectations upon NHS participants who are unaware of their obligations to the NHS process.

c) *Establish representation from jurisdictions not actively involved in the NHS process.* On several occasions, interview respondents from various components of the TAC reported that progress was thwarted by vacant seats of partner agencies that had no representative. Working with partner agencies to make sure that they have representation within various components of the NHS will contribute towards more successful outcomes of the partnership process.

d) *Identify and implement a mechanism for improving meeting attendance*. Findings of this review indicate that there are several explanations for the poor, sporadic, or inconsistent attendance that stymies the efforts of NHS working group and committees (ie: travel barriers, NHS is low priority, busy schedule, participants don't feel their expertise is relevant). The NHS should endeavour to develop a mechanism for attendance improvement that addresses these multiple issues on a component-by-component basis (ie: NHLWG, NCCC, etc.).

e) *Discuss with NHS participants the utility of continuing to run committees or working groups with two leaders*. Interview data indicate that once TACs had a designated leader and coordinator in place they became much more task-oriented; and ultimately successful. However some respondents felt that at times the built-in efficiency of having a steady pair of committee leaders reduced the involvement of remaining committee members in the decision-making process. The NHS should examine this issue further.

f) *Design and implement a strategy which sees representatives from the NHS visit various communities to monitor and assist with TAC initiatives*. Interview data reveal that while most of the initiatives that TAC members embark upon are well received by northern communities, variation in capacity and understanding prevent uniform implementation of these initiatives.

g) *Encourage each TAC to host special-topic forums that are initiative-driven.* The successes of past forums held by TACs (ie: perinatal forum, suicide prevention forum) suggest that similar events hosted by other TACs may generate several benefits: (a) increased capacity of care providers; (b) more involvement of northern care providers and stakeholders in TAC initiatives; and (c) increased understanding of the NHS and its various objectives.

h) *Utilize communication technologies already in place at many healthcare agencies.* One of the more significant barriers to meeting participation was travel and time restraints. The use of Telehealth may increase participant involvement without sacrificing the human element of the TAC process (ie: visual and audio vs. audio only). If Telehealth capabilities are not in place the use of conference calling could also improve meeting attendance*.*

i) *Work with leaders of partner agencies to generate a clearer understanding of what support is needed by TAC members during the implementation of certain initiatives.* Feedback from NHS participants suggests that although the leadership of partner agencies are aware of the TAC process, they may not have a clear understanding of ways in which

they can help in the implementation of TAC initiatives (or at the very least, ease some of the barriers stemming from within their own organization).

j) *Continue to communicate the message of the NHS with northern stakeholders, care providers and community leaders—including NHS achievements and aspirations.* Findings from this review indicate that although the NHS has been quite successful in sharing its ideas and strategies for reform, there are still many key players in the North who lack a clear understanding of what the NHS is.

k) *Build upon the recent successes of the Mental Health and Addictions TAC to streamline its method of operation and overall direction.* Past differences in professional understandings of the mental health and addiction field have had a negative impact on the MHATAC. However recent accomplishments have forced a reconciliation of the many differences that once troubled this committee. The NHS should identify the common ground upon which this reconciliation process occurred and build upon that strength to continue the committee's active engagement of its members.

l) *Identify the cost-savings attributable to the capacity-building and barrier-removal processes of the NHS.* There is much praise for the cross-jurisdictional partnerships facilitated by the NHS. However little is known about the actual costs to the various healthcare systems that are saved by the changes which have been implemented through this partnership process (ie: reduction of redundant services; increased capacity of local care providers).

m) *Work with the NHS partners to address the inefficiencies which occur when committee or working group members lack the autonomy to take part in decision-making.* The NHS brings together various agencies to identify common problems and solutions to these problems. Although partner agencies are committed to the process, many members of the TACs must still report back to their home agencies and confirm approval of a decision before they can contribute to the TAC decision-making process. This inefficiency in decision-making could be resolved if a more open understanding of the TAC process would occur among agency leaders.

FULL REPORT

1.0   INTRODUCTION

In December of 2008 the evaluation team—including representatives from the Northern Health Strategy (NHS) and Saskatchewan Population Health and Evaluation Research Unit (SPHERU)—met to discuss a review of the Northern Health Strategy's ongoing efforts to foster a cross-jurisdictional decision making process in the healthcare services provided to northern people in Saskatchewan. The Northern Health Leadership Working Group (NHLWG) and the Northern Health Strategy Working Group (NHSWG) are two major components of this process that this particular review examines. Receiving action recommendations directly from the latter of these two components are seven different Technical Advisory Committees (TACs). These committees are responsible for advancing initiatives in the areas of chronic disease management, mental health and addictions, oral health, perinatal and infant health, human resources, emergency preparedness and community development. Of these seven, the first five were chosen by NHS to be included in this evaluation.

The overall purpose of this review is twofold: (a) to evaluate the progress made toward the ongoing effective multi-jurisdictional partnerships and decision-making processes; and (b) to evaluate progress in specific areas of work undertaken by the NHS Technical Advisory Committees. To satisfy the needs of this review, considerable attention is given to 5 main evaluation objectives:

- Identify and describe the process used to promote cross-jurisdictional partnerships among partners of the NHSWG.
- Identify and assess aspects of the cross-jurisdictional partnerships that are working successfully; as well as those aspects that are challenging.
- Identify and assess the cross-jurisdictional decision-making process.
- Document the ongoing partnership development and progress towards the specific activities identified for the TACs.
- Provide an assessment of the change in health service delivery in selected areas of the project.

Over the course of a year and a half, members of the review team worked to complete an evaluation plan that includes document analysis, focus groups, observations and interviews with participants of the NHS. The findings of that process are presented within this report.

The opening section of this report introduces readers to the main objectives of the NHS, including its purpose and guiding goals. In that section, logic models are used to complement and highlight the main structural features of the NHS main components. Following an overview of the NHS is a review of literature that is used to identify the methods and findings of other evaluators who in the past have examined cross-jurisdictional decisions-making and

partnership formation. The methodology section of this report is preceded by an identification of the main questions guiding this review process. Within the methodology, descriptions of data collection processes prepare readers for a thorough analysis of the interview and focus group data collected for this report. A discussion of findings and key themes within the data is used to support several evidence-based recommendations proposed in the concluding section of this report.

2.0   BACKGROUND

In 2001, the Northern Health Strategy was formed to address issues related to health care access and delivery. One important factor is the complex jurisdictional environment that makes up the northern healthcare sector.

To begin the development of a strategy for dealing with these shared challenges, several executives and managers (or their representatives) from various agencies and organizations across Northern Saskatchewan signed a memorandum of understanding (MOU). This agreement paved the way for development of the Northern Health Strategy and the NHS Accord which was signed in February of 2002.

According to the NHS, the Northern Health Strategy Accord provided the following direction to partner agencies[3]:

Articulate a Northern Health Strategy and communicate it to others;

Facilitate the development and approval of a work plan which addresses immediate, short-term and long-term actions associated with the implementation of a Northern Health Strategy;

Develop partnerships/agreements between and among member organizations.

Partners to the NHS include agencies from Provincial, Federal and First Nations jurisdictions. Table 1 identifies the various partners to the NHS.

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[3] Northern Health Strategy. (undated). Northern Health Strategy: Building the Momentum. An *Aboriginal Health Transition Fund Integration Project Proposal,* submitted by Northern Health Strategy.

Table 1:
Northern Health Strategy Partners

Partner	Abbreviation	Jurisdiction
Lac La Ronge Indian Band	LLRIB	First Nations/Federal
Meadow Lake Tribal Council	MLTC	-
Peter Ballantyne Cree Nation	PBCN	-
Prince Albert Grand Council	PAGC	-
Northern Inter-Tribal Health Authority	NITHA	-
First Nations and Inuit Health (Health Canada)	FNIH	-
Kelsey Trail Regional Health Authority	KTRHA	Provincial
Keewatin Yatthe Regional Health Authority	KYRHA	-
Mamawetan Churchill River Regional Health Authority	MCRRHA	-
Population Health Unit	PHU	-
Saskatchewan Health	-	-
Northern Medical Services	NMS	-
Athabasca Health Authority	AHA	First Nations/ Federal/Provincial

By the spring of 2002 the Northern Health Strategy Working Group was formed. Its overall purpose was to "improve the health of the residents of northern Saskatchewan through a more holistic approach to health and health services, and by working together"[4].

As the NHS began to take shape, several concepts of holistic primary health care were identified as the governing principles of the NHS and its working group. These include collaboration; cooperation; a holistic 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. During its inaugural meeting of the NHSWG, a five-part mandate was designed to help fulfill the new mission of the NHS: "to work cooperatively to improve the health status of all residents in northern Saskatchewan"[5].

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.

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[4] Northern Health Strategy Working Group. Cited in Brown, S et. al. (2006). *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 to the Northern Health Strategy Working Group. Prince Albert, SK: Saskatchewan Population Health and Evaluation Research Unit.

[5] Northern Health Strategy. Ibid. p.8.

Develop partnerships while ensuring diversity.

Ensure equitable resource allocation.

Project Funding

The original source of funding for the NHS came out of the Primary Health Care Transition Fund. These funds allowed for the development of the NHS various components—including the Technical Advisory Committees and a comprehensive primary health care approach to health services delivery across the North. The second source of funding for the NHS came from the Aboriginal Health Transition Fund. These resources allowed the NHS to build on the planning and development of its former successes to implement strategies in its main priority areas.

Shared Paths for Northern Health Project

One of the first projects of the NHSWG was to utilize working relationships among partners of the membership to develop a primary healthcare approach that is comprehensive, accessible, coordinated, accountable and sustainable. Known as *Shared Paths for Northern Health*, this project intended to enhance the health status of all northerners by focusing on attainment of several objectives in the areas of community development and organization improvement.

To achieve these ends, the NHSWG developed, created and utilized various committees known as *Technical Advisory Committees*. These committees were made up of northern healthcare professionals and residents that represented different parts of the North. According to internal documentation provided by the NHS, the purposes of these TACs are to provide a forum for collective discussion, information sharing, strategizing, and action planning concerning all matters related to the specific areas of health; 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[6].

According to an evaluation of the Shared Paths project, "Through multi-disciplinary (representations 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)

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[6] Brown, S. et. al. (2006). *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 to the Northern Health Strategy Working Group. Prince Albert, SK: Saskatchewan Population Health and Evaluation Research Unit.

representations, the TACs identified shared needs throughout the North and worked towards equitable and practical access to health services for all northern residents"[7].

At the beginning, six TACs were originally planned for the areas of mental health and addictions, chronic disease, perinatal and infant health, oral health, information technology and health information management. In time, the efforts to create TACs for information technology and health information management were replaced by the desire to have TACs in emergency preparedness and community development. At the time of this review, five TACs are leading a majority of the work done by the NHS. The areas of these various TACs include mental health and addictions, chronic disease care, oral health, perinatal and infant health and human resources.

Cross-jurisdictional Decision-making Process for Northern Saskatchewan

A second initiative of the NHS was to develop a cross-jurisdictional decision-making process for northern Saskatchewan. To accomplish this task, researchers from the Manitoba First Nations' Centre for Aboriginal Health Research were contracted to document NHS participant experience, build upon participant vision and facilitate the development of northern solutions to northern problems.

The work of the Manitoba team led to the identification of different jurisdictional levels within northern health care. It also documented the many gaps in provincial-federal health care systems that warranted the need for a cross-jurisdictional decision-making process. After working with multiple partners involved in the NHS, and after observing the work of the NHSWG and its various TACs, researchers from the Centre for Aboriginal Health Research identified a central theme that permeated much of the work they had done for the NHS:

> *The test of seamlessness in the northern healthcare system will only be realized by improved communications, coordination and commitment. While current gaps in services may be addressed with clearer definitions and prudent wording, new gaps will continue to emerge over time as opportunities emerge, needs change and as long as federal and provincial governments continue to plan and operate autonomously. Coordination is the key to ensure that organizational decisions made in the context of defined mandates do not create duplication, gaps, undue hardship on northerners and yield an effective use of resources[8].*

The work of the Manitoba team, in conjunction with participants of the NHS, led to a decision-making mechanism that includes two additional entities: the Northern Leadership Forum (NLF) and the Northern Health Leadership Working Group (NHLWG). The former of these included

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[7] Ibid, p.5.
[8] Lavoie, J. (2006). *A Cross-Jurisdictional Decision-Making Process for Northern Saskatchewan, v.1 Findings, Analysis and Recommendations*. Winnipeg, MB: Manitoba First Nations – Centre for Aboriginal Health Research.

broad representation from chiefs and mayors while the latter includes representatives from each partner's health board of directors and/or management. The decision-making mechanism designed for the NHS has the NLF meet once or twice a year for information sharing while the NHLWG meets more often; with the NHLWG setting the broader parameters for the NHSWG and its various TACs to work within.

Building on the Momentum

The most recent task of the NHSWG was to continue the efforts it has made in previous years with new funding from the integration envelope of Health Canada's Aboriginal Health Transition Fund. The funded project was titled *Northern Health Strategy: Building on the Momentum*. This project serves as the main focal point of this evaluation report.

According to the project funding proposal, the overall objective of the NHS is to "work cooperatively and collaboratively to improve the health status of all Northern residents. The NHS will continue to focus its efforts on activities which result in better integrated and adapted services that improve access to quality programs and services in the North"[9].

Several other objectives also guide the NHSWG in its most recent undertakings:

Better adapted and integrated health services that improve access to quality programs and services throughout northern Saskatchewan.

Improved health status of residents of northern Saskatchewan.

Improved care and quality of life for residents living with chronic disease.

Improved access to dental services for residents.

Increased access to mental health and addictions services.

Increase awareness of value of breastfeeding and number of women doing so.

Integrated northern e-health strategy developed.

Health and social indicators for First Nations developed to monitor progress.

Improved recruitment and retention of health care providers.

Increased health promotion, access to health care, health provider education.

Develop and implement a health human resources planning model for northern Saskatchewan.

Increased information sharing, collaboration and strategic planning among CEOs and senior executives of the NHSWG.

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[9] Northern Health Strategy opt. cit. p.4.

Capacity building within the NHLWG and the NLF participants as they come together to learn more about health issues and work on solutions such as creating healthy public policy.

By reaching these objectives, the NHSWG aims to produce four main outcomes through its *Building on the Momentum* project[10]:

An ongoing effective multi-jurisdictional decision-making process.

Specific service program improvements in priority sectors (increased access to dental services for northern residents; multi-party healthcare training program for northerners; increase in breastfeeding).

Analysis and advocacy to effectively address inter-jurisdictional issues and common services issues that are not currently known but which can be expected to arise;

Supporting and promoting related projects where smaller groups of partners are taking the lead.

In continuing its efforts to improve equal access to healthcare among northerners, the NHS and its various components work to build cross-jurisdictional partnerships and foster cooperative decision-making within those relationships. The following sub-sections describe each of NHS various components in more detail.

2.1   Northern Leadership Forum

The Northern Leadership Forum is a gathering of mayors, First Nations chiefs, Métis leaders and other Northern leaders that meets to discuss issues that affect their communities. These forums also provide an important opportunity for the NHS to share its message about the importance of partnerships. Forum attendees are also informed of the multiple activities undertaken by the NHS and its various components.

2.2   Northern Health Leadership Working Group

According to documentation from the NHS, the NHLWG is a component of the NHS that is comprised of two representatives from each partner's board of directors. The group meets semi-annually to guide development and discuss issues or initiatives that are presented to them by the NHSWG. Federal and provincial representatives who act as witnesses to the

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[10] Ibid.

signatories of the NHS Memorandum of Understanding are invited to attend and participate in meetings of the NHLWG[11].

According to the group's statement of intent, the working group has two primary roles and responsibilities. These include "recommending and advising on northern health policy development to all levels of government, health agencies and organizations which may be deemed to have influence in the North's determinants of health. Additionally, the NHLWG is responsible for the overall development and implementation of NHS priorities and initiatives".

The major principle of decision-making within the NHLSWG is consensus. The group's statement of understanding describes consensus building as being the key to successfully addressing northern health concerns; legislation impacting member organizations; and issues emerging from federal and provincial policies. It is under this style of decision-making that the NHLWG has been able to move forward with its agenda of many priorities and initiatives:

Provide broad strategic advice on health development policy.

Provide relevant advice and direction on quality of healthcare delivery and the general performance of healthcare in the North.

Review and action health leadership priorities.

Provide insight to the NHS priorities and initiatives.

Offer strategic advice on communication of NHS development, initiatives and public health concern.

Review and approve contribution agreements with and from funding agencies.

Review and approve NHS budgets.

Review and approve NHSWG activities and work plans.

Organize and lead an annual Northern Health Leadership forum.

Ensure nurturing of the NHS partnership.

Provide efforts to link key stakeholders and community organizations.

Advocate strengthening of the northern health infrastructure and capacity.

Review and approve adjustments to NHS membership.

NHLWG co-chairs may from time to time be required to participate in the NHSWG meetings.

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[11] Northern Health Strategy. (2007). *Northern Health Leadership Working Group: Statement of Understanding*. Internal document of NHS.

2.3   Northern Health Strategy Working Group

The NHSWG, as aforementioned in this report, was the starting point for the NHS. Chief executive officers and directors of various health organizations, along with provincial and federal health representatives, were brought together to work on a strategy to help northern care providers and their communities reduce the many barriers to health care access caused by jurisdictional divides.

The role of the NHSWG is to prioritize jurisdictional issues and their solutions as they emerge or are identified. The work of the NHSWG is carried out through the use of its TACs and various consultants. An overview of the NHSWG's main activities and intended outcomes is provided in the following table[12].

Table 2:
Activities and Intended Outcomes of NHSWG

Activities	Intended Outcomes
- develop a NHS community development action plan - professional development of TACs - annual northern community development symposium - develop a community development contact data base - establish a community development information repository - integrate community development principles and philosophy into the health system - advance understanding of determinants of health and holistic health - emergency preparedness leadership - response to emerging issues - review health jurisdiction relationship instruments	*Immediate* - cross-jurisdictional collaborative approaches appreciated and strengthened - cultural competence improves - determinants of health emerge in northern consciousness - collaborative efforts move beyond health sector - community development local/regional gatherings planned *Mid and Long-term* - consistent community development local/regional gatherings - enhanced capacity to community self-determined development initiatives - community development champions contact base established - cross-sectoral strategies include considerations of health determinants - a northern health human resources strategy is developed - northern residents create northern community development networks and alliance

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[12] Information for this table was collected from internal documents provided by the NHS.

2.4   Northern Chronic Care Coalition

The Northern Chronic Care Coalition (NCCC) serves as the NHS technical advisory committee in the area of chronic disease. The Coalition is a network of representatives from NHS partner organizations who have a shared interest in working together to improve chronic disease management, prevention and screening in northern Saskatchewan. According to meeting notes provided by the NHS, there are several main purposes of the NCCC:

Launch chronic disease initiatives in the North

Provide a forum for networking between partner agencies to share knowledge, experiences and resources on chronic disease management

Bring a collective voice and advice to policy makers regarding best practices in chronic disease management and prevention in the North.

Coordinate the efforts of each of the partners to build upon their expertise and reduce duplication to maximize the resources of the North.

Additional documentation provided by the NHS indicates that there are several activities and intended outcomes of the NCCC. Table 3[13] summarizes these items.

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[13] Information for this table was collected from internal documents provided by the NHS.

Table 3:
Activities and Intended Outcomes of the NCCC

Activities	Intended Outcomes
- host meetings - expand committee memberships, alliances and network - created a chronic disease communications strategy - regional/local workshops and information sessions - create and utilize chronic disease management systems	*Immediate* - collaborative decision-making knowledge - stakeholder partnerships formalized - community driven initiatives and strategies - general CDM knowledge and implementation options/processes - growth in cultural competence/attitudes - development of chronic disease management processes - wider-community knowledge of chronic diseases and management and prevention processes - networking and alliances built - Coalition membership and contact data base grows *Mid and Long-term* - chronic disease management tools accepted and widely utilized - community and stakeholders develop and enhance health public policy - NCCC membership grows - CDNAP expands specialized services to and in communities - HQC models northern and aboriginal success in chronic disease management - community capacity and supports developed

2.5   Northern Oral Health Working Group

The accessibility to consistent dentist services has been a problem in northern Saskatchewan. In 2003, the Northern Oral Health Working Group (NOHWG) was established with the objective of improving the oral health status of residents of northern Saskatchewan through treatment, prevention and health promotion services delivered by dental team members—including dentists.

During its development, a workshop was held to identify dental needs in the North—and subsequently the main direction of the NOHWG. In response to these needs the TAC narrowed its concentration on four priority areas: (a) improve access to dentist services for northern residents; (b) lead a northern oral health needs assessment; (c) develop effective oral health information management systems; and (d) promotion and prevention. To develop these priority areas, the NOHWG has identified several activities and intended outcomes that guide its actions[14], as outlined in Table 4[15].

Table 4:
Activities and Intended Outcomes of the Northern Oral Health Working Group

Activities	Intended Outcomes
- improve access to dentist services - conduct northern oral health needs assessment - integrate oral health practices into primary health care - develop communications strategy to further efforts in oral health promotion and prevention - aid oral health promotion and prevention through development of resource material - professional development in key priority areas	*Immediate* - collaborative decision-making knowledge - needs assessment framework and funding proposal - professional development - promotion and prevention initiatives - enhanced framework for oral health communications strategy *Mid and Long-term* - northern oral health professional development symposium - enlightens providers and residents of the importance of oral health and its relationship to overall health - residents are much more knowledgeable about oral health and oral health services - promotion and prevention materials being used in schools and by families - oral needs assessment provides quantitative/qualitative materials from which oral health strategies are developed - consistent dentist services are provided across northern Saskatchewan

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[14] These priority areas were identified by an internal document authored by the NHS.
[15] Information for this table was collected from internal documents provided by the NHS.

2.6   Northern Health Sector Training Sub-Committee

The difficulty to attract and retain skilled healthcare workers is an issue all too common in northern Saskatchewan. The development of a Human Resources TAC enabled the NHS to begin finding ways to minimize this hardship on healthcare agencies across the North. In an attempt to formulate an effective committee, the NHS teamed up with Northlands College to co-chair the *Northern Health Sector Training Sub-committee*; which is housed within the Northern Labour Market Committee. This entity serves as the Human Resources TAC for the NHS. The main activities and intended outcomes of the Northern Health Sector Training Sub-committee are summarized in Table 5[16].

Table 5:
Activities and Intended Outcomes of the Human Resources TAC

Activities	Intended Outcomes
- TAC meetings - NHS and Northern Labour Market Committee Co-chair the Northern Health Sector Training Sub-committee - Efforts to evolve northern health human resources multi-party multi-year training agreement - development and circulation of career development information and materials	*Immediate* - appreciation, recognition and strengthening of cross-jurisdictional collaborative approaches - analysis of gaps in health human resources - develop northern health human resources model to achieve Northern Health Human Resource Strategy - recruitment and retention materials distributed at northern schools *Mid and Long-term* - training targets are met; enabled by multi-party training agreement - northern young people hold health careers as a valid option - progressive and effective recruitment and retention policies - implantation of a Northern Health Human Resource Strategy

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[16] Information for this table was collected from internal documents provided by the NHS.

2.7   Mental Health and Addictions Technical Advisory Committee

The links between health outcomes and suicide, drug and alcohol usage, and trauma related to residential school abuse are but a few of the reasons why the NHS identified a need to promote long-term prevention and healing programs in the North. The Mental Health and Addictions Technical Advisory Committee (MHATAC) of the NHS was developed to meet this need.

In 2006, the MHATAC developed a statement of services, standards and recommendations to serve as the TAC's foundation for self-development. Several components make up this TACs core vision:

For all sectors of the system to work together so that:

> Optimal capacity is developed in the natural informal caring network at the community level so that people may help themselves and each other.

> Community workers are able, with training, consultation and support from others; to meet the needs of most members of their communities most of the time.

> Community members who need trained help are referred between levels of the system to receive the best support possible.

> Resources from outside of the communities support the workers within the communities: a) by recognizing and relating to them as team members; b) by providing them with training and consultation; c) by offering professional help for community members when required; and d) by sharing information which is appropriate between members of the team.

While this TAC's vision provides direction for the group to navigate the broad issue areas of mental health and addictions, there were several priorities which dominated the TAC's agenda:

> Delivering specialized services that are culturally competent and inclusive while exploring multiple models (alternate and existing) that incorporate a community continuum of care.

> Facilitate community development that enables, supports and works with communities to facilitate their own action plans.

> To maximize the delivery and effectiveness of specialized services by using the services roadmap. Such a mechanism shall provide a clear description of who offers what services, when, how (protocols), and to whom in each community – local, regional, provincial, and federal. It shall target both the service providers and the clients. It must link client needs to available services while at the same time acting as a tool that facilitates other priority items including: partnership and collaboration, specialized services, and community development.

The main priorities of the MHATAC are present in the summary of this committee's logic model as described in Table 6[17].

Table 6:
Activities and Intended Outcomes of the Mental Health and Addictions TAC

Activities	Intended Outcomes
- TAC meetings - review delivery model options - develop a specialist advisory committee - develop a cross-jurisdictional services roadmap - create options for community support and development - hold regional workshops and information sessions - enhance expert diagnostics and specialist services in northern region - pursue technology in some treatment areas - develop public education of issues pertaining to mental health and addictions	*Immediate* - collaborative decision-making knowledge - specialist advisory committee - mental health and addictions delivery model - stakeholder partnerships formalized and strengthened - engages and enhances regional health provider teamwork - growth in cultural competence and attitudes - wider community engagement in creating community support *Mid and Long-term* - services roadmap developed and updated - community support developed for mental health and addictions stakeholders - improvement of expert diagnostics and specialist services in northern region - increased public awareness of mental health and addictions issues and initiatives - mental health and addictions model for the North

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[17] Information for this table was collected from internal documents provided by the NHS.

2.8   Perinatal and Infant Health Technical Advisory Committee

The Perinatal and Infant Health Technical Advisory Committee (PINHTAC) was developed to serve as a forum for collective discussion, information sharing and action planning on issues pertaining to perinatal and infant health. The need for the committee came in response to the many gaps in service for expectant and new mothers. Many women from the North must temporarily relocate prior to their expected delivery. Most often, there are insufficient supports set up for these women and poor communication between healthcare providers who care for the patient. Other concerns which this TAC was designed to address were the low breastfeeding rates in the North. This issue required a need for considerable training and education for both healthcare workers and the general public. The activities and outcomes of the PIHTAC are described in Table 7[18].

Table 7:
Activities and Intended Outcomes of the Perinatal and Infant Health TAC

Activities	Intended Outcomes
- TAC meetings - revive northern breastfeeding initiative - secure funding for northern lactation consultant facilitator - annual perinatal and birthing issue forum - influence increased baby friendly environments - professional development in key priority areas including community development	*Immediate* - collaborative decision-making knowledge - needs assessment framework and funding proposal - professional development - dialogue and discussions of perinatal/infant health issues and solutions continue to strengthen - enhanced framework for communication strategy *Mid and Long-term* - perinatal and infant health issues gain more prominence in communities, organizations, families and residents - residents are much more knowledgeable about the merits and benefits of breast feeding, more mothers are breastfeeding - promotional materials are developed and used by families - increased understanding of northern birthing issues by southern healthcare providers - infant health celebrated - annualized funding for effective support for lactation courses

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[18] Information for this table was collected from internal documents provided by the NHS.

2.9   Future Ambitions

In the autumn of 2009, the Northern Health Strategy issued an internal report titled *The Northern Health Strategy: The Future*. The report stated that the NHS was enabling stronger relationships with northern residents, northern leaders, the NHS partners and federal and Saskatchewan governments and would continue to fulfill its mission to improve the health of northerners through four main strategic directions. Below is a summary of NHS future aspirations.

a) *Support Progressive Health Service Programs and Services:* strengthen the chronic disease prevention and management effort of the NCCC; explore strategies for health protection, health promotion and disease prevention initiatives; examine alternatives for electronic oral health records that are interoperable across different jurisdictions; continue efforts to expand the dentist access initiative; build strategies for health promotion and disease prevention in oral health; and provide ongoing training for labour assistants.

Quality Improvement: work with the Health Quality Council to improve quality in healthcare; develop and monitor quality indicators for northern health services to strengthen awareness and quality by both providers and users; lead patient experience information gathering in the North to follow up the provincial *Patient First Review* report.

Capacity Building: work to implement the Northern Health Human Resources Training Strategy, which aims to prepare 365 northern health workers over 5 years; provide partners with ongoing professional development, community education and knowledge building; work on more equitable funding formulas that recognize the high health needs and long distances of the North; carry out community development work to engage northern communities in community strategies to improve health; engage think thanks and partners in discussion of strategies that respond to new and emerging issues; develop and explore options of health career promotion among northerners; strengthen northern awareness of the importance of math and science in school; implement a northern suicide prevention strategy; and arrange for advanced training for emergency preparedness for the health sector.

Improved Coordination, Communication and Advocacy: strengthen NHS relations with Métis organizations; work on building referral and planning relationships with southern healthcare organizations; develop a northern transportation task force to address issues surrounding medical transportation; continue to serve as an information hub for agencies that wish to work with the northern healthcare system; carry out a northern long-term care needs assessment and strategy development; enhance cultural competence and northern relevance in programs, new initiatives and services; lead discussions and frame policy discussions around traditional medicine; and develop accountability through an elected leadership forum.

3.0   LITERATURE REVIEW

The evaluation of a project of this nature can benefit from some familiarity with the literature on cross-jurisdictional decision making, intra-agency partnerships, and collaboration among agencies from different levels of practice. A brief review revealed a number of publications and other documents that were of use to the evaluators in the research design and data analysis portions of this review process.

Table 8 provides an overview of the most relevant documents found in the literature on cross-jurisdictional decision-making and partnership formation. As the far left column of the table shows, there are different types of documents that lend themselves to this evaluation. While some documents mentioned in Table 8 present original research, others provide illustrations of cross-jurisdictional decision-making, models for forming organizational partnerships, and evaluations of collaborative projects. As shown, there are a limited number of documents which describe such issues within the context of healthcare for Aboriginal or Northern people.

It is important to recognize that this literature review was not completed with the intent of comparing the NHS to different organizations or initiatives. Instead, the intent of this search was to identify the most relevant and up-to-date information on methods, themes and challenges that appear in reviews of cross-jurisdictional initiatives.

Table 8:
Literature Review Matrix

TYPE	REFERENCE	RELEVANCE
research	Minore, B., and Hopkins, H. (2003). *Suicide Response Plans: A Comparative Cross-Jurisdictional Analysis*. Lakehead University: Centre of Excellence for Children and Adolescents with Special Needs	The report examines how suicide response efforts were arranged to coordinate the delivery of care from among the existing health resources in a community. Some of the programs looked at establishing system-wide protocols between the networks of agencies serving a geographic area. The paper looks at the debate over whether a national strategy should be implemented and how partnerships should be formed [communication with the author revealed that while interviews were completed in preparation of this paper, no instruments could be found].
partnership	Martin, B. (2005). Kansas City Cross Jurisdictional Partnership. Kansas City, MS: Kansas City Missouri Health Department.	This source describes several partnerships between health and law enforcement agencies that formed under the guise of public health emergency preparedness [communication with agency staff revealed no further documentation on this].

TYPE	REFERENCE	RELEVANCE
partnership	South Australian Aboriginal Health Partnership. (2006). Aboriginal Health: Everybody's Business' Regional Resource Package. Aidelaide, South Australia: Australian Ministry of Health. Retrieved January 20, 2009 from www.health.sa.gov.au	The Aboriginal Health Partnership in Australia focuses on cross-jurisdictional efforts to develop cross-sector strategic directions in areas of diabetes, social well-being, substance misuse, health information sharing, and workforce development. It includes agencies from the state, regional, organizational and community level. The goal is to establish cross-jurisdictional cooperation that will lead to increased pathways to access, proper self management, better trained workers and an increased flow of information between care providers [communication with ministerial representatives has so far failed in an attempt to find further information].
partnership	Public Health and Law Enforcement Emergency Preparedness Workgroup (2008). A Framework for Improving Cross-Sector Coordination for Emergency Preparedness and Response: Action Steps for Public Health, Law Enforcement, the Judiciary and Corrections. Washington, DC: Centers for Disease Control and Prevention.	Report describes intricate partnership between the U.S. Department of Justice and the CDC's Public Health Law Program on issues related to bioterrorism, influenza pandemics and other infectious disease threats. Of particular relevance to this evaluation is that the CDC report explains the many different elements necessary for establishing a working group and what functions each partner fulfills in the initiative.
evaluation	Feldmen, P, et al. (2007). Home Health Aide (HHA) Partnering Collaborative Evaluation: Final Report. New York. NY: Center for Home Care Policy and Research Visiting Nurse Service of New York.	The collaborative project was designed to improve the quality of work life and retention of home care paraprofessionals as well as increase clinician and aid support for patient self-management. The methodology included a job perceptions survey, observations, document review, collection of human resources and administrative data, and an outcomes information dataset. Reviewers looked at multivariate analyses on the quantitative data.
research	Fuller, J., et al., (2005). Sustaining an Aboriginal Mental Health Service Partnership. In Medical Journal of Australia-Supplement, v.183, n.10, pp.s69-s72.	Article examines an Aboriginal mental health services partnership. It focuses mainly on the drivers of the program (longstanding problems with aboriginal peoples' access to mental health care), linkage processes (formal agreements, common care management tools, training) and the program's sustainability. The methodology of this case study included a Medline search of articles, tape-recorded interviews and two case vignettes used in a workshop.
evaluation	Dobson, I. (2003). Aboriginal Youth Mental Health Partnership Project: Evaluation Report. South Australia: Aboriginal Youth Mental Health Partnership Project.	This partnership project was aimed at Aboriginal young people who are at-risk of involvement in the juvenile justice system. The purpose of the evaluation is to assess the overall effectiveness of the program in achieving its objectives. One objective quite relevant to the current evaluation is the involvement of agencies participating in the project and their attempts to collaborate effectively in responding to the social and emotional wellbeing of Aboriginal young people. The methods used in this review include stakeholder focus groups, individual interviews concerning the overall impression of the project, and additional interviews later in the evaluation process on specific topics.

TYPE	REFERENCE	RELEVANCE
partnership	Bullard, C. (2008). Improving Cross-Sectoral and Cross-jurisdictional Coordination for Public Health Emergency Legal Preparedness. In Journal of Law, Medicine and Ethics, v.36, supp.1, pp.57-53.	Article discusses options for improving cross-sectoral and cross-jurisdictional coordination for public health emergency preparedness. In particular, it identifies that special efforts should be made to coordinate tribal public health with other entities involved in the partnership.
research	Bazzoli, G. (1997). Public-Private Collaboration in Health and Human Service Delivery: Evidence from Community Partnerships. In Milbank Quarterly, v.75, n.4, pp.533-561	Article examines the dynamics of public-private relationships in health and explores various ways to explain these interactions. This research may be useful to the current review in that a similar independence exists between provincial and First Nations health agencies and private and public health agencies.
models	Halverson, P. (1997). Not-so-Strange Bedfellows: Models of Interaction between Managed Care Plans and Public Health Agencies. In Milbank Quarterly, v.75, n.1, pp.113-138.	A theoretical article that introduces different models of health partnerships.
partnership	Partnerships for Health. (2009). Collaborating for Better Diabetes Care: Questions and Answers. Retrieved February 23, 2009 from www.partnershipsforhealth.ca	Website discusses how the Partnerships for Health Initiative in Ontario focuses on integrating various components of the healthcare system by sharing information across a continuum of care. Purpose is to develop chronic disease prevention and management. The methodology of this evaluation includes patient interviews, provider surveys and chart audits [project is underway, evaluation not yet available]
models	Eilbert, K. (2004). A Community Health Partnership Model to Improve Planning and Evaluation of Collaborative Public Health Practice. In Academy Health Meeting, v.21, abstract no. 1561.	Paper introduces a community health planning model that uses open systems theory and institutional theory to identify forms of affiliation and problems that need to be addressed within public health partnerships.

4.0   EVALUATION QUESTIONS

The broader objectives of this evaluation are essentially to identify the process of partnership formation, describe successes and challenges of that process, describe the decision-making process within various components of the NHS, report on the progress of five main TACs and assess the impact of such progress on change in health care delivery.

The following questions guided the evaluation plan. Each question is addressed specifically within the findings section of this final report; however references to these questions are also made throughout other sections of the report.

How are cross-jurisdictional partnerships being promoted?

Where are cross-jurisdictional partnerships forming?

What are some of the successes and challenges concerning cross-jurisdictional partnerships?

How are decisions made within this cross-jurisdictional partnership process?

How are cross-jurisdictional relations being enforced?

How is information and knowledge shared within these partnerships?

How is information from various components of the NHS being shared with northern communities?

What direction should cross-jurisdictional partnerships and decision-making be headed in the long-term? Short-term?

Are the partnerships formed through the NHS sustainable?

What process do the TACs use to communicate, make decisions, and accomplish their objectives?

What progress are the TACs making towards accomplishing their goals and objectives?

What impact have the TACs made on the delivery of healthcare in the North?

5.0   METHODS

The main objectives of this review are addressed through data collected from interviews, focus groups, observation and documents. An effort was made by evaluators to collect data from enough sources to allow for triangulation of the findings produced by each analysis. Although very useful findings came from analysis of the data collected through focus groups, observation and documentation, the dialogue of interview respondents proved to be the richest source of data used in this evaluation. As such, while findings from all three types of analysis are used to build the recommendations of this report, findings from the analysis of interview data were relied upon the most.

To illustrate the use of these data—in addition to their sources and indicators—two separate evaluation matrices outline the main activities of this evaluation. Table 9 identifies data collection information for partnership formation and decision-making; Table 10 displays similar information for identifying TAC progress and development.

Table 9:
Evaluation Matrix: Cross-Jurisdictional Partnerships & Decision Making Processes

OBJECTIVES	QUESTIONS	INDICATORS	SOURCES	METHODS
Identify and describe the process used to promote cross jurisdictional partnerships. Identify and assess aspects of the cross jurisdictional partnerships that are successful as well as those aspects that are challenging. Identify and assess the cross-jurisdictional decision making process	- How are cross-jurisdictional partnerships being promoted? - Where are cross-jurisdictional partnerships forming? - What are some of the successes and challenges concerning cross-jurisdictional partnerships? - How are decisions made within this cross-jurisdictional process? - How are cross-jurisdictional relations being enforced? - What direction should these partnerships be headed in the long run? The short run? - How is information from NHS shared with northern communities?	- agreements - terms of reference - initiatives - communication - announcements - joint ventures - structural changes - shifts in knowledge - challenges overcome - policies - decisions - group discussion	- final reports - monthly reports - email correspondence - meeting minutes - work plans - logic models - media releases - proposals - NHS staff - NHSWG members - NHLWG members - TAC members - partners to NHS	- semi-structured interviews - document analysis - focus groups - observation - ongoing communication with NHS staff

Table 10:
Evaluation Matrix: Progress and Development of Technical Advisory Committees

OBJECTIVES	QUESTIONS	INDICATORS	SOURCES	METHODS
Document the ongoing partnership development and progress toward the specific activities identified for the Technical Advisory Committees Provide an assessment of the change in health service delivery in the project areas (i.e., mental health and addictions, chronic disease, perinatal and infant health, oral health).	- What process do the TACs use to communicate, make decisions and accomplish their objectives? - What progress are the TACs making towards achieving their intended goals and objectives? - What impact have the TACs made on the delivery of healthcare in the North? - What challenges have the TACs faced in their endeavours?	- initiatives - communication - announcement - common approach for chronic disease management - patient self management program - implementation of a dental service plan - common oral health education plans and policies - support for breastfeeding strategy across the north - perinatal forum - promotional material - partnerships - intersectoral approaches	- final reports - monthly reports - email correspondence - meeting minutes - work plans - logic models - media releases - proposals - NHS staff - NHSWG members - TAC members - partners to NHS	- semi-structured interviews - document analysis - focus groups - observation - ongoing communication with NHS staff

5.1   Document Analysis

The compilation of document data from the NHS was a gradual process. Between January of 2009 and March of 2010, 888 documents were received and organized by type. The different files were grouped into seven types of documents: logic models, communication with funders, evaluation requirements, Northern Health Leadership Forum, Northern Health Leadership Working Group, Northern Health Strategy Working Group, and Technical Advisory Committees (see Table 11). The number in parentheses after each document category indicates the number of documents found in each category. As expected, there are noticeably more documents for the TACs.

Table 11:
Categories of NHS Documents

Category	Number of Documents
communication with funder	11
northern health leadership forum	1
northern health strategy working group	14
logic models	8
evaluation requirements	3
northern health leadership working group	6
technical advisory committees	845

The 845 documents on TACs were subdivided into additional subcategories. These include 8 subcategories, two of which had substantially more documents available than the other subcategories. The two most prevalent types of documents in the TACs folders were on chronic disease (particularly the Northern Chronic Care Coalition) and human resource development (particularly the Northern Health Sector Training Sub-committee). Table 12 summarizes the content of these TAC subcategories.

Table 12:
Subcategories of Technical Advisory Committee Documents

Category	Number of Documents
basic emergency management	12
community development	0
mental health and addictions	17
perinatal and infant health care	31
chronic disease	52
oral health	6
human resources	732
committee member phone numbers	1

As documents were submitted, each was grouped into the existing categories unless they require the development of a new category. All of the documents fit into the categories and subcategories listed in Tables 11 and 12. Appendix F provides a comprehensive overview of all documents and folders provided by NHS staff.

For the most part, analyses of the documents provide information on the history, development and progress of each component within the NHS.

5.2   Interviews

As previously noted, the more robust findings of this review stem from interviews with participants of the NHS. Between July of 2009 and March of 2010, evaluators used email and telephone calls to contact 78 potential respondents. In total, 36 individuals responded to the request and were eventually interviewed via telephone or in-person. No one contacted through this review process actually declined to be interviewed. Table 13 provides a glimpse at the respondent sample.

Table 13:
Respondent List*

Key Interviews	TAC Interviews
NHSWG (8 interviewed, 13 contacted)	Mental Health & Addictions (5 interviewed, 6 contacted)
NHLWG (5 interviewed, 5 contacted)	Northern Chronic Care Coalition (4 interviewed, 8 contacted)
NLF (2 interviewed, 17 contacted)	Oral Health Working Group (4 interviewed, 11 contacted)
	Perinatal Infant Health (5 interviewed, 9 contacted)
	Human Resources (3 interviewed, 9 contacted)
	_N_ = 36

* Respondents *contacted* include all those who were left telephone and email messages—including those interviewed. No respondents refused to be interviewed. Interviews were arranged with respondents who returned calls and emails.

Once a respondent agreed to take part in the evaluation process they were provided with a letter describing the interview process (Appendices A and B) as well as a form for informed consent (Appendix C). At the time of the interview, respondents were asked to confirm whether the interviewer has consent to audio-tape the interview. They were also reminded of the anonymity and confidentiality of their responses. With three exceptions, all interviews were conducted over the telephone. The average interview lasted around 30 minutes. Recordings of the interviews were transcribed and maintained within the possession of SPHERU.

The questions asked of each respondent were designed to solicit discussion on topics pertaining to cross-jurisdictional partnership formation, decision-making processes and NHS progress. Key respondents (*N* = 15) belonging to the Northern Health Strategy Working Group, Northern Health Leadership Working Group and Northern Leadership Forum were asked questions that were guided by an 11-item instrument (Appendix D).

Similarly, members of the Technical Advisory Committees (*N* = 21)—Northern Chronic Care Coalition, Perinatal Infant Health, Oral Health Working Group, Human Resources (Northern Health Sector Training Sub-Committee) and Mental Health and Addictions—were asked different questions that appear on an 11-item instrument (Appendix E).

The first two questions on the key respondent instrument inquired about the interviewee's position within their group and how long they had been involved with the NHS. Answers to

these questions were used to gauge the experience and context in which further answers to the questionnaire were provided.

The next three questions asked key respondents about their understanding of cross-jurisdictional partnerships—whether they know of any, how they thought cross-jurisdictional partnerships are promoted and how they actually operate. The fourth and fifth questions asked of key respondents solicited discussion on cross-jurisdictional decision-making and the various factors that contribute to successful and unsuccessful attempts at making collective decisions within a partnership. The next pair of questions invited respondents to explain how decisions of various components within the NHS are communicated beyond the NHS; and how these decisions are actually implemented. The final substantive question asked of interview participants is "what direction do you think the partnerships and collective decision-making built within the NHS should be headed in the future?" The interview closed with a request for respondents to provide any information on NHS documents that may contribute to this review.

Similar to those asked of key respondents, the first two questions posed to members of the TACs inquired about the position and duration of each respondent's membership on their respective committee. The third question posed to TAC members asked respondents to describe the working relationship between members of the TAC. Following this, the questions sought responses about decision-making processes within the TAC as well as how decisions made within the NHS are communicated externally. The next pair of questions requested interview participants to comment on the progress that their TAC made, as well as what factors they thought were attributable to that progress. The eighth item on the instrument asked respondents to speculate on whether they felt their TAC had contributed to the change in any particular health service delivery. Next, TAC members were invited to discuss any shortcomings or weaknesses that they felt their TAC had experienced. Finally, respondents were encouraged to offer suggestions for improving the operation of their TAC as well as the overall NHS. The last question on the instrument once again inquired about any additional documentation that could contribute to this review process.

5.3　Focus Groups

The third source of data used in this review was two focus groups—one held with the Northern Chronic Care Coalition and the other with the Perinatal and Infant Health Technical Advisory Committee. A member of the evaluation team was invited to attend and observe meetings of each of these committees. At the end of the meetings, time was set aside for the evaluation consultant to facilitate a focus group discussion. In total, 15 members of the NCCC and 7 members of the PIHTAC participated in the focus groups; both were held in October of 2009.

Questions posed to members of the NCCC dealt with general benefits of the NCCC, enablers of the NCCC, benefits of the partnerships formed through the TACs, impacts of the NCCC, the influence of other TACs, decision-making autonomy and improving attendance. Questions asked during the PIHTAC focus group concerned the impact of the PIHTAC on health care practices in the North, what participants found helpful to their committee's endeavours, the strengths in partnerships fostered by the NHS and delays in progress caused by variation in decision-making autonomy and attendance of committee members.

5.4   Observation

In total, three opportunities for observation were provided to the evaluation team. Two of these opportunities were TAC meetings hosted by the NCCC and the PINTAC. Both of these opportunities occurred at the same meetings in which the focus groups with each of these TACs were held. The third opportunity for observation occurred with the Northern Health Leadership Working Group in February 2010, where a member of the evaluation team was able to sit in on a discussion of sustainability surrounding the NHS.

The observation data collected at the two TAC meetings lacked the relevance necessary to be included in this report as an independent source of data. Both meetings involved discussion of topics and initiatives that are too specific to fit within the broader context of this evaluation. In contrast, the data collected through observation of the NHLWG meeting on sustainability of the NHS provided relevant data which contributed to the scope of this evaluation.

6.0   DATA ANALYSIS

The following subsections present information on each NHS component starting with a description of the component based on information gathered from the document analysis; an overview of the information obtained through the interview process; and a summary of the feedback generated through focus group discussion (where applicable). Following each subsection is a summary of the main results deriving from the data described within that section.

6.1   Northern Leadership Forum

The Northern Leadership Forum is a broad representation of First Nations chiefs, mayors, Métis leaders and other northern leaders. The purpose of the forum is to bring forward issues to community leaders and at the same time provide them with updates on progress made by the NHS and its various components.

Within the time period of this evaluation, a leadership forum was sponsored by the NHS and New North in June of 2008. The forum, held in Prince Albert, included presentations from various northern leaders, subject experts and health organizations. The forum was attended by over 160 different health board members, healthcare workers, program coordinators, mayors, municipal councilors, tribal leaders, educators, media and provincial politicians.

NHS reporting on the forum indicates that round table discussions with forum participants provided some concrete themes. These included the need to work together; effective partnership building; realization of the northern uniqueness; importance of community development; effective communication; the need to promote and share successes; protection of northern culture and values; respect for jurisdictions and boundaries; and education on issues critical to the North.

During the June 2008 meeting, some of the major priority areas identified by forum participants include the reduction of alcohol and drug abuse; support for healthy lifestyles; youth, elders and cultural development; mental health (suicide prevention); chronic disease reduction (diabetes and obesity); environmental and economic balance; and sustainability in a northern context. To work on these issues, four key strategies for capacity building were identified: (a) community development; (b) partnerships; (c) communication; and (d) northern way.

6.1.1   Interview Process

As described earlier in this report, the interview process with members of the Northern Leadership Forum had very limited success. Several attempts to contact a number of chiefs and mayors resulted in only two interviews. Discussions with each of the two mayors

focused on communication between the NHS and Northern Communities as well as the impact that various NHS initiatives have had on the North.

Mayoral Feedback

Dialogue with mayors of two northern communities indicate there is a common understanding that the NHS is a strong advocate for northern communities. Both respondents felt that they had a good working relationship with the NHS coordinator and felt that their concerns were heard.

In terms of activities produced by the NHS, respondents from the NLF felt that the suicide prevention forum was a well-attended and particularly important event. Comments from one of the mayors indicate that the NHS community development forum and general work of the NCCC were major successes. Another major attribute to the progress of the NHS is the work done by the Northern Health Sector Training Sub-committee.

In summarizing the main strengths of the NHS, one of the mayors felt that the NHS is considerably effective at bringing northern communities together to work on initiatives. Another output of the NHS is that it also helps encourage communities to work with the existing resources within their community to build better capacity to address important issues.

One concern raised by a NLF respondent was that although the NHS circulates letters, advertisements, emails and books on its goals and various accomplishments there are still many people who are unfamiliar with the organization. As the mayor explained, "We need to know what the NHS is, what it's doing and how effective it is. There are so many different partnership groups out there in health that it'll make your head spin".

Closing commentary offered by one of the respondents was that the NHS should continue with what it already does: "the NHS needs to be used as a vehicle to face the many issues in the North. It needs to keep being an agency that pulls all the other agencies together to work on issues. It is a well-respected organization".

6.1.2   Summary

Although somewhat limited, the interview data collected from members of the NLF reveal that the NHS is reaching out to leaders of northern communities. The familiarity of the two mayors with the NHS and its various initiatives suggests that the NHS is making in-roads not only with health care providers but with those who handle many other concerns in northern communities.

6.2   Northern Health Leadership Working Group

One means to include a broad spectrum of stakeholders in the cross-jurisdictional decision-making process is the Northern Health Leadership Working Group. This group meets semi-annually to discuss various recommendations, issues and initiatives passed on by the Northern Health Strategy Working Group. The membership of this group is comprised of representatives from each partner agency's health board of directors. Federal and provincial representatives to the partnership which formed the Northern Health Strategy are also invited to attend meetings of this group.

Analysis of documents produced during the time period of this evaluation (2008-2010), reveals that meetings of the NHLWG were held in April of 2008 and February of 2010. During these meetings, active member organizations of the NHLWG included AHA, KYRHA, NITHA, PBCN, PAGC, MCCRHA, Saskatchewan Health, KTRHA, the community of Hatchet Lake and NHS staff. One elder was also a part of the working group during these meetings.

Proceedings of these meetings included NHS activity reports, TAC activity reports, planning for a NHLF, the Saskatchewan Association of Health Organizations conference, an overview of the NHLWG work plan, midwifery, physiotherapy, care quality and patient safety, the potential role for Prince Albert Parkland Health Region in the working group, and general roundtable discussion from members of the working group.

6.2.1   Interview Analysis

Interview data were collected from five (5) members of the Northern Health Leadership Working Group. Respondents discussed their observations of cross-jurisdictional partnerships, the decision-making process among the various partners, and future directions of the Northern Health Strategy.

Cross-jurisdictional Partnerships

Discussions with respondents from the NHLWG note that the main purpose of the Northern Health Strategy is to foster partnerships that fill the gaps in health care left by administrative divides between the federal and provincial health care system. One group member defined the Northern Health Strategy as "a commitment of northerners to work together to deal with northern health issues specifically by bringing together the various jurisdictions that can become partners in collaboration and inter-nation cooperation to change health outcomes for people in the North". As such, when asked to discuss cross-jurisdictional partnerships they have experienced, most respondents start by acknowledging the important role of the NHS itself.

One cross-jurisdictional partnership described by several respondents includes the Athabasca Health Authority and the Province of Saskatchewan. In many areas of the North, federal and provincial-funded health care workers were providing the same services in the same communities. Northern leaders felt that the various inefficiencies in the long-standing administrative quagmire be resolved. Developers within the Athabasca Health Authority worked with their counterparts in the Provincial health care system to minimize overlap of services; which in turn improved services and reduced barriers to health care for both First Nations and non-First Nations patients.

Other partnerships mentioned by respondents include the Northern Health Sector Training Sub-committee that involves both provincial and federal actors; the cooperation of the Northern Medical Services Branch and various health agencies to bring physicians to the North; and the diverse work of the NHS technical advisory committees that involve First Nations, Federal and Provincial partnership-building. Most of these partnerships, as indicated by interview respondents, are supported by the work of the NHS. As one group members explains, "the work of the NHS has been consistent around building cross-provincial collaboration and opening doors to more discussion along that line".

In an attempt to identify key factors that promote cross-jurisdictional partnerships, members of the NHLWG were asked to describe the various sources of cooperation which eventually led to the cross-jurisdictional partnerships they were aware of.

One major driving force behind some of the cross-jurisdictional partnerships are the opportunities provided to participants. According to one respondent, when groups come together they identify what the issues are, they then try to work together to address these issues and share the responsibility of addressing these issues with others in the partnership. This generates working conditions that are far more favorable than if partner agencies were to address issues alone. The collective effort made by the partnership not only has an impact on the issue at hand but puts participants of the partnership in situations where they can benefit from one another's help and support.

Another mechanism that encourages cross-jurisdictional partnerships is the opportunities for information sharing and brainstorming that comes from different groups. Feedback from interviewees suggests that partnership opportunities help agencies realize that many other agencies have the same issues and ideas for solving those issues. Working together to deal with particular matters provides a rich opportunity for learning.

One insightful account of what promotes cross-jurisdictional partnerships is the need for communities to work together to overcome many of the barriers which drive them apart. As one member of the NHLWG explained, "the nature of communities and their desire to not be divided [is what] brings them together. It is the federal and provincial government

that creates the decisions which separate communities. This occurs mainly through legislation surrounding the Indian Act or the Federal government's responsibility for First Nations healthcare". As this explanation suggests, the result of government policies that divide communities is an underlying desire for those communities to find ways to bridge that gap: one way is through cross-jurisdictional partnerships.

An alternative perspective on the role that government can have in cross-jurisdictional partnerships is not in dividing the group—and therefore creating a desire for them to work together—but in forcing bilateral approaches to addressing certain health issues. As one interviewee describes, this promotion of partnership engagement happens when governments limit funding; thereby forcing agencies to amalgamate services and work together. A different respondent echoed that when there is limited funding, there develops a strong willingness among health care agencies to avoid duplication of services.

Overall, it appears there are multiple factors that promote cross-jurisdictional partnerships. Some stem from the direct benefits of partnership involvement whereas others stem from the response that Northern agencies develop to address concerns of jurisdictional division.

Once cross-jurisdictional partnerships are formed, the general process in which they operate is much like that which is described by members of the technical advisory committees. Essentially, various agencies come together and identify common issues and understandings of those issues. Collectively, the group then works to identify common goals and a vision that will lead the group. Under the banner of the NHS, partner agencies identify what each member can bring to the table and use that information to develop roles for member agencies.

As most respondents describe, the direction of the partnerships are largely up to the CEOs and leaders of the agencies involved. The NHLWG, as described by its members, is a visionary group. Its job is to determine what is to be accomplished, while agency leaders are responsible for making sure the actual work is getting done.

One respondent explained that when partnerships are formed it is very important for all staff members to understand the purpose and importance of a partnership. The reason for this is because staff on the ground level are the ones who actually make the partnerships work. They are the individuals who—after receiving direction from agency leaders—set out to work on the collaborative initiatives spearheaded by the partnership. If there is a misunderstanding of the purpose of the partnership or perhaps a difference in the expectations of the role that each agency plays, difficulties can arise between partner agencies. Ground level staff are those most engaged in partnership activities, so it is important that they not only understand the process but support it as well.

Decision-Making

Decision-making within the NHLWG occurs in much the same ways as in the TACs. As respondents describe it, members of the working group put ideas on the table. Most of the ideas put forth to the group come from regional health authorities and First Nations care providers. As a group, the membership discusses each issue and uses these discussions to determine the direction the NHLWG should pursue. Many of the decisions made by the NHLWG are then passed through representatives of the federal and provincial governments to determine their opinion—but not necessarily their approval.

A general understanding of those interviewed is that there are multiple factors which are required for a successful decision-making process. According to a NHLWG member, decision-making occurs after there is relationship building, a common understanding of the problem and a common interest in addressing the issue. As the respondent states, "these are the key pieces to bringing people together to make collective decisions". A different respondent felt that cross-jurisdictional decision-making is made easier when people are positive about the process and believe in bettering services. The process of decision-making within the NHS is driven by the principles of cooperation and collaboration among agencies from different health jurisdictions. A third felt that "successful decision-making all depends on how well partner agencies come together and discuss what they can bring to the table".

Other facilitating factors of communication that were mentioned by respondents include willing partners, a commitment to build good relations, a common understanding of the issues at hand and a shared vision for health care needs across Northern Saskatchewan. One comment provided was that "the Northern Health Strategy has done a very good job providing a unified vision for health care in Northern Saskatchewan". Another suggests that the Northern Health Strategy is effective at using this vision to help communities understand the importance of taking ownership over their own health.

Although there were several identifiable enablers of decision-making mentioned in the interviews, respondents were also able to identify significant hurdles to the process as well. According to interview data, barriers to cross-jurisdictional decision-making include diverse funding arrangements, committee meeting absences, misunderstandings of the North, and government policy and competition for staff and resources. One other obstacle in decision-making is the incredible challenge of influencing change within federal and provincial policy structures—something that is often required for decisions of cross-jurisdictional partnerships to be implemented.

Despite the fact that many barriers to decision-making stem from outside any given partnership, one respondent was clear in expressing the opinion that misunderstanding

from within a partnership is the biggest barrier to the process: "The major barrier to decision-making is when there is a limited understanding about the different interests, realities and expectations at the table. Mostly, barriers occur when people come to the table with limited thinking, a lack of open-mindedness and little willingness to engage people who want to benefit from improved health status or health services".

Other internal challenges to decision-making are when those involved are not completely informed. As one interviewee explains, "proper information is the key in this process". Another explained that incomplete information can lead to misunderstandings or variation among expectations of the partnership process. A third felt that changes to the status quo are very difficult. He claimed that "it is important for leaders to report back to their membership otherwise rumours start circulating; and that tends to break down the process".

One unique obstacle is administrative policy and regulations that do not fit the Northern or Aboriginal context of health care. According to a respondent, it is quite rare that different jurisdictions have a different view of the problems that need to be solved. More often government legislation and structure stand in the way of allowing for collective decisions to be made.

One final barrier to cross-jurisdictional decision-making is an inconsistent commitment towards sustaining the NHS itself. As one group member explained, the Northern Health Strategy plays a vital role in facilitating much of the cooperation and partnership formation that is needed to have effective cross-jurisdictional decisions-making. However it is very difficult for agencies to move forward and make long-term commitments without knowing if the NHS will be around to facilitate such cooperation and reduce the many barriers it does address.

If cross-jurisdictional partnerships are able to overcome the many barriers to collective decision-making, those decisions are communicated to a wide audience. Feedback from respondents suggests that within the NHLWG, committee members most often take back information from NHS meetings to their own tribal councils and health authorities. There, information is given to health board members and directors. Once delivered to these organizations, information is then passed through each agency internally.

Another mode of communication occurs when the NHS provides information to partner agencies and participants at NHS events. The NHS is also described by respondents as being very effective at describing to various groups what the NHS is and what its activities are. It was also explained by respondents that information on decisions and initiatives of the NHS are communicated through newsletters and radio ads.

The last stage of the decision-making process is implementation. Comments from members of the NHLWG indicates that once decisions are made by the leadership entities of the NHS, the Northern Health Strategy Working Group and various Technical Advisory Committees take on the responsibility of implementation. Essentially the NHSWG coordinates the implementation while the appropriate TAC carries it out. During this process, as one respondent explains, "once there is an agreed upon action, every partner in the NHS picks their part of the activity to carry out".

Future Directions

Feedback from respondents on what direction the NHS should pursue was supportive of the importance of the sustainability of the NHS. One respondent explained that it is important for the NHS to continue because of the consistency it brings to cross-jurisdictional matters in the North. "Communities in the North have the commitment to collectively move forward, but to continue the momentum required to make sure all of these communities pull together and not focus on their differences requires a vehicle like the NHS. Without it, things become piecemeal and sporadic. Nothing happens without consistency".

Another reason sustainability of the NHS is important is because of the opportunity it provides in encouraging government change. As one group member described, "[The NHS] should continue with the path they're on; eventually the provincial and federal government are going to trust Northern people enough that we can manage our own affairs. They may eventually back-off and meet the needs of our own people. When that happens, having an existing model like the NHS will be a good thing. It will mean better service provisions for people all across the North—whether they are non-aboriginal, First Nations or Metis."

When it came to offering specific suggestions for improving future developments of the NHS, one interview participant felt that having more people involved from the health regions and the province would be a tremendous asset. The expanded involvement of these organizations may provide increased opportunities for initiatives to be implemented and new ideas to be shared and acted upon.

Another specific suggestion concerned the failure of the NHS to address specific matters pertaining to several issue areas. In particular, these include non-insured benefits within the context of ambulatory services, homecare and mental health. The contributor of this suggestion felt that these issues are of great relevance to cross-jurisdictional negotiations concerning improved access to health care.

6.2.2 Observations

In February of 2010 the Northern Health Leadership Working Group held a meeting in Prince Albert to review the progress of NHS, its various TACs and the NHSWG. The main purpose of this meeting was to hold a forum on sustainability. An open roundtable discussion led by the NHS Coordinator indicated a strong desire among Northern health leaders to sustain the NHS.

One of the main themes from that discussion was that sustainability of the NHS will continue to bring health care providers together in a common venue. This process eases the hardships which come from a lack of continuity within the leadership of both health care agencies and communities. Another major discussion surrounded the importance of the NHS to facilitate meetings that bring people together not only to share ideas but to actually work on building initiatives together. A final theme in the sustainability discussion was that, as the NHS moves forward, it needs to come up with a communication model that reaches out to a broad audience. The main message of that communication should be that the NHS is as enabler rather than a doer. Sending this information to communities, health care providers and Northern leaders will minimize false expectations and invite involvement from organizations and agencies that see the benefits in cross-jurisdictional partnership formation and collective decision-making.

6.2.3 Summary

Interviews with members of the Northern Health Leadership Working Group suggest that there are numerous partnerships throughout the North that cross jurisdictional boundaries. The opportunity of forming a cross-jurisdictional partnership brings benefits to participants in terms of information-sharing, collaboration and the rewards that come with collectively solving a shared problem.

Once partnerships are formed, the effectiveness of those cross-jurisdictional relationships depends upon parity among group members in terms of commitment to the partnership, contributions to the partnership and a common understanding of roles and expectations of participants to the partnership process.

Decision-making within partnerships requires common understandings of a given problem, effective communication and proper information. Barriers to decision-making vary considerably and can stem sources that are internal as well as external to the partnership.

Once decisions are made within the NHS, information is communicated to a wide audience through a number of methods. Success of the ensuing implementation process is dependent upon each partner carrying out their part in the initiative.

Observations of a NHLWG meeting as well as closing comments during interviews with working group members indicate that the NHS should be sustained. The ultimate success of many cross-jurisdictional partnerships and their collective decision-making processes is dependent upon the Northern Health Strategy and the facilitating role it plays in these processes. Most importantly, the NHS serves as a central venue of communication among care providers. Due to a lack of continuity in the leadership of communities and health care agencies in the North, a continuous means to communicate with other health care providers is critical.

6.3   Northern Health Strategy Working Group

The Northern Health Strategy Working Group serves as a facilitating vehicle for its 13 partner agencies. The purpose of the NHSWG is to bring together CEOs and senior executives of northern health agencies on a monthly basis to discuss issues of common concern, set priorities and develop and implement strategies to address these concerns. The NHSWG is also tasked with prioritizing jurisdictional issues as they emerge or are identified. Many of the initiatives of the working group are carried out by the various TACs. Each member of the NHSWG is responsible for seeing that their agency works to fulfill their obligations to the recommendations and actions taken by the group.

During this evaluation period (2008-2010), members of the NHSWG met once every two months—with some periods seeing 3 or 4 monthly meetings in a row, followed by a 2 or 3 month period with no meetings. The main business of these meetings included updates from the various working groups and committees, presentations from other agencies and experts, roundtable discussions on health-related issues and solutions, and planning sessions for the NHS and its various TACs. Active members of the NHSWG during this time period include representatives from NITHA, AHA, MCRRHA, LLRIB, Saskatchewan Health, MLTC, FNIH, KYRHA, KTRHA, RAGC, PBCN and the Population Health Unit.

6.3.1   Interview Process

The largest sample of respondents in this review (*N* = 8) is that of the Northern Health Strategy Working Group. Members of the working group provided both rich and detailed discussion on a variety of issues that are central to the main themes covered in this review process. These include cross-jurisdictional partnership formation, barriers to cooperation, cross-jurisdictional decision-making processes and challenges, and future directions of the NHS.

Cross-jurisdictional Partnerships

When asked to identify partnerships which cross jurisdictional lines in the North, members of the Northern Health Strategy Working Group were quick to point out that the NHS itself is a partnership. One respondent explained that the uniqueness of many member organizations themselves—including Northern Inter-Tribal Health Authority, Athabasca Health Authority, and Mamawetan Churchill River Regional Health Authority—are also based on partnerships. One of the major feats of the NHS in terms of partnership formation has been in getting First Nations health services and regional health authorities involved in the same processes and participating in the same structures.

Another common illustration of partnerships provided by respondents has been the technical advisory committees. According to interview data, the TACs demonstrate that there is a very practical level of cooperation that occurs across jurisdictional areas. One TAC mentioned by different respondents was the Northern Oral Health Working Group. This TAC was described as an excellent example of how different agencies from across several jurisdictions pulled together to provide programming in the North that greatly improved access to dental care in the North. Another TAC mentioned in the interviews was the MHATAC. Their suicide prevention forum drew stakeholders from across the North together to identify a unified approach to the problem of youth suicide. Other notable partnerships mentioned are those which have led to extended access to nurses on reserve and ambulatory coverage to communities in the North.

When it comes to promoting the formation of cross-jurisdictional partnerships, respondents from the NHSWG identified several contributing factors. The most common factors were mutual respect and having similar priorities, goals and values between different jurisdictions. Identifying the same issues across jurisdictions and developing collective plans for addressing those issues is also a major mechanism for promoting cross-jurisdictional partnerships.

Other descriptions of how partnerships develop focus on a range of other factors. One respondent noted that partnership formation is essentially a *northern thing*. There are many communities that are from different jurisdictions that work together despite whatever barriers may be present. According to the respondent, "most of the North is one large community divided by legalities. Despite this, there's a long standing practice in the North to work together for the betterment of the North. There are a lot of cross-jurisdictional partnerships here, not just in health care".

Another genuinely northern explanation for cross-jurisdictional cooperation came from an individual who felt that there is a *northern identity*: "Within the northern identity we have common problems that perhaps need some common solutions and shared solutions. Many

of these jurisdictions know that things can't be done alone. As such, they end up pooling financial resources, human resources and even political influence. We know that in order to move ahead in the North we need to move together".

A similar observation made by a different group member was that the partnership formation process is really a matter of practical necessity. In Northern Saskatchewan there are such wide-spread smaller populations that by necessity people cannot afford to stay separate. There are not sufficient resources for excessive specializations for each individual agency.

Alternative explanations for the formation of cross-jurisdictional partnerships suggest that efforts align when there is an opportunity to improve services and care. People are willing to work together when there is an opportunity to move beyond the status quo way of providing services so that people within the communities that they serve are able to get improved care and enjoy a higher standard of health.

Other factors which tend to bring health agencies together are having common needs and experiences of agencies in the partnership. Specific areas for partnerships to work on, rather than just broad projects, help bring people in on a working level. A third explanation was that "the scarcity of resources and access to health care makes people look beyond federal and provincial jurisdictions to focus on their unique needs of a practical approach to better quality services".

One view of the partnership formation process is that knowledge and understanding of potential partners, along with a strong presence of trust is what can ultimately decide a partnership. According to one working group member, "trust between partners is a major factor. People need to know that the potential partner is willing to share, make compromise and give a bit of control up in order for things to work out".

The final suggestion offered by respondents was that the Northern Health Strategy, although described by many respondents as being a partnership itself, is also a major contributing factor to partnerships that have formed in Northern health care. As one group member explained, "the Northern Health Strategy provides a venue for agencies to meet, collaborate, interact and work on projects together. It allows partners to collaborate on ventures that improve the health and well-being of First Nations communities in the North".

Despite the many cross-jurisdictional partnerships that have developed from the NHS, the beginning stages of the partnership formation process were not always easy. According to one respondent, First Nations were hesitant to participate in the same forum as provincial health authorities. The source of this hesitation came from the fear of losing autonomy.

First Nations also did not want to be publicly involved with the Province because of their relationship with the Federal government.

Over time however, First Nations partners grew more comfortable with the ideas and opportunities provided through the partnership. The First Nations and provincial partners collectively identified common interests, needs and solutions. According to a respondent, a need for members of the partnership to integrate new services forced the Province and First Nation health care providers to find a way to establish new precedents. The result was a situation where representatives from the regional health authorities and First Nations health care providers worked together to assess different needs and put together recommendations for cross-jurisdictional projects and initiatives. As a different respondent explained, "the involvement of NITHA in the NHS talks eased the entry process for First Nations leaders considerably".

Once partnerships form between willing and committed agencies, there are some factors that respondents have identified as important to their overall sustainability. According to interview data, cross-jurisdictional partnerships operate as long as the involvement between members is mutually beneficial across the jurisdictions. They would generally not operate for long if they worked to benefit only one group's advantage. Other important elements of a lasting partnership are consistent information sharing, a commitment to work together and a sharing of resources and responsibility.

In terms of how cross-jurisdictional partnerships operate, interview participants explain that they take considerable time to develop. Also required are meetings and actual work on the initiatives outlined by the partnership. One participant felt that all views within the partnership need to be voiced and everyone must feel like they have an equal chance to share their opinion. Overall they tend to be a "friendly exchange of ideas accompanied by formal aspects such as written agreements which define the partnership and programs which stem from it".

Decision-Making

The process of decision-making within the Northern Health Strategy Working Group is described to be much like that of other NHS entities: consensus-based. Respondents explain that the group members work to make sure that everyone is in support of the decisions made. There is a strong understanding among members that everyone is free to express their viewpoints and contribute to the deliberation process.

One understanding of the decision-making process is that the process is not always quick. According to one interview participant, the decision-making process can take quite some

time because of the time needed for potential partners to understand not only one another's positions on matters, but their circumstances and capacity to become involved.

In spite of the amount of time required to make decisions, there are several factors that can lead to the decision-making process becoming more effective. Figure 1 summarizes statements from respondents describing these factors.

Figure 1:
Determinants of Successful Cross-Jurisdictional Decision-Making

- Simply recognizing the principles of shared responsibilities and building trust over time. Having shared success together on a number of fronts also fosters effective cross-jurisdictional decision-making.

- One independent factor that makes decision-making easier is when the decision improves the services within a jurisdiction and breaks down barriers to health care. These types of decisions become an easy win-win scenario for everyone involved.

- Success comes from the problems that exist. If everyone agrees on the same definition of that problem then partnerships work together to reduce duplication, fill gaps in services and pool resources.

- Success in cooperative decision-making comes when people respect and trust one another. It also helps if there is a common problem and a willingness to share with one another and reach a common decision that is suitable across different jurisdictions.

- Having a group of people at the table who are willing and committed to reaching success. Sometimes you can see there are people who are there that do not understand what it is we're trying to do until they get involved and start seeing what the principles of the NHS really are. Once they understand this it is easy to work together because people are willing, committed and determined to improve their health status.

- Decisions come when there is a proper understanding of the issue and there is a shared benefit that each partner can see in that particular decision.

One detailed observation shared by a member of the NHSWG is that cross-jurisdictional decision-making works in Northern Saskatchewan because nothing else seems more logical. As the respondent described, "Considering the local structures and agreements in place in the North, governments—[both provincial and federal]—are willing to deal with us in a different way than the South because we can show the merits of integrated services across different jurisdictions. Considering the multiple barriers to care that are exclusive to northern populations, integrated services become a necessity in the North because nothing else makes sense".

Although respondents were able to identify several enablers of effective cross-jurisdictional decision-making, members of the NHSWG also identified several factors that may contribute towards unsuccessful attempts at making decisions within cross-jurisdictional

partnerships. Most of these factors stem from some form of misalignment between the partner agencies in terms of role expectations, understandings of the goals and plans and capacity to contribute to the decision-making process. Figure 2 summarizes respondent explanations of factors which lead to unsuccessful attempts at cross-jurisdictional decision-making.

Figure 2:
Determinants of Unsuccessful Cross-Jurisdictional Decision-Making

- The biggest barrier to decision-making is probably personalities and a lack of development within these personalities. You need to have good leadership within the NHS for decision-making to work. When it hasn't worked it is because of personality clashes and misunderstanding.

- Unsuccessful attempts at decision-making comes from the inability of partnerships to break down barriers to accessing funding that could be used to pave the way to change. It also comes from an inability to change the way people do business or a lack of commitment to change among decision-makers.

- Failures occur when partners are at different ends of the decision-making process. If there are no equal commitments among partners than that will serve as a barrier to success.

- Success in decision-making is hard to achieve when people are not willing to attend partnership meetings. It is hard to make decisions when not everyone is at the table.

- It is difficult to move forward with decision-making when our efforts are stymied by our large centrally-structured organizations—who for their own convenience and better understanding want consistency of practice across both province and country.

- A major barrier to cross-jurisdictional decision-making is the divide between federal and provincial jurisdictions; everyone is worried about their own affairs first and foremost.

- One challenge is whether the actual decision maintains relevance in terms of process of change. Although the NHS is strategic, there still has to be a tactical way to address the problems at hand—which means there needs to be a mechanism for people to enhance or share resources in order to improve care.

- The limited capacity of some organizations makes it hard for some agencies to become involved.

- Inadequate funding and a lack of community awareness about the NHS make it difficult to bring some of the necessary people to the table.

- Decision-making becomes difficult when there is turf protection. There can be a sense that if we all pull our resources together, then somebody might lose something.

The many barriers to cross-jurisdictional decision-making identified by respondents from the NHSWG infer that the entire process can be fairly difficult to predict. Just as difficult is the implementation phase of these decisions. According to one respondent, implementation depends on a lot of concessions: "Regional Health Authorities must agree that their model could be tweaked some to meet local needs and First Nations must agree

to work at adapting their programs to bring more consistency in service delivery. Most importantly, leaders must inform their people to get to know one another and work together in an integrated fashion to improve services".

A very similar viewpoint was offered by a different respondent who also felt that negotiations and concessions between partners is important in implementation: "It all depends on what the decision is and how a program has to be changed. It seems that most commonly there is an agreement with regards to a certain standard and the sharing of resources to meet that standard across jurisdictional boundaries. While there may be a difference in the changes to services there usually is an evening-out in terms of access and delivery of care services".

Other respondents felt that the implementation process can occur when the corresponding activity is manageable and adequately resourced. Once this occurs, the terms of reference for each of the TACs, combined with directives from the NHSWG, guide the implementation process. Critical at this stage is proper role identification, capacity assessment, and sufficient collective will.

Communication of these decisions and their chosen implementation process usually occurs at the same time as the latter. Interviews with working group members suggest that once a decision and implementation process is final, it is generally the responsibility of each group member to inform their own organizations. When major developments occur within the NHSWG, the leadership of the partner agencies is informed through their representatives. Other forms of communicating NHSWG decisions and activities are through newsletters, radio, Internet and word of mouth.

Future Directions

When asked to discuss future directions of the NHS, members of the NHSWG were able to point out a variety of options for continuation of this organization. Some suggestions were to continue funding, others focused on expanding partnerships, while several identified the need to work with provincial and federal governments to build their support for the NHS and the initiatives it has created. Figure 3 provides a summary of the comments provided by NHSWG members concerning future directions of the NHS.

Figure 3:
Respondent Feedback – Future Directions of the NHS

- The NHS needs to ensure that people have an understanding of what they are doing, what they have already accomplished, and what impact their accomplishments have had on the health care system in terms of cross-jurisdictional participation and partnership formation. There are still many people who don't know what the Northern Health Strategy is and what it is trying to accomplish.

- The NHS should identify what it brings in terms of cost savings for health care.

- The NHS should continue to look at opportunities (funding or program sharing) that they can take advantage of in a cooperative way to improve the resource base and services that they can provide. Of course, there is no sense meeting for the sake of meeting; so something real has to be happening.

- There should be a continued look at the TACs and the recommendations that have come forward to see if we can activate more of them. There is also a need to refocus the Mental Health and Addictions TAC as well as develop an Information Technology TAC.

- The provincial and federal governments need to recognize and support these ongoing processes. They need to support the structures established by the Northern Health Strategy and be willing to accept its proposals on the basis of merit; even though that's not the government's established way of managing health care.

- The NHS is a valuable asset that should continue. Anytime you engage the leadership of various groups to the extent that they sit down together you have a much better chance of making a difference in the health of the population.

6.3.2   Summary

Respondents from the Northern Health Strategy Working Group pointed out significant cross-jurisdictional partnerships in the North. Effective and meaningful cross-jurisdictional partnerships are propelled by mutual respect and trust, clear role expectations, and a shared understanding of problems and their solutions. According to several respondents, the uniqueness of Northern Saskatchewan provides a natural environment for partnership formation. To several, cross-jurisdictional partnerships are a practical necessity considering the many barriers to health care in the North. Interview data reveal that the processes of partnership formation are not easy. There are many challenges a partnership must address before it becomes both sustainable and effective.

Decision-making within the NHSWG, like most other entities of the NHS, is consensus-based. Interview participants were quite detailed in their descriptions of the determinants of successful and unsuccessful attempts at cross-jurisdictional decision-making. One key component is proper communications. Another is a shared perspective of the goals of the decisions as well as the benefits that may flow to each partner agency.

As for the process of implementation, concessions within the decision-making process may be required. This will allow for a sharing of responsibilities and resources that is much needed in the partnership process.

Some respondents from the NHSWG suggest that the NHS should move forward with a greater effort to convince provincial and federal governments of two issues. The first is that the NHS various successes merits further changes to the status quo health care system. The second is that funding should be extended because the NHS is working. The NHS is creating cross-jurisdictional partnerships and fostering effective decision-making that is reducing barriers to health care delivery and improving access to services for people living in the North.

6.4   Northern Chronic Care Coalition

The Northern Chronic Care Coalition works to increase access to quality health care services for Northern people living with a chronic disease. A variety of activities and numerous meetings has produced several documents that have been beneficial to this review process. These documents indicate that the NCCC usually meets once a month.

During this evaluation period, active members of the NCCC include representatives from KTHR, PAGC, NITHA, FNIH, KYRHA, PHU, AHA, PBCN, Saskatchewan Health, MLTC, PAPHR, HQC, NHS staff and Saskatoon Health Region. The committee's meeting agendas are often comprised of some discussion on the group's overall direction; along with dialogue on specific initiatives such as the patient self-management program, PAGC's Chronic Disease Network and Access Program, medicine wheel training, peer leader training, further implementation of the Expanded Chronic Care Model, collaborative opportunities with the Health Quality Council and other activities of the NHSWG.

Through observation and document analysis, the evaluation team has learned that the NCCC has a fairly committed membership. Individuals who attend and contribute to meetings and activities of the NCCC are often consistent in their efforts to see that the NCCC is successful in achieving its goals. Data collected through interviews with individual members and a focus group with several members provide insight into the internal relations, decision-making, progress and needed improvements of the Northern Chronic Care Coalition.

6.4.1   Interview Analysis

One source of information on the NCCC was through interviews with four active members of the TAC. The respondents' years of experience on the NCCC ranged from 1 year on the TAC to 5 years. Despite this variation, each respondent appeared confident in their role within the group and was able to answer most of the questions asked of them.

Internal Relations

The first of four main topics of discussion concerns the relationship among members of the Northern Chronic Care Coalition. Feedback from members of the TAC indicates that group members work well together. There is a general feeling among members that everyone is welcome to present their ideas and suggestions, and that despite considerable diversity among group members, there is great comfort level among members of the group.

The single concern raised during the interviews was that the relationships among group members—although positive—were not very clear. As one respondent describes, "there seems to be a disconnect when people miss meetings. When this happens, it is hard to have a clear sense of the working relations between members of the group". To moderate this observation, a different respondent admitted that the veteran members of the group seem to be more willing to make stronger commitments, do the actual work required, and keep one another informed.

Decision-Making

The second topic of discussion surrounded decision-making within the NCCC. Respondents generally described the process to be consensus-driven. Each member of the group is encouraged to share their opinions on each matter presented. During the interviews it became clear that the position of coordinator was effective in leading the group through each agenda item by sustaining the momentum of the TAC. One account of the groups' decision making process suggests that when larger more complex items need to be decided upon, they are sent to a subcommittee for more in-depth analysis. After members of the subcommittee become satisfied with their decision, it is sent to the full group for final approval. Once decisions are made within the NCCC, they are forwarded to the Northern Health Strategy Coordinator for approval.

When discussing the process of decision-making, members of the NCCC felt that the process generally worked quite smoothly. One concern mentioned by a few respondents however. was in disseminating the information surrounding their decisions outside of the group. Three of the four respondents in the NCCC sample made reference to the struggle that the TAC has had with informing communities and stakeholders about their decisions; and essentially their progress. One respondent explained that "I think [information sharing outside of the group] has been quite limited. There have been a few ads in the paper but there needs to be a more aggressive approach to filtering information from the TACs to health managers in the communities". A second respondent expressed a similar concern: "This area is a weakness of ours. We assembled a community communication plan that allowed us to visit communities but I'm not too sure how the rest of our members send

information back to their communities. Another issue is I'm not really sure what message we want the public to hear."

Progress

Discussions with members of the NCCC on progress of their TAC yielded some detailed information. Respondents felt that progress of the TAC was generally marked by information sharing, educational opportunities and ongoing training in the areas of chronic disease prevention and management. One respondent pointed to the efforts made to have northern care providers trained in patient self-management as well as clinical guidelines. Another cited that the majority of the TAC's work is to not only provide these opportunities, but also encourage the involvement of community in chronic care.

As for carrying on their regular activities that lead to progress, one respondent explained that the NCCC is guided by several goals and intended outcomes. Members of the TAC generally look at what other groups are doing in the area of chronic disease and try to share this information with health care providers to better meet the needs of the North: "We try hard not to reinvent the wheel; as such we use some of the tools of the [Health Quality Council]. Ultimately though, our major successes come from the work of the [Chronic Disease Network and Access Program]".

Respondents of the NCCC attribute the success of their TAC to a variety of factors. Two of the more prominent mentions were the hiring of a coordinator and regular attendance of group members. The coordinator has helped to organize the group's working agenda and make sure that everyone is informed and prepared. Regular attendance at meetings helps to ensure that group members are there to make decisions and accomplish the work. One individual on the TAC provided a detailed explanation of why the TAC coordinator and member commitment are important: "The leadership and committed members of the group serve as a core group of people that continuously attend meetings. When we develop our tasks or to-do lists everyone comes back to each meeting having done what they said they were going to do. A consistent group of interested people, as well as good leadership and communication from our chair and coordinator have helped considerably".

In addition to leadership and commitment, another factor contributing to the TAC's success has been support from stakeholders and health care providers who, according to one respondent, "see the NCCC not as a service group but a support mechanism to agencies trying to implement best practices in diabetes, COPD and cardiovascular disease". According to the same individual, there is a belief that people support the work of the coalition. "Identifying what issues in the North are important, helps bring more commitment to the NCCC and what we are doing".

Progress of the NCCC may be marked by the number of meetings, seminars and training opportunities provided but its success is shown through changes in health care. Information from respondents indicates that the TAC has fostered communication between different care provider groups that may otherwise not have communicated. This has allowed for new opportunities of learning and information sharing that would affect health care delivery. Respondents explain that the TAC has also raised considerable awareness on patient self-management and clinical guidelines. One respondent describes that "the NCCC is starting to have some impact in terms of awareness among health care professionals. The patient self-management work and CDNAP's chronic disease toolkit has had a slight impact on the awareness of healthcare providers which will hopefully lead to change in service delivery; and ultimately health care outcomes".

Challenges

Despite the progress of the Northern Chronic Care Coalition, respondents felt that their TAC had some challenges. Some of these issues originate internally whereas others can be attributed to the external barriers that the Northern Health Strategy itself is trying to help health care providers overcome (distance, jurisdiction, communication gaps). In addition, several problems within the TAC present themselves simply because the area of chronic disease is so large and complex. Table 14 summarizes the main shortcomings or challenges of the NCCC, as identified by four respondents from the TAC.

Table 14:
Respondent Feedback: Challenges of the NCCC

Internal Issues

- The goals, objectives and work plan of the group do not seem prioritized. The TAC has not figured out its main priorities.

- There is no strong orientation for new members.

- There is little known about the role of the partners in the NHS and what their expectations are.

- There are very few timelines or decision-making models to guide our progress.

- It seems that everyone wants to accomplish different things; there is no uniform effort; the energy it takes to do so many different things makes it hard to focus on particular priorities.

- Everyone has their own workload at their home agency; that makes it difficult to get work done efficiently.

- It seems like the NCCC is more about sharing than actual doing; as such it is hard to implement programs or make changes.

- General TAC members are not as committed to the NCCC as subcommittee members; that makes decision-making difficult because their positions on issues go unrepresented.

External Issues

- The travel barriers make it hard to bring people together.

- While there are funds to bring members together there are few resources to facilitate communication between members and their communities.

- Career changes, organizational shifts and dynamics related to agency resources result in considerable turnover within the TAC.

- Commitments from health regions are continuous but facilitating communication and commitment from First Nations agencies is difficult because of the high turnover following elections.

Topic-Related Issues

- Since chronic disease is such a broad area to cover we end up trying to do it all; that makes things inefficient and ineffective; we need to focus on a few select areas of chronic disease management.

Improvements to the NCCC

Interviews with members of the Northern Chronic Care Coalition provide some insight into ways in which the TAC could possibly be improved. Suggestions by members seemed to focus on reducing travel barriers for meetings, improving communication between members and more clearly defining the roles and responsibilities of the partner agencies involved in the TAC.

The first of the recommendations from respondents pointed out that because the outcomes of the NHS are for the North, more meetings should be held outside of Prince Albert. One respondent felt that members would be more stimulated and committed if the meetings were held in the North. Another pointed out that meetings held in the North

would better enable people to come from various communities, and also provide an opportunity for NCCC members to link with these communities.

The second suggestion focused on means to improve communication between group members. One respondent identified that the use of telehealth would not only be ideal for TAC meetings but also for providing an annual orientation to all current and potential partners to the NHS. A second respondent echoed the need to ease communication between group members by suggesting that more work be done through email versus in-person meetings. A final suggestion was made that the NCCC should work on forming stronger communication between TAC members and the various organizations in their communities. Essentially, TAC members communicate their NCCC undertakings to their immediate supervisor and board but they seldom represent the TAC in their home community.

The final recommended improvement identified a need to better define the roles and responsibilities of the NCCC. This will help members determine how the group can work with other agencies both internal and external to the NHS. Fulfilling this objective, according to the respondent, will help TAC members narrow down their priorities and realize the means to achieve their goals.

6.4.2 Focus Group Analysis

On October 13, 2009, the evaluation team observed a meeting of the Northern Chronic Care Coalition held in Prince Albert. In total, 15 members of the NCCC participated in this focus group. Data were collected through the use of a tape recorder and hand written notes taken by the facilitator. Discussion among participants was guided by several questions posed by the facilitator.

The following sections summarize the dialogue of participants surrounding the following major topics: general benefits of NCCC, helpful contributions to NCCC endeavours, benefits of the partnerships formed through TACs, impact of NCCC on the North, the influence of other TACs, decision-making autonomy and improving attendance to TAC meetings.

General Benefits of the NCCC

The first question posed to focus group participants inquired about the benefits that the NCCC brings to health care providers in the North. Participants provided a variety of responses—most of which focused on networking and knowledge sharing.

Speaking to the former, the first participant to share her opinion explained that the NCCC provides an excellent opportunity for different people to get together and work

collectively. Others felt that the NCCC not only allows for networking among members but is one of the few forums where all of the main players from multiple jurisdictions can gather around the same table.

In terms of knowledge sharing, several participants felt that the NCCC allows for good and innovative ideas to be shared with others. One participant mentioned that "this periodic exchange is good; it keeps people up to date and makes sure that resources are used efficiently". Another participant believed that the NCCC acts as an advisory body and a sharing place for new ideas.

Collectively, it seemed that the group saw a lot of benefit in being members of the NCCC. Not only does it foster networking and knowledge transfer but as one participant shared, "it provides a lot of support for us in the work that we do".

Helpful Contributions to the NCCC

In an attempt to identify catalysts for TAC progress, the facilitator prompted participants to discuss helpful contributions to the NCCC. Although feedback was limited, two very clear opinions were offered. The first was that the coordinator of the NCCC plays a very important role in getting proper information out to members and in getting the members together for their meetings. A second suggestion was that the continued focus on patient self-management over the past few months has made the NCCC both effective and efficient.

Benefits of Partnerships

One of the main themes of this evaluation is the partnership formation process— particularly across different jurisdictional barriers. When asked to discuss some of the benefits to the partnerships that have formed because of the Northern Chronic Care Coalition, focus group participants provided an array of feedback.

According to the group, such partnerships facilitate information sharing; validate the work of NCCC members; foster new partnerships; expose members to different skill sets; help move initiatives forward; generate awareness; and promote communication among members. One fairly thorough understanding of the benefits that such partnerships bring suggests that "they allow health care professionals to help northern care providers by using external [as opposed to strictly internal] partnerships". This comment speaks to the progress that the Northern Health Strategy is hoping to achieve in reducing cross-jurisdictional barriers to health care in the North.

Impact of the NCCC

Although it is very difficult to measure some of the impact that the Northern Health Strategy has on health care in the North, we did ask TAC members to describe some of their observations concerning the impact of the NCCC. Several comments were provided by participants.

The first suggests that the NCCC not only brings people together but it actually encourages them to work together (beyond just meetings and workshops). Another respondent felt that the NCCC increases the recognition of Northerners and the services they are able to provide to their patients despite numerous barriers to health care, human resources and technology. These two comments essentially highlight progress made not only in cross-jurisdictional partnership formation but also in collective decision-making.

The third comment suggests that the NCCC brings improved services to the North. The provider of this comment moderated her feedback by adding that the impact of the Northern Health Strategy is still in its early stages; as such, clearly visible benefits won't be seen for a while. A second respondent added that the successes and magnitude of NCCC's impact won't be seen for a while because at this stage, the Northern Health Strategy is developmental.

Generally, these contributions to the evaluation point to the fact that even those working within TACs understand that the product of their valuable efforts is something that won't be completely realized for some time. Nevertheless, the groundwork that goes in to forming partnerships and reducing barriers to cooperation are vital for future improvement to occur.

Progress of Other TACs

While most of the discussion with focus group participants centered on the NCCC, a small amount of time was set aside for discussing the activities of other technical advisory committees. The intent of this question was to gauge the extent to which TAC members are aware of what others with similar ambitions have accomplished. This serves as a rudimentary and very subtle indicator of TAC activities and awareness.

To begin, several participants pointed to the work of the Oral Health Working Group and the initiatives they have taken on in the past few months. Some respondents reported that the Oral Health Working Group is having a fairly substantial impact on the conditions it is trying to affect. Another TAC mentioned by participants was the Mental Health and Addictions Technical Advisory Committee. Their widely publicized suicide prevention forum was discussed as being a big success. Lastly, the Perinatal and Infant Health Technical

Advisory Committee was seen as not only generating a lot of interest among practitioners, but as securing a lot of commitment from those who sit on that committee.

Although not all of Northern Health Strategy's technical advisory committees were mentioned in this discussion, it should not be assumed that the others are not faring well in their endeavours. In fact, as one participant pointed out, "the only reason I know of other TAC progress is because their work is particularly supported in our community". A second mediating statement was that "from [my agency's] perspective, there has been a lot of awareness of all the TACs and support for their initiatives".

Decision Making Autonomy

As mentioned previously in this section, the focus group was held after individual interviews with members of all TACs had already been conducted. Two of the major challenges indentified through the interviews were decision making autonomy and member attendance. Decision making autonomy is considered a problem when TAC members cannot contribute to decision making or commit to an idea without first taking information back to their home agency for approval. Member attendance was explained as a problem in that much of the work done by the TACs depends upon consistent communication and decision-making that almost always happens at TAC meetings.

Regarding the former of these two challenges, the facilitator prompted discussion around ways that the effect of decision-making processes on TAC progress could be minimized. Collectively, participants felt that a more proactive approach to getting information to agency leaders is imperative. One participant suggested that briefing notes should be given to administrators before a meeting so that TAC members could receive their agency's direction before the TAC meeting. A different participant explained that TAC members should try to sense their agency's position on matters to the best of their ability without overwhelming their administrators with nuances of the TAC process. A third respondent believed that members of the Northern Health Leadership Forum and Northern Health Strategy Working Group should more clearly outline expectations to staff that sit on the various technical advisory committees.

Overall, it wasn't entirely clear whether a common response to the problem of decision-making autonomy could be formulated. As was clear in the focus group meeting, some members of the NCCC had the autonomy to represent their agency in decision-making and others did not. While everyone agreed that such lack of parity limited the progress of TACs, finding a solution is very difficult because most agencies have a fairly well defined process of decision making.

Improving Attendance

As mentioned in the previous section, there was a concern that attendance variation affects the efforts of TACs to move ahead with their agendas. In response to a prompt on this topic, one participant pointed out that "it is frustrating to have people coming to meetings who rarely are there; and when they come they change the whole direction of the meeting or group". Other dialogue on this topic revealed that booking meetings much earlier in advance would allow members to arrange their schedules around proposed dates. A second suggestion was that telehealth should be used to minimize travel times and other barriers that members experience.

Although the discussion was geared towards methods of improving TAC member attendance, two participants pointed out what helps maintain their own attendance. The first explained that "having a good coordinator really helps get the group going and keeps us consistent". The second participant explained that "what helped me get here is Northern Health Strategy paying for my trips to these meetings".

Overall, it was clear that most participants acknowledge the stress that variation in attendance places upon the group. According to participants, resources to cover travel to TAC meetings, advanced notices, strong coordination, and the option of telehealth can all play an important role in increasing and sustaining TAC attendance.

Additional Feedback

The final segment of the focus group allowed participants to provide feedback on topics not covered by the questions and prompts given by the facilitator. Three sets of comments emerged during this closing discussion. The first focused on the progress of the NCCC itself. The second identified exclusive characteristics of *the North*. The third set of comments related to the ability of the TACs to build relations and use these partnerships to overcome limitations that constrain health care.

In terms of overall progress, one participant felt that the NCCC has just started to make a difference and that continuing on is ideal: "Keeping up the momentum of what we have has been a lot of work. Because of the nature of chronic disease it takes a while to do anything. But moving forward is really important because we've just started to get things going." Other participants agreed that a lot of work had already been accomplished through the NCCC and more is still yet to be done.

A second theme that emerged from the focus group discussion was the exclusive characteristics of the North; particularly as it relates to organizational relationships and people. This discussion began when one participant pointed out the vast differences

between Northern and Southern Saskatchewan in terms of relationships between agencies. She continued to explain that, "everyone knows everyone up North. The South is very segregated". A third participant noted, "yes, the North has lots of cross-jurisdictional cooperation that benefits care providers". A fourth contributor provided further comparison: "something is happening here that doesn't happen in other places. [Down South] there are competing priorities that don't happen up here". One participant explained that she would like to see some long-term partnerships maintained so that the NCCC continues to move forward. She concluded by saying that "We've accomplished so much and if we do not have something in place we could go back to how the South does things instead of the North".

A final comment from the focus group discussion highlighted the unique ability of the TACs to foster relationships that bring a multitude of benefit. As one participant explained, "Our group is good at building on the strengths that we have. While there are formal relations that exist, the [NCCC] really gives us a chance to build informal relations despite the many legislative and cross-jurisdictional barriers that there are". A second participant explained that these partnerships are quite helpful in assisting health agencies overcome limitations in scope and capacity. She then provided the example of how CDNAP [Chronic Disease Network and Access Program] helps fill a void where Northern Health Strategy did not have funding for clinical work. A final comment suggested that in terms of future partnership formation, participants really need to sit down and establish if a relationship between different agencies is going to be one of cooperation, coordination or actual collaboration. There are differences in these types of relationships and they can affect what groups such as the NCCC produce.

6.4.3   Summary

Overall the feedback provided by respondents through individual interviews and focus group discussion offers considerable information on many topics that are pertinent to the overall evaluation of the Northern Health Strategy. The role that technical advisory committees themselves play in cross-jurisdictional partnership formation and cooperative decision-making is effective. As described by members of the NCCC, the work of the TACs is clearly a catalyst for networking and knowledge transfer that has a positive impact on health care in the North. Within the area of chronic disease, considerable efforts have been made to improve client understanding of patient self-management and care provider use of clinical guidelines in both the management and prevention of chronic disease.

The main outcomes of the Northern Chronic Care Coalition are difficult to quantify. However NCCC members suggest that long term gains of the NCCC will be evident if these processes of communication, information sharing and agency networking continue.

In summary, these data provide a preliminary measure of NCCC progress more than they do change in health care delivery. Most importantly however, they serve as a measure of the extent to which the NCCC has helped foster the cross-jurisdictional partnerships and decision-making opportunities that can lead to improved access to quality care for people living in the North.

6.5   Northern Oral Health Working Group

Since 2003 the Northern Oral Health Working Group has been active in a number of areas related to promoting oral health across Northern Saskatchewan. Much of the work of this TAC is focused on providing opportunities for networking as well as continuing education to dental professionals in the North. Other activities of the group are to standardize treatment, prevention and oral health promotion programs based on best practices and provide fluoride varnish training resources to non-dental care providers. Another notable development of the NOHWG is the exploration of electronic dental records.

One of the larger initiatives of the Oral Health Working Group has been the adult dental program that expands access to dentist care among adults in several northern communities. The impetus for this initiative came in 2003 when a pilot project was proposed within Athabasca Health Authority to address the issue of lack of dentist access among northerners. Over a three year period the NOHWG conducted research on the structure, coordination and logistics of expanding dentist services in the North. A request for proposal process was facilitated in 2005. The University of Manitoba's Centre for Community Oral Health was awarded the opportunity to provide dentist services in Northern Saskatchewan. Starting in Fond du Lac and Black Lake, the dentist access initiative aimed at northern adults has now been implemented in eight different communities.

During this evaluation period, a number of partner agencies have been involved in the various initiatives of the NOHWG: University of Saskatchewan College of Dental Surgeons, Health Canada's Office of the Chief Dental Officer, Dental Health Promotion Working Group of Saskatchewan, Saskatchewan of Health, Population Health Branch, University of Saskatchewan College of Dentistry, University of Manitoba Centre for Community Oral Health, Northern Healthy Communities Partnerships, KYRHA, AHA, and MCRRHA.

6.5.1   Interview Analysis

Interviews with four members of the Northern Oral Health Working Group served as the main source of data collection for this TAC. Feedback from interview participants suggests that this particular TAC is focused on more specific initiatives within oral health, and this, combined with the strong working relationship of TAC members, had led to considerable success.

Internal Relations

Data collected through interviews with the Northern Oral Health Working Group indicate an overwhelming consensus that internal relations within the TAC are extremely positive. Traits used to describe the working environment within the TAC include collegial, respectful and unified in terms of forward direction and goal setting. Adding to this mix of traits is diversity of member expertise. According to one respondent, the diversity of the group helps enrich the team's collective skills and capacity. Another contributing factor mentioned in the interview process is the history of the relationships within the group: "Folks seem to be happy because we've been together for so long".

Several of the respondents pointed out that the positive working environment within the TAC helps create a well-melded group of very committed individuals. It was also suggested that this type of environment allows for team members to work together and remain on the same page; something that may have been a struggle for some of the other TACs.

In all, it was clear from the four respondents interviewed for this review that the internal conditions within the TAC supports for good working relations. This outcome has transferred through to decision-making practices within the Northern Oral Health Working Group.

Decision-Making

The interview comments describe the decision-making within the oral health TAC as consensus-based. Respondents describe that items are placed on an agenda and discussed openly by all group members. Involvement and input during the decision-making process is common among all members. Once deliberations are near completion, the group collectively decides on the matter at hand. One respondent felt that the decision-making process is smooth because all group members share similar perspectives on the issues. In particular, "we have discussion and everyone provides input but I can't even think of a time when we've even voted on something because everyone on the TAC thinks the same way".

Once decisions are made in the Northern Oral Health Working Group, information on the TAC's activities and goals are passed along to the NHS coordinator; who then shares this information with various health directors. At the same time, members of the committee take information back to the management at their home agencies where they present it to CEOs, directors and fellow staff members. Two other forms of communication used by this TAC include annual reports that highlight the progress of the committee; and invitations for dental professionals to attend the various meetings and workshops put on by the Northern Oral Health Working Group.

Discussion with respondents on the progress of the Northern Oral Health Working Group identifies several achievements. One of the first successes was the provision of not only continuing education but networking opportunities for dental professionals who are often isolated in the North. As one committee member explains, "I think we've come a long way in terms of continuing education; now each jurisdiction doesn't have to go off and do their own thing. We're saving a pile of money in the long run".

Another achievement mentioned during the interviews was the progress made in providing a safe environment where stakeholders felt comfortable discussing various ideas and opinions in the dental profession. According to one respondent, this has allowed for the development of a work plan that should lead to the committee establishing goals of improving and promoting oral health for the residents of northern Saskatchewan.

More specific outputs of the group identified during the interviews include moving northern dental professionals towards electronic (rather than paper) charting; sending out information packets to communities on oral health care and prevention; and providing various opportunities for dental professionals to both share and learn best practices and the latest standards of care.

Of all the accomplishments achieved by this TAC, perhaps the most identifiable progress of the group is their delivery of dentist services to adults in the North. Partnerships between dental professionals from regional health authorities, First Nations health jurisdictions, the Athabasca Health Authority, the College of Dentistry at the University of Saskatchewan, the Centre for Community Oral Health at the University of Manitoba and the Office of the Chief Dental Officer of Canada led to increased access to regular dentist services in many northern communities where there were previously none.

In identifying attributes of the success experienced by the TAC, members who were interviewed pointed to a variety of factors. One respondent explained that because oral health is generally not covered by health dollars, dental professionals in the North are forced to work harder at prevention and oral health. Another respondent explained that while the entire group worked hard in their efforts, three individuals were critical in the overall success of the TAC: a committed dentist that contributed extensive knowledge, a strong facilitator that took the group through the work plan, and an effective chair person that kept the group moving forward as well as abreast of other NHS activities. A third respondent pointed out that the diversity of members on the committee, combined with their hard work and the support they received from the Northern Health Strategy made success more possible. A final explanation of the committee's success pointed to how

everyone in the group has the same focus or direction. The group also benefits from the absence of turf protection, since "everyone is willing to share, help and get involved".

Discussions with respondents on the progress of the Northern Oral Health Working Group provided some insight into the changes in health care that may have occurred because of the work done by the committee. Each of the four respondents shared something different when asked to describe the impact of their TAC. One respondent explained that many changes within pre-school populations were made by implementing fluoride varnish programming. There has also been significant progress made in train-the-trainer programs for those working in pre-school settings. Another respondent felt that because many dental professionals in the North work independently, having the committee provided very valuable direction, training opportunities and professional relationships. The third respondent described how the working group increased access to dental services for patients in the North. The final respondent echoed this claim: "We've provided educational resources that have helped improve the services of dental therapists and have increased adult dental services in different areas. That has been a great benefit to people in the North".

Challenges

During the interview process, several unintended occurrences were described by respondents as having somewhat of an impeding effect on the TAC's progress. The first caveat mentioned concerned time restraints of committee members. According to one respondent, "In fairness to all of the membership it is quite challenging at times because this committee is not their main job. Sometimes we will be working on projects and people want to be able to spend as much time as they would like on a project but simply cannot". Further feedback from the same respondent points out that funding shortfalls or lateness has held the group back quite a bit; as did the absence of a coordinator for some of the early years.

A second comment to the interview data focused on events within the actual meetings; more specifically the tendency for the group to occasionally get off course: "We sometimes get sidetracked because we haven't seen each other very often. We end up going off topic and find it hard to stick to the agenda. It's also difficult when new members join—or absent members rejoin us—because we have to spend a lot of time bringing them up to speed on what the group has been doing".

A third respondent explained, one weakness of the TAC is the vacant committee seat not filled by the Northern Inter-Tribal Health Authority. According to the interviewee, NITHA plays a vital role in the administration of health care services in the North and their presence at the table would provide very much needed help and support to the committee.

A final comment offered on the topic of shortfalls or challenges of the Northern Oral Health Working Group concerns a gap in communication between the committee's leadership and its membership. According to one respondent, "Sometimes the chair person and the lead dentist have their own meetings on the side and then later come into the larger meeting with an agenda already in place. Through this they assume that the rest of us know what they're talking about but we don't. I don't think it is an intentional mistake but it does happen and it does cause confusion in the group."

Improvements

The suggestions given by respondents on how to improve the Northern Oral Health Working Group overwhelmingly focus on making changes that would improve the process of the TAC.

One suggestion is that more representation needs to be solicited from those jurisdictions not actively involved in the TAC. This will ensure that their opinions are heard and considered. Another perception of the situation is that more people are needed at the meetings more often. The contributor of that suggestion did preface the comment with the realization that it is quite difficult to get people out of their communities to become involved. One suggestion to help the TAC overcome this barrier was the use of Telehealth.

A final concern raised over the Northern Oral Health Working Group was that the committee needs to be led by a single chair person rather than two co-chairs. This is suggested as a possible way to increase the efficiency and effectiveness of the committee's leadership.

6.5.2 Summary

Overall the TAC reviewed in this section has had multiple successes and considerable partner involvement. Decision-making within the committee was helped by the fact that most group members not only shared the same vision for a committee goal, but identified the same means to achieve that goal. Of the main activities undertaken by the Northern Oral Health Working Group, provisions of ongoing professional training, networking and knowledge on best practices have had a positive impact on health care professionals. These include positive changes to services provided for pre-school children, and general services provided by dental therapists across the North. The most significant success of this TAC has been the expansion of regular access to a dentist for adults in various parts of the North.

6.6   Northern Health Sector Training Sub-Committee

The Northern Labour Market Committee and the Northern Health Strategy co-chair the Northern Health Sector Training Sub-committee. This committee serves as the human resources TAC for the Northern Health Strategy. Its expected outcomes are to assess and meet health sector training needs in the North, develop a northern health human resources model, create an effective human resource strategy, implement progressive and effective recruitment and retention policies and build upon all of these outcomes to establish a five-year multi-party training agreement that is designed to build human resource capacity in the Northern health sector.

In attempting to deliver on these intended outcomes, the first outcome of the sub-committee work was a commissioned document titled *A Report on a Northern Health Human Resources Data Collection*. This 2008 report outlined the current human resources situation in the North, identified priorities and provided direction for initial training priorities.

The second development of the sub-committee was a feedback session on the findings of this report from the perspective of federal and provincial government organizations, post-secondary and K-12 education organizations and healthcare providers. Following this meeting, a second report commissioned by the NHS provided a review of strategies to support science and math education for health careers in northern Saskatchewan.

Both reports, as well as the feedback meeting, led to the development of a proposal for the group's most significant goal: a Northern Health Human Resources Strategy. The Strategy consists of a multi-year multi-party training agreement between health care employers, education institutions, and federal and provincial funders. Efforts of the NHS have been made to develop a letter of understanding with federal and provincial funders to support this initiative. Internal NHS documents suggest that Revisions of the Northern Health Human Resources Strategy have pulled the project in-line with recommendations of the provincial *Patient First Review* report released in October of 2009.

A proposal presented to federal and provincial funding agencies provided the sub-committee with sufficient funds to at least start the program. One development stemming from this start-up money is a *Northern Nurse Education Strategy* that maps out the infrastructure needs for delivery of nursing education in the North.

Other ongoing achievements of the Human Resources TAC include the Health Career Promotion Project. This initiative saw the NHS make a presence in the classrooms of high-school students across the North. According to internal NHS documents, roughly 565 students from close to two dozen schools were introduced to a variety of career options in healthcare.

Throughout the last three years, there has been steady involvement of several agencies who have become involved in the Northern Health Sector Training Sub-committee. These organizations include First Nations University of Canada, Indigenous Peoples' Health Research Centre, NITHA, Northlands College, Saskatchewan Indian Institute of Technologies, Northern Teacher Education Program/Northern Professional Access College, Gabriel Dumont Institute Training and Employment, KTHR, MCRRHA, Saskatchewan Health, Services Canada and Laurie Thompson Consulting.

6.6.1 Interview Analysis

Data collected through interviews with members of the Northern Health Sector Training Sub-committee provide additional information to what is provided in the document analysis. Although interviews were conducted with only three members of the sub-committee, the data provided through this process are considerably broad in scope and rich in detail.

Internal Relations

The working relationships among members of the human resources TAC are generally positive. The source of these strong relationships within the group stems largely from the many longtime relations that have occurred prior to the formation of the sub-committee. According to one individual, "Everyone knows everyone else. The different interconnecting circles we have make this process much easier. A lot of the relations we depend upon to make progress are already there".

A different description of the internal relations of the sub-committee points not towards the interaction of group members but towards their confidence in sharing information with others. According to one respondent, "There are various levels of comfort in which members speak. It is difficult to equalize the input of each member. Some are quiet, some are talkative and others are rarely there". This variation in member contributions to the group—caused by comfort level and/or meeting attendance—may have a small yet important impact on the outcomes of meetings. Respondents in the sample were not quite sure how they could gauge the impact; nonetheless it is factor to consider in the overall understanding of the Northern Health Sector Training Sub-committee.

Decision-Making

Comments surrounding the decision-making process within the human resources TAC of the NHS suggests that decision-making begins with an agenda usually set out by the co-chairs. Collectively, the group reviews items on the agenda and discusses the merits of each choice in the decision. According to one individual, the goal of decision-making within this

TAC is to find a consensus-based decision that works well for all organizations involved. Of course doing so is not always an easy task.

One challenge in making decisions that appease everyone in the group is that not all of the conditions affecting the matter to be decided upon are equal between one jurisdiction and the next. As one respondent explained, "finding the middle ground is not always easy because of the differences between different areas of the North. In particular, salaries are different for the same job simply because one individual is paid by the province and another is paid by the federal government. Even though it is the same job, this makes things difficult for decision-makers in our group".

Another issue raised in respondent discussions on decision-making relates to those who are involved in the decision-making process. The view of one group member interviewed was that although decision-making within the group is generally unanimous, the actual decision-making should be left in the hands of the Northern partners. These would include health authorities, First Nations organizations, funding agencies, post-secondary funding sources, Northlands College and the Northern Health Strategy. Other parties involved in the sub-committee—namely various provincial and federal entities—should be informed about what is going on but not actually included in the decision-making process. The reason for this is because maintaining a sub-committee solely of northern agencies maximizes the probability that positions taken within decision-making process reflect a purely Northern context.

A final topic raised in the decision-making discussion referred to the capacity and autonomy of group members to make decisions on their own. According to one respondent, several members of the TAC do not have direct decision-making capacity; in other words they cannot commit a position of their organization. As a result, many group members have to return back to their home agency to seek direction and permission. This process produces several barriers to decision-making in that many times progress will be moving along quite well until various members of the group hold off on making further commitments until they confer with their agency's administrators. Sometimes this process can take a long time, especially when the issue at hand is not at the forefront of that particular agency's list of administrative priorities.

Once decision-making within the Northern Health Sector Training Sub-committee is complete, information is shared with various organizations through reports to chiefs, directors and colleagues at various staff meetings. Facilitating this is a coordinator and communications person who sends out messages to partner agencies in person, through letters, in newspapers and on the airwaves.

Respondents from the human resources TAC also explained that when they make decisions to move forward with particular initiatives the TAC assembles stakeholder groups where various partners are brought together. The TAC introduces partner agencies to what they have accomplished and plan to accomplish. Information on various human resource-related topics is also shared. The intent of these gatherings is to move the North closer to achieving a multi-year multi-partner commitment to providing health care training in the North.

Progress

Much of the progress made by the sub-committee has been described by interview participants as *raising awareness, collectively*. One respondent explained that the group has made considerable progress in continuously raising awareness of the issues and shortfalls facing northern human resources in the health sector. According to this individual, the collective voice of the group members has secured various supports (including funding arrangements) that would not have come had the group members acted unilaterally. Another illustration of the utility seen in collective awareness-raising was provided by a different respondent: "This TAC has demonstrated that there is a common voice being heard by the provincial and federal government and they are listening and recognizing the challenges faced by Northern Saskatchewan health services. Mostly, they are recognizing that challenges in the North are different than those faced in the South. Getting government to realize the tremendous shortage of health human resources in the North is significant progress".

Other forms of progress mentioned by respondents include a variety of initiatives that help train and recruit Northerners to the work force within the health sector. Specific examples given during the interviews include community health worker training, meetings with employer groups and aggressive recruiting of young people to the health sector.

Although all three TAC respondents feel that their group is making good progress, at least two of them identified that this hasn't always been the trend. As one respondent recalls, "prior to the committee becoming a NHS technical advisory committee we had slow progress. However since the merger it has really helped northern health employers come to a common understanding of seeing where we have common needs and where there are specific needs through each of the organization's members". The second respondent added that "earlier years of the committee were difficult because few groups showed an interest or commitment. We put the time and effort in to secure the interest of others".

Once member interest and commitment started to increase for the group, the motivation to move the group forward came from the idea of setting up a multi-party multi-year agreement. One respondent explained that the group had to work hard to ensure that employers were having a strong voice in the delivery or training within the health sector—

much like that which occurs in apprenticeship training. The challenge with the health sector, as another respondent explained, is that unlike the mining sector, the health sector is very process-oriented. As such, the entire path to success takes a long time.

A final account of the progress made by the TAC suggested that once the motivation and unified voice was there to move the group forward, the sub-committee began to build partnerships throughout the North. This started by the sub-committee approaching CEOs, health boards and other stakeholders with a proposed letter of understanding. Once these partnerships began to form, TAC members conducted a considerable amount of lobbying to ministers and their deputies on a regular basis. As one respondent claims, "This has started to get us some leverage over government decision making. We want a multi-year agreement so we're not shopping for money every year. The process has so far taken three years. We're close but we're not done yet".

When discussing the main factors contributing to the progress made by the sub-committee, participants in the interview process identified one common source: *bringing together partners from different jurisdictions*. As one interviewee described, "the biggest plus to our efforts is that understanding of the importance in bringing together various services. Bringing together federal and provincial services to work collaboratively is often unheard of. Our biggest attribute to success is trying to work together rather than providing repetitive services". A second respondent also felt that the large and diverse number of partners involved from different jurisdictional areas has been a tremendous asset to the process. According to this individual, "the large number of stakeholders and high level of commitment by people who are around the table has also helped".

While respondents discussed these measures of progress and the factors contributing to their success, each was asked to speculate on the change that has occurred in health service delivery because of their efforts. The main feedback gathered on this topic once again surrounded the notion of awareness-raising. Some issues mentioned by respondents include raising awareness on the need for additional health care workers—including those who work on addictions and mental health. Another issue raised by the group is that learning institutions need to provide training that is not only relevant but also accessible to the North.

A third element of change claimed to be attributable to the awareness raised by the Northern Health Sector Training Sub-committee has been the understanding of health care professionals, trainers, governments and employers on the practices of First Nations health care delivery. As one interview participant shares, "[The TAC] has changed our consciousness to be aware of things. Our work has identified the contradiction between mainstream society and the First Nations way of delivering services. The main focus of our work has been to identify to our partners the holistic, family-oriented and community-

involved approach to First Nations healthcare. We have moved the conversation point to where the two sides can now acknowledge differences without disagreeing".

Challenges

Members of the Northern Health Sector Training Sub-committee who were interviewed for this evaluation mentioned several unrelated challenges facing the group. These issues relate to member commitments to the group, the sub-committee's leadership, and influence and size.

The first challenge raised by respondents relates to the commitment of group members to the overall subcommittee process. One issue raised earlier on in the committee process was the resistance on a part of First Nations governments and agencies to become involved in the Northern Health Strategy's overall efforts. According to one group member, there was a concern that the processes of partnership formation—particularly involving the provincial and federal governments—may infringe upon Aboriginal autonomy. Considering most partnerships require concessions from all parties, some First Nations groups feared being told what to do.

Once the majority of partner agencies realized what was involved in the NHS, they began to accept partner roles in the overall process. On the human resources TAC, even though commitments were there from agencies and individuals to be a part of the group, attendance at meetings is still somewhat sporadic. As one respondent describes, "Because we're all from separate organizations we have our own priorities that we are dealing with. Often times this creates situations where only a few members are available to meet for a short period of time. When this happens, it leads to the group having a hurry-up-and-get-started approach to things. The rushed agenda of the group combined with the natural consensus of the group makes it hard to really look at issues in any specific detail."

A different issue raised in the interviews concerned the perception of leadership. According to one TAC member, there are periodic times when the individuals hired to lead the sub-committee fall under the impression that they are in charge. As such, when others come forward on a volunteer basis to work on specific initiatives it becomes awkward when they are told what to do. Essentially what happens is a misunderstanding of the group's dynamics. Summarizing the respondent's thoughts, the leaders are trying to direct the activities of the group in meaningful ways while the members simply approach their sub-committee involvement as an opportunity to network and share ideas—all-the-while contributing to the greater cause of the TAC.

A third issue mentioned in the interviews was the TAC's inability to actually implement anything. As the respondent describes, the sub-committee does sponsor and host

occasional workshops and training sessions but the larger goals of the group require other entities to make a change. He continues that, "We can only try to influence government and the other groups. Since we don't have the authority to do very much we must be proactive enough that people become prepared to do things together collectively".

The final concern raised by a respondent in the sample was that the sub-committee was just too large. Although one of the aims of this particular TAC is to include all of the relevant players involved in human resources of the health sector, the group's overall size has a negative impact on its overall effectiveness. Since the decision-making pattern of the group is usually one of consensus, tabling any new ideas or action plans takes a very long time. According to one respondent, the group has collectively recognized this matter and will begin considering different ways to address this issue.

Improvements

Respondent feedback on the necessary improvements of the sub-committee was limited. One respondent felt that the group was still at a formative stage and the primary focus at this time is to secure funding and maintain the current direction of the group; which is to solidify training for the health sector in the North. Another respondent also felt that the TAC was still at the early stages of its development. The difficulty however is that "most people desire the same end—however the devil is in the process to that end. Only time will tell". A different respondent suggested that more should be done to clarify the purpose that the sub-committee fulfills within the broader scope of the Northern Health Strategy.

6.6.2   Summary

Overall, the Northern Health Sector Training Sub-committee, which serves as the NHS human resources TAC has solid internal relations that have been supported by past work opportunities of the membership. Barriers to the decision-making process are posed by jurisdictional matters that produce differences in job pay across the same profession. Another challenge to decision-making is the lack of autonomy some members have to make their own decisions while the matter is on the table. Progress of the human resources TAC is marked by awareness that has been raised collectively by multiple groups. Awareness of issues within health human resources is possible because of the large mutual effort to include all of the relevant stakeholders in the North. The main accomplishment of the sub-committee is its movement towards establishing a multi-year multi-partner agreement that brings training to the North which also is relevant to the North.

6.7　Mental Health and Addictions Technical Advisory Committee

The main expected outcomes of the Mental Health and Addictions TAC are to provide a much-needed service roadmap for providers and clients, improve access for First Nations mental health and addictions services, improve the mental health status of Aboriginal people who suffer from mental illnesses and integrate various mental health and addictions services to better serve people in the North.

The MHATAC is comprised of mental health and addictions managers and directors from various northern health regions and First Nations communities; including representatives of the federal and provincial governments. During the period of this evaluation (2008-2010), examples of some active members of the MHATAC were representatives of the villages of Pinehouse, Sandy Bay and Ile a la Crosse; as well as the Canadian Mental Health Association, KYRHA and Saskatchewan Justice.

Throughout much of 2008 and 2009 the MHATAC—with the guidance of the committee's coordinator—worked with specialists and stakeholders to build a foundation for the services roadmap. While this process continued, the dire need for a response to youth suicide in the North emerged as the most important issue of the mental health priorities. The result was a Northern Saskatchewan Suicide Prevention Forum held in Prince Albert.

In June of 2009 over 200 participants convened to reach four main objectives: (a) examine the roles, strengths and service gaps in prevention, intervention and post-intervention suicides; (b) address the needs of front-line workers and clinicians; (c) encourage a collaborative approach to suicide that is informed by community members; and gather information and strengthen the network of community members and service providers[19].

According to internal documents of the NHS, participants at the forum "examined the current state of youth suicide and suicide prevention in their communities and moved towards a collaborative approach to identifying and addressing needs. A considerable amount of information was gathered and shared; and links between suicide rates and community development were explored. Participants declared their intention to engage in more specific planning, and plan implementation in their communities. The forum supported the development of a suicide prevention strategy".

Following the Suicide Prevention Forum, members of the Mental Health and Addictions TAC met to discuss their response to the directives offered by forum participants. The work of developing a suicide prevention strategy continues to be the main focus of this TAC.

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[19] Northern Health Strategy. (2009). *Northern Saskatchewan Suicide Prevention Forum: Report*. Prince Albert, SK: Northern Health Strategy.

6.7.1 Interview Analysis

The five respondents included in the sample of members from the Mental Health and Addictions TAC provided diverse answers to the questions posed by the evaluation team. Their comments serve as clear illustration of the multiple dynamics that surface when health care professionals and their administrators form partnerships across different jurisdictional boundaries, health professions and even models of treatment delivery.

Internal Relations

The internal relations within the Mental Health and Addictions TAC have in the past been more strained than the other groups within the Northern Health Strategy. Much of the difficulty among group members stemmed from differences in practice and methodology rather than differences in goal setting or understanding of the problems being addressed.

According to one respondent, the relationships in the beginning years of the TAC were not strong. In fact the divide among group members was so pronounced that it almost resulted in the demise of the TAC. Another respondent observed that members of the committee did not share the same vision for the committee nor did they have a similar professional understanding of mental health and addictions.

Once a new coordinator was put in place however, members of the TAC began to work together more. As one group member recalls, "Some who were resistant to the changes withdrew for a while but then came back when they changed their minds. There are still a few issues that need to be worked out between this group and the Northern Health Strategy but we're getting there". A different group member explains that as of late things are generally affable among committee members.

Decision-Making

The decision-making process within the MHATAC is described by respondents as consensus-based. The group discusses issues and tries to work towards a mutual agreement. The result is that there are very few occasions where a vote is necessary. Once decisions are made at the TAC level, recommendations from that process are sent to the Northern Health Strategy Working Group, who according to one respondent, "are the ultimate decision-makers".

Much like the internal relations of this committee, the decision-making process is not without its dynamics. According to one member, the decision-making process is generally consensus-based depending on who shows up to the meetings. A different respondent also felt that there is often a contrast of opinions within the committee.

Another barrier to decision-making relates to the capacity of the group to affect change. Even if members of the committee are able to settle their differences and arrive at a mutually agreeable decision, there is often trouble transmitting that consensus into action. As one interview participant summarizes, "there is frequently a mismatch between the higher level or principal agreement that people reach and the ability of our group to actually implement those changes at a community level". A similar comment by a different respondent also suggests that because of different understandings within the committee, members of the TAC become frustrated because they feel that they cannot accomplish anything new. The result is that many committee members decide to just stay within their own programs and rarely come out to meetings.

When decisions are made within the TAC, some respondents reported that they take the information back to their home agencies to share with colleagues and superiors. One respondent admitted that they were not entirely sure how communities and partner agencies were made aware of TAC decisions or initiatives. Another respondent felt that the NHS should try to be more effective in communicating information to others: "Information from our TAC goes to the [Northern Health Strategy] Working Group to be shared with communities. But I don't think that the communities hear as much about what is going on. I really think the NHS needs to do a lot more public relations in terms of getting the word out there on what's going on".

Overall, it seems that the sample of respondents interviewed from the MHATAC are not confident—or at least are not aware—of the communication that occurs between their committee and the outside world. In fact one respondent felt that at times there is not only an absence of communication between the NHS and other agencies regarding this TAC but an actual resistance to share certain pieces of information that may have stemmed from the Mental Health and Addictions Technical Advisory Committee. No further explanation of this view was given by the respondent.

Progress

Perceptions of success achieved by the Mental Health and Addictions TAC differ among those committee members interviewed. Two respondents identified the Northern Saskatchewan Suicide Prevention Forum held in June of 2009 as the major mark of success for the TAC. A third respondent felt that the opportunities for professional networking and knowledge transfer that have been provided by the TAC are also forms of progress.

A fourth respondent felt that the changed perception towards mental health and addictions in the North is a key part of the TAC's overall progress. According to this member, there has traditionally been considerable resistance among committee members to look at alternative approaches to mental health and addictions. The TAC experienced a

lot of resistance to moving away from the clinical aspects of the federal and provincial systems of care. However overtime the resistance weakened and individuals became more willing to look at new ideas—particularly with things like suicide responses. The interviewee felt that through these processes, "the bottom line is that we've made some progress in changing the status quo".

Although some of the respondents felt that the TAC had made some progress, several also felt that very little has come out of the Mental Health and Addictions TAC—especially compared to the other TACs of the NHS. One respondent explained that, "I don't think that this committee has been effective in making any changes. There has been some accomplishments—but relative to the time, effort and work achieved by the other TACs it has been considerably less." Another respondent felt that although the suicide forum was a successful event, the progress of the TAC hasn't extended beyond that: "It's been frustrating at times; to the point where I pondered continuing my involvement in the committee. It seems like so often we're spinning our wheels. It was very important to change the status quo in mental health and addictions but so many others resisted. Another factor was that there were very few Aboriginal people on the committee, at times this made altering world views a difficult idea to present".

Despite the various issues occurring within the TAC, and even if the outputs of the TAC were not as robust as those created by other TACs, the Mental Health and Addictions TAC did achieve some success. Interview respondents identified two main factors contributing to the success that they did achieve. The first was strong leadership and the second was the fact that the TAC *had to accomplish something*.

Regarding the first factor, several respondents explained that the hard work of the NHS coordinator and the TAC coordinator to organize some very concrete events and a website made a tremendous difference. Other comments regarding the coordinators include, "the bold leadership of the NHS coordinator to push this agenda through is the main reason we had a suicide prevention forum"; and "the new TAC coordinator's experience in mental health is rich—particularly in providing services to First Nations and northern communities". Collectively, the leadership of the NHS and the Mental Health and Addictions TAC were described by one TAC member as being effective because they remained unscathed by the resistance of regional health authorities and government structures which tried to preserve the status quo.

The other impetus of progress for this TAC was the feeling among members that despite all of the hiccups along the way, they had to accomplish something. As one respondent explained, "the need to accomplish at least something was what pushed our successes with the suicide prevention forum". Another interview participant felt that "the main attribute

to our progress was that the TAC was told that we have to do something in response to northern suicides".

The impact that the Mental Health and Addictions TAC has had on change in health service delivery is difficult to identify. Many respondents felt that the suicide prevention forum may have had some impact in terms of educating care providers, but any overarching changes to delivery of mental health and addictions services is non-existent. One committee member spoke to the variation in commitment that different jurisdictions are making towards adapting care provider perceptions of mental health and addictions. This individual felt that, "It is hard to see what impact we're having on mental health and addictions. I think that the positions of health care providers on mental health and addictions are changing but not everywhere. First Nations communities have the freedom to make positive changes in service delivery—some are doing so. However other communities within the provincial system are held back from making these changes. In fact, the biggest changes from the Province came in justice and advanced education. These entities are recognizing and including community input while the health sector is not".

Challenges

As noted throughout this analysis, many of the challenges experienced by members of the Mental Health and Addictions TAC stem from internal disagreement over whether or not to maintain the status quo methods of providing mental health and addictions services. Comments from the interviews suggest additional issues which have affected the forward movement of this TAC.

One suggestion was that the whole area of mental health and addictions itself does not provide a clear separation of professionals and non-professionals. This leads to role confusion and even incongruence among preferred practices; something that makes collective decision-making difficult.

Another concern mentioned during the interviews was that the Northern Health Strategy realizes that in order to provide effective services in mental health and addictions, and in order to accomplish the goal of healthier communities, existing services need to work with each community rather than keeping to themselves within their own system. As discussed previously, there are considerable systemic barriers within health regions and the provincial and federal governments which make these changes very difficult.

An additional probe into the problems caused by differences between groups suggests there is also a *disconnect* between Aboriginal community members and health care staff. According to one respondent, many First Nations staff say that they are not being listened

to by senior mental health and addictions professionals. The consequences of this are they do not feel validated as having any good ideas to meet their own community's needs.

The fourth difficulty mentioned by respondents relates to the capacity of the TAC to initiate change. During the interview process, a committee member pointed out that funding and personnel within mental health and addictions are generally kept within the provincial bureaucracy or regional health authorities. These resources are limited and neither of these entities have sufficient power to increase their own capacities. Further down the line, the TAC has even less capacity to change the mandate or priorities of mental health and addictions funding and resources. Even if the provincial or regional health authorities had the capacity to change their resource structure, approaching these entities would be nearly futile. The reason for this, according to the respondent, is because unlike other TACs that are in-line with most status quo funding initiatives, that isn't the case for the Mental Health and Addictions TAC.

One internal problem that complicates matters within the Mental Health and Addictions TAC is irregular attendance of its members. According to at least two respondents, the lack of commitment, travel barriers and time restraints of TAC members makes progress difficult to achieve. Compounding the issue is the fact that even when members are present at the meetings, most cannot commit to any particular decisions or initiatives without first getting approval from superiors at their home agency.

Improvements

Despite the comments on shortcomings, challenges and barriers faced by the Mental Health and Addictions TAC, very few suggestions for improvement were offered by interview participants. One suggestion was that committed funding towards some of the TAC's initiatives would help develop progress. Another thought shared by respondents was that more consistent membership and attendance would definitely strengthen the capacity of the TAC to move forward. Lastly, one respondent felt that "the TAC needs to be more vocal about what we do. Some members are very capable of being vocal about what they do; they need to help us overcome the resistance to change".

6.7.2   Summary

Interviews with members of the Mental Health and Addictions TAC suggest there are some longstanding differences between ideology, preferred practices, and even vision. For quite some time members of the TAC found it difficult to move forward because of the divide within not only their committee but their profession. Strong leadership shown by the NHS coordinator and TAC coordinator helped break down some of the internal barriers to change so that committee members could work together more effectively. The major

output of this committee has been the Northern Saskatchewan Suicide Forum; which according to some respondents was a must-do event not only in terms of client need but agency expectation. Many different types of barriers have affected the progress of the Mental Health and Addictions TAC. Some are internal while others stem from the systemic rigidity of the provincial, federal and regional health entities that preserve the status quo in the delivery of mental health and addictions services.

6.8   Perinatal and Infant Health Technical Advisory Committee

The purpose of the Perinatal and Infant Health Technical Advisory Committee is to offer NHS members and other partner groups a forum for collective discussion, information sharing, strategizing and action planning; concerning matters related to perinatal and infant health. Since its first meeting in November of 2004, the TAC has been working on developing awareness on pre and post-delivery issues, breastfeeding and sexual health. It has also made efforts to provide perinatal education and care.

Since 2008, most of the PIHTAC meetings have been held every two months. Members of the TAC who have been most active during this evaluation period (2008-2010) include an elder from Little Red Reserve, as well as representatives from AHA, MLTC, LLRIB, Public Health Agency, MCRRHA, KYRHA, Canadian Prenatal Nutrition Program, PAGC, and NMS.

One of the TAC's early achievements was its first perinatal forum held in October of 2008. Forum participants and members of the Perinatal and Infant Health TAC unified around a vision that all expecting parents and their families will experience the optimum in care, participation and choice around the celebratory experience of child birth. Forum participants identified that working with pre and postnatal services in Prince Albert, Saskatoon, North Battleford and Meadow Lake would be critical steps in this process.

Other achievements of the TAC include a lactation management course held in March of 2009 and labour assistant training held in August 2009. Both of these capacity-building opportunities were offered in Prince Albert; and were open to northern health care providers.

The most recent success of the Perinatal and Infant Health TAC was a second forum held in February of 2010. At this event, participants were provided with information on breastfeeding and diabetes prevention, midwifery, oral growth and development, methods of improving services to expectant mothers, and the role of culture and tradition in the celebration of birth. Feedback from participants revealed that a majority of the information and knowledge shared at the forum was useful and relevant to the day-to-day tasks of participants. Consensus surrounded the notion of a birthing centre to be established in northern Saskatchewan.

6.8.1 Interview Analysis

In total, 5 members of the Perinatal and Infant Health TAC were interviewed. Dialogue on the TAC provides insight on the different training opportunities provided by the TAC, as well as stakeholder forums on sexual wellness and improving care for expectant mothers. Feedback from interview participants does reveal some difficulties in retaining membership.

Internal Relations

According to members of the committee, the working relationship among members of the TAC is positive and effective. Several of the members have been on multiple committees together in the past and so are familiar with one another's ideas, perspectives and abilities. Others who were new to one another became easily acquainted and the team grew more effective as members got to know one another. Other major contributors to the positive environment of the group were the NHS coordinator and committee chair who established good relations with and between TAC members. Over time, as one member reveals, members grew collectively interested in putting their heads together to solve various issues.

Decision-Making

The process of decision-making within the Perinatal and Infant Health TAC is not unlike the process of many other NHS TACs. According to respondents, group members put forward ideas and through a round-table process consider the strengths and weaknesses of each option. From this they begin to set priorities based on either what is most attainable or what is more important. Remaining aware of the terms of reference for the TAC, committee members work to build a consensus around whatever decision they make. Once decisions are made surrounding information or initiatives, the group presents it to the leadership group and various stakeholders.

One description of the decision-making process took on a different context than the descriptions summarized above. The experience of one interviewee was that "The decision-making process is kind of difficult because we were there to represent the interests of our own organizations and to identify common issues and concerns. We couldn't really make decisions to change anything because none of us—including provincial, federal and transferred bands—had any control over program outcomes. We're essentially there to identify gaps in service".

The main difference between these two perspectives on decision-making is that the first few respondents simply spoke to the actions involved in decision-making while the latter

respondent commented on the committee's tendency to make decisions based on its capacity to influence the status quo rather than what it truly desires for perinatal and infant health care in the North. This provides for some useful information that can be used to better understand not only decision-making processes within this particular TAC, but all committees and groups of the Northern Health Strategy.

When asked how others learn about the decisions and planned activities of the TAC, a majority of members said that information is passed onto the Northern Health Strategy coordinator. The coordinator then shares this information with the leadership groups of the NHS who are thought to have been sending it to their communities and agencies. Some TAC members indicated that they too take information from their committee back to their agencies and share it with colleagues and superiors. One final means of communicating decisions and intentions of the TAC was the use of a forum.

Although most of the 5 committee members interviewed felt moderately content with the communication process of the Perinatal and Infant Health TAC, one member felt that communication was an issue with the committee: "We had plenty of input from communities and care providers going into our work but we didn't really have an effective strategy for getting it back out. Some of us did report back to our own agency's directors but for the most part not a whole lot of people knew what the Northern Health Strategy was".

Progress

The main markings of progress, according to those interviewed from the Perinatal and Infant Health TAC, are the training opportunities and professional forums put on by the committee. Special types of training arranged by the TAC include information on breastfeeding, labour assistance (DOULA) and patient follow-up. The two forums mentioned in the interviews concerned sexual health and various issues related to after delivery.

Another form of progress described by one interview participant was the movement of the group towards not only developing but following a work plan. One other additional form of progress revealed in the interviews was the fostering of large scale networking among various stakeholders in perinatal and infant health. The result of these sharing opportunities, according to one respondent, was the identification of gaps in services for patients and their families.

When asked to provide some insight on what factors contributed to the progress made by the committee, several TAC members provided comment that highlighted the internal composition of the group. One respondent explained that members of the group are

passionate about what they do and are interested in the initiatives the group elects to take on. Another felt that the wide range of the people in the group willing to use their diverse skills collectively is a huge asset. A third also felt that progress made by the group came from diverse individuals working together: "We work across jurisdictions and we work on the same purpose: to better the health of young moms".

Although several respondents felt that most members of the TAC were responsible for the progress made by the committee, three felt that the group's leadership deserves some of that credit. One felt that the TAC has "a really good coordinator who is interested in what she does". Another concluded that "a lot of success has come because of having a consistent chair person. The TAC membership is constantly changing because of turnover and transfer in the North. We spent a lot of time summarizing what we were about to new members but the chair kept us moving despite that". The third committee member believed that the networking which has been conducted by both the NHS coordinator and TAC coordinator have helped the TAC consistently move forward.

When it comes to gauging the impact of the various successes of the Perinatal and Infant Health TAC on health care service delivery, respondents from the committee were not overly confident that their efforts were far-reaching. One commented that the group has put forth many recommendations but was not sure that anything has ever came out of them. Another felt that although the TAC is improving support for breastfeeding in the North, the process is drawn out. The extent to which practitioners are using the training in their place of work varies.

Despite the uncertainty in exactly how effective the TAC has been in changing service delivery, the committee is providing exposure to ideas, practices and training that have not been shared in the North before. One respondent explains that "Our impact hasn't been earthshaking but the training has definitely been an asset in that it is the first of its kind. We've encouraged mothers and trained staff in labour assistance, breastfeeding and other matters. Many of the health care providers in the North do not have the experiences or resources to provide proper perinatal care. We have provided a lot of training".

Challenges

One of the main topics that seemed to produce similar responses from members of the TAC concerned the committee's main challenge: inconsistent membership. Some members describe the issue as occurring because of turnover within partner agencies. In other words, there are many job changes within some agencies and accompanying those staff changes are new members of the committee. Another cause for issues concerning membership is that not all partner agencies have been able to fill their seats on the

committee. As one respondent complains, "some partner agencies have had a vacant position on our committee for two years".

Another concern that interview participants seemed to agree on was meeting attendance. Several respondents felt that for quite some time there has been little consistency in member attendance. One recalls that, "there were a lot of no shows from different agencies. Many don't come because they are too busy—some are nurses while others are managers. These are busy people". Another felt that even though partner agencies appointed representatives to sit on the TAC, it is difficult to maintain their participation.

Despite the variation in committee membership and meeting attendance, one respondent felt that the remaining members on the TAC are committed and active. The result of this is that the TAC is able to engage in networking, which is thought to perhaps bring new members onboard.

One barrier mentioned by a respondent that is separate from the similar concerns discussed above relates to the negative impact that funding can have on the TAC's overall operation. As the committee member describes, "the expiration of funding to the Northern Health Strategy is a major hurdle. It seems like we're just starting to get things going and then all of a sudden there are no more funds to continue".

Improvements

When asked to identify improvements that would advance the way in which the Perinatal and Infant Health TAC works, participants offered limited feedback. One committee member felt that the TAC could become more effective if more people from the NHS could travel into the North to make sure that initiatives and new service techniques were implemented properly. This would not only decrease the steepness of learning curves but would bring the NHS closer to the health care providers it strives to serve.

Another respondent expressed some concern over the lack of substantial funding. If there was a source of continuous funding that was sufficient, the TAC could be in a better position to act on its agenda. A related concern shared by the same respondent was that "we need TAC members who have the capacity to make decisions regarding funding—without that most issues die in the water".

The last suggestion for future activities of the TAC is to hold more forums. One interviewee felt that the forums not only provide good information to participants but serve as excellent hubs for networking across professions and jurisdictions. Providing more forums would increase the knowledge-base and connectedness of the perinatal and infant health fields of health care.

6.8.2   Focus Group Analysis

In October of 2009 SPHERU facilitated a focus group with the Perinatal and Infant Health TAC. The brief meeting centred around the impact of the TAC on health care practices in the North, what participants found helpful to their TAC endeavours, the strengths in partnerships fostered by the Northern Health Strategy and delays in progress caused by variation in decision-making autonomy and attendance. Data were collected through hand written notes and an audio recording. While most of the meeting's 7 participants were physically present at the meeting, two connected to the meeting through a teleconference call.

Impact on Northern Health Care

When asked to discuss the impact of the TAC on health care in the North, participants pointed mainly to the awareness and networking that has increased because of their activities. One participant explained that there was noticeably more sympathy and awareness for moms who have to travel down South to deliver a baby. She also added that there has been an increase in knowledge of issues that come with traveling to deliver—such as pre-delivery and post-delivery needs. Some members of the TAC felt that while there is definitely an increase in knowledge, there hasn't been a lot of change in the delivery of services. Essentially, the work of the committee has made some in-roads but more work needs to be done.

Another impact of the TAC on northern health care is the creation of understanding between health care providers in the North and South. According to one participant, the networking that the TAC has fostered among health care workers from different agencies gives northern health care workers the ability to share stories from the North. This helps health care workers in more southern parts of the province to understand what conditions and barriers health care workers and patients face in the North.

In summary, it seems that participants in the focus group identify knowledge transfer as being the most visible impact on health care not only in the North but in the South. The discussions described herein suggest that informing other health care workers of the conditions and barriers to perinatal and infant health could open doors for change that is much needed throughout Saskatchewan.

Helpful Contributions to the Perinatal and Infant Health TAC

Dialogue surrounding the most important things that help TAC members in their endeavours indicates that training and information sharing are crucial. One participant explained that being able to take training specific to breast feeding has been a major asset.

According to another participant, the training and information she has received from conferences and workshops has been very helpful. Her community does not have a lactation consultant and so the knowledge she has been able to bring home to her community is very useful. A closing comment on the topic of breastfeeding training indicates that participants have their own jobs and duties at their home agencies away from other TAC members. However, having the opportunity to receive such training gives them the support and confidence to continue on with their work both effectively and efficiently.

Strengths and Benefits of Northern Health Strategy Partnerships

One of the main themes guiding this evaluation is partnership formation and the strengths of these relationships within health care. When asked to discuss some of the benefits to the partnerships, participants of the focus group pointed to some of the issues already discussed by the group. One participant claimed that the partnerships fostered by the Northern Health Strategy bring people together from across the North who all work in the same field. This allows for increased awareness of different issues that affect perinatal and infant health. Another considerable benefit was the access to professional opinions and recommendations that is made available through committee events and meetings.

Overall it appears that the greatest benefit of the NHS to health care workers is the networking that it fosters. According to focus group participants, this networking leads to information sharing and training opportunities that improve the confidence and ability of health care providers.

Sources of and Solutions to Progress Delay

Respondents who participated in the interview phase of this evaluation were asked to identify barriers or challenges that delayed progress of the TAC. Two sources of delay in the progress of the Perinatal and Infant Health TAC were variation in both attendance and the decision-making autonomy of members.

One participant suggested that there is considerable value in acquiring and contributing knowledge. However, the process would be much more productive if members were to have someone along with them to make decisions at the table. Having individuals at the table that had authority would reduce the time that TAC members spend reporting back to their home agencies and waiting for a reply; then bringing that response back to the TAC. However, having someone from the home agency come to meetings would be difficult. As one participant explained, "we just don't have the bodies available for that kind of thing anymore".

The other problem mentioned by participants in the focus group and interview respondents is variation in attendance. When trying to move forward on initiatives it is difficult when not all of the agencies involved are present. As one focus group participant describes, "it is very difficult because there are a lot of vacancies on the committee that stem from agencies who have not selected a representative to sit on the committee". Another concern raised was that some times people are placed on the committee by their home agency and the work of the committee—or at the very least attending TAC meetings—is not in their list of priorities. Finally, having the time and capacity to travel to meetings, especially over large distances, is often difficult. Geographic locations of agencies are an important factor in determining which representatives attend meetings.

In terms of solving some of these problems, one of the participants mentioned that face to face meetings are ideal, but not always practical. Instead, teleconferences and the use of Telehealth may be helpful in increasing attendance.

Additional Feedback

In wrapping up the focus group, the facilitator asked participants if they had any additional comments to make regarding any topic covered or not covered in the session. One participant offered additional feedback: "because of the need for networking in health care, many TAC members are tied up with work in various committees. If they join too many, there is a risk that their effectiveness lessens".

A second participant provided additional information: "We need more support from our CEOs. We often get pushed back because [perinatal and infant health] is not a hot topic; as a disease is or something". Though not mentioned frequently in the interviews conducted for this evaluation, the salience of issues concerning perinatal and infant health quite possibly could be overshadowed by issues of more salience in the North (ie: chronic disease, addictions, suicide, etc.).

A third participant explained that increasing the attention to infant health is important, particularly in the North. There are many barriers to care for the new/expecting mother and her child; increasing knowledge on this matter may help reduce some of these barriers.

6.8.3   *Summary*

Overall, data collected from members of the Perinatal and Infant Health TAC reveal significant value in the progress achieved by this group. The multiple opportunities for training and knowledge sharing have benefited both health care providers in the North and South. Breaking down some of the barriers faced by new/expecting mothers both before and after delivery is important. Much of the work done by this TAC—according to

participants—contributes to reducing these barriers. As suggested by participants of this focus group and interview respondents, considerable work still needs to be done. Overall, finding a way to improve meeting attendance, attract continuous membership, secure sustainable funding and give committee members more decision making autonomy could help advance the progress of this TAC.

7.0   FINDINGS

As outlined in the opening section of this evaluation report, one purpose of this review was to evaluate the progress made toward the ongoing effective multi-jurisdictional partnerships and decision-making processes. Another purpose of this review was to evaluate progress in specific areas of work undertaken by the Northern Health Strategy's Technical Advisory Committees, as well as to identify the impact of the TACs on healthcare delivery.

To fulfill these purposes, evaluators from the Saskatchewan Population Health and Evaluation Research Unit sought to identify and describe the process used to promote cross-jurisdictional partnerships, as well as the challenges and successes of that process. The review team also examined decision-making processes within these relationships and undertook an in-depth analysis of the various successes and challenges of the NHS Technical Advisory Committees. These various tasks were carried out through the collection and analysis of data which derived from respondent interviews, focus groups, evaluator observation and documentation provided by the NHS.

Cross-Jurisdictional Partnerships and Decision-Making

The core findings of this review indicate that cross-jurisdictional partnerships are formed in northern Saskatchewan because of a shared need among healthcare providers to reduce barriers of equitable access to quality health care for all northerners. Barriers identified in this research include distance, language, culture, economy, capacity and knowledge. The largest barrier is the many administrative hurdles presented by jurisdictional differences among healthcare providers. Assisting in the process of partnership formation—and subsequently barrier removal—are the facilitating efforts of the Northern Health Strategy and its various components.

Decision-making within such partnerships is often possible because of a mutual understanding of the problem and preferred solutions. While most decision-making within NHS partnerships is consensus-based, cooperative efforts are often affected by misinterpreted role expectations, a lack of decision-making autonomy among partner representatives and variation in the stages in which each partner agency is at concerning its own deliberation of a given issue or initiative.

TAC Progress, Challenges and Impact

Members of the Northern Chronic Care Coalition have succeeded in providing patient-self management training, medicine wheel teachings and peer-leader training. They have also made several in-roads with the implementation of the Expanded Chronic Care Model and have benefited from the numerous undertakings of PAGC's Chronic Disease Network and Access Program. Some of the challenges encountered by the NCCC include travel barriers that make meeting attendance sporadic; a lack of decision-making autonomy among some members, which makes the partnership process somewhat inefficient; and the broad context of the chronic disease field which makes prioritizing goals a challenging process. The most significant impact of the NCCC has been its training in patient-self management as well as the work done by CDNAP. These efforts have improved the ability and capacity of healthcare providers to provide better care.

The Northern Oral Health Working Group has achieved progress in providing oral health promotion throughout northern communities; fostering opportunities for networking and continued education for dental professionals; spearheading the standardization of treatment and prevention processes; delivering fluoride varnish training programs; initiating movement towards the use of electronic dental records; and expanding access to a dentist in the North. Some of the challenges which have affected efforts of the NOHWG are time constraints on particular projects, vacant committee seats, and communication difficulties between committee members and its leadership. The greatest impact of the NOHWG has been the increased access to dental services among northern residents. Other impacts have been the increased capacity of communities to implement proper oral health prevention and treatment programs—including fluoride varnish; and increased opportunities for dental professionals to network and continue their education.

The Human Resources TAC, known formally as the Northern Health Sector Training Sub-Committee, has made considerable progress in a number of areas: it examined human resource priorities in the North; identified several strategies for promoting math and science among northern schools; developed a foundation for a Northern Health Human Resource Strategy; spearheaded a Northern Nurse Education Strategy and promoted health careers to high school students throughout the North. Some of the difficulties faced by members of the NHSTSC are sporadic attendance, role misunderstanding, and other challenges that are associated with having too large of a group. One struggle commonly experienced by the Human Resources TAC is that the changes within the human resources sector requires many other entities (outside of the NHS partnerships) to accept change and provide actual support to the change process. These conditions contribute to slow progress for the NHSTSC. The major impact of this group has been awareness-raising of two issues: (a) the need for additional healthcare workers in the North; and (b) the need for learning institutions to provide training that is not only relevant but also accessible to the North.

The Mental Health and Addictions TAC was progressive in developing its own work plan and identifying some of the barriers to reform within the mental health and addictions profession. The main indicators of success for the MHATAC are the Northern Saskatchewan Suicide Prevention Forum; its development of a services roadmap; and construction of a Northern Suicide Prevention Strategy. Some of the issues constraining efforts of the MHATAC have been sporadic attendance; internal relations issues that arise from differences in practice as opposed to differences in goals; struggles that arise from the lack of separation between professionals and non-professionals in the mental health and addictions profession; communication gaps between mental health and addictions workers and other healthcare staff; and constraints on change which arise from the fact that the mental health and addictions service delivery system is an entity of the provincial health care system. The most significant impact of the MHATAC has been in helping northern stakeholders and care providers identify warning signs and intervention methods of suicide—particularly for youth.

The Perinatal and Infant Health TAC achieved progress by developing awareness of pre and post-delivery issues, breastfeeding and sexual health; hosting two different perinatal forums; offering training in lactation management as well as labour assistance; and building consensus around the need for a birthing centre in northern Saskatchewan. Although the PIHTAC celebrated many successes within this evaluation period, it had to overcome several challenges: inconsistent attendance; vacant committee seats; changing committee membership; uncertainty of funding; a lack of decision-making autonomy among group members; and a lack of understanding among healthcare providers and community leaders around the issues facing new and expectant mothers in the North. The PIHTAC has had some impact on healthcare delivery by expanding care provider access to new ideas, practices and training. The labour assistant and lactation management training provided through the committee has also increased the service capacity of care providers in the North.

Overall, the combined progress of all five TACs explored in this review can be marked by three main developments: (a) levels of raised awareness; (b) increased specialization, standardization and knowledge transfer; and (c) networking in new areas. While many of the TACs share similar experiences in their endeavours, each has also experienced its own unique set of successes and challenges. One major impact of the TAC process has been expanded service capacity of care providers in the North. Training sessions, knowledge transfer and networking have all been used as tools to increase the quality of care that patients receive from their caregivers in the North. A second major impact has been increased access to services for northerners. The development of initiatives designed to break down barriers to healthcare have allowed more northerners to access the care they need.

7.1   Evaluation Questions and Answers

As described in the opening sections of this report, the review was guided by 12 evaluation questions. Further discussion of the findings is used to address each of these questions.

How are cross-jurisdictional partnerships being promoted?

Several explanations on the promotion of cross-jurisdictional partnerships were highlighted through this evaluation process. One is that the direct and indirect benefits of a partnership draw in potential partners. These benefits include information sharing, capacity building and access to a broader support network. Partnerships are also promoted where members share problems and feel they can work together to find a shared solution. A third major factor for promoting partnerships is the fact that partnerships are a practical necessity in the North. In other words, the many barriers to northern healthcare make collaboration inevitable.

Where are cross-jurisdictional partnerships forming?

The North has a natural inclination to work together, however it is divided by institutional structures from different levels of government. Partnerships form where there is a collective need to overcome these barriers which tend to drive agencies apart. This process is seen through the formation of the Athabasca Health Authority and the Mamawetan Churchill River Regional Health Authority. Other partnership formations stem from the Northern Health Strategy itself. The many events and meetings of the NHS various components bring healthcare professionals and community leaders together so that they can create collective solutions to their shared problems.

What are some of the successes and challenges concerning cross-jurisdictional partnerships?

Success stems from shared understandings of problems, as well as agreement on the preferred solution to that problem. Success in cross-jurisdictional partnerships also occurs when the partners have a common knowledge and understanding of one another, and share an element of trust towards the other partners. One final determinant of success is when the benefits of the partnership appear to yield equal positive outcomes for each partner agency. Several challenges to the process of partnership formation can lessen the extent of such success: diverse funding arrangements, meeting absences, misunderstandings of the North, the difficulty of affecting change in government systems, contrasting understandings of the issues at hand, dissimilar role expectations, reinforcement of the status quo, and inconsistent commitments to the sustainability of the NHS.

How are decisions made within the cross-jurisdictional partnership process?

Decision-making within cross-jurisdictional partnerships occurs through a process of consensus. The various partners contribute their understandings of the issues and work together to generate solutions that all members can agree upon. During this process it is important that there is a common understanding of the problems being addressed. It is also critical that the partners share the same principles of cooperation and collaboration and that there are effective forms of communication between those involved. Most importantly, members to the partnership need to be equally committed to success and the process required of reaching that success. Difficulties within decision-making can occur when members are at different stages of their own decision-making process, when members are absent from partnership meetings, or when members lack the autonomy to make decisions on behalf of their home agency. One final challenge in decision-making is when there is a lack of leadership within the group. It is important throughout this process that someone is able to move the partnership forward so that it does not get distorted by the many challenges which may occur through the decision-making process.

How are cross-jurisdictional relations being enforced?

There is very little in terms of an enforcement mechanism which keeps partnerships together within the NHS. Cross-jurisdictional relations are for the most part, self-determining. Although memorandums and letters of understanding bring groups together in a more formal process, it is the perceived benefits of the partnership that determine the behaviour of members within the partnership. The shared understanding of problems facing the North, combined with a collective will to generate effective shared solutions to these problems, is the biggest reason for continued involvement of the partnership members.

How is information and knowledge shared within these partnerships?

Members of the various components of the Northern Health Strategy (ie: NHSWG, PIHTAC, NOHWG, etc.) play the biggest role in sharing information and knowledge within the NHS partnerships. Members of the various committees and working groups exchange ideas, practices and training with one another on a regular basis. As decisions are made within each component of the NHS, leaders of each component will share that information with leadership of other components—who will in turn distribute that information to its own group members. As members of these committees and working groups return to their home agencies, they will often share this information with their administrators—who then generally inform their agency staff about the NHS.

How is information from various components of the NHS being shared with northern communities?

As decisions are made and initiatives of the NHS near the implementation process, the NHS will reach out to communities and inform them of such progress. This occurs through newsletters, email, information sheets and radio or newspaper ads. A more direct means of communication with northern communities is through visits or letters to chiefs, mayors and other community leaders. The NHS coordinator spends considerable time informing these various stakeholders of the NHS past accomplishments and future ambitions. Another way that information is shared with northern communities is when committee and working group members return home and share NHS information with their community. A final means of communication with the North is through the Northern Leadership Forum—which sees northern leaders periodically assemble in an effort to identify common concerns and future directions of the NHS.

What direction should cross-jurisdictional partnerships and decision-making be headed in the long-term?

The findings suggest that the NHS should continue its current direction. While northern communities and healthcare agencies are committed to the partnership process, their success is dependent upon the involvement and coordination of the NHS. Other long-term goals should be for the NHS to include more partners, establish a mechanism for improving meeting attendance, improve its communication strategy and identify the cost-savings in healthcare that are attributable to the outputs of the NHS.

Are the partnerships formed through the NHS sustainable?

Observations and interview data indicate that there is a great desire among partner agencies to continue the partnerships they have formed. These partnerships will remain sustainable as long as members remain committed—and at the same time—continue to feel that they are experiencing as much benefit from the partnership as the other members—relative to what they put into the partnership. One major factor in partnership sustainability is funding which allows various partnerships to continue their work in an initiative-driven fashion.

What process do the TACs use to communicate, make decisions and accomplish their objectives?

The various TACs explored in this review meet to share information on a given topic. When ideas are presented all members are given the opportunity to provide feedback and exchange different positions on the topic. Through a fair and open process, the TACs work towards a final decision that is consensus-based. Once decisions are made, information is sent to the NHSWG for approval of this decision. From there, members of the TACs take the decisions to their home agencies and share the information. Other means of

communication include information meetings, advertisements, letters and personal contact among NHS participants.

What progress are the TACs making towards accomplishing their goals and objectives?

All five of the TACs have made some progress in achieving their goals—some more than others. Collectively however, they have raised levels of awareness concerning health issues confronting northerners; increased specialization, standardization and knowledge transfer; and have developed networks among healthcare professionals who had not previously interacted with one another.

What impact have the TACs made on the delivery of healthcare in the North?

One major impact of the TAC process has been expanded service capacity of care providers in the North. Training sessions, knowledge transfer and networking have all been used as tools to increase the quality of care that patients receive from their caregivers in the North. A second major impact has been increased access to services for northerners. The development of initiatives designed to break down barriers to healthcare have allowed more northerners to access some of the care they need.

8.0   RECOMMENDATIONS

Based on findings presented in the report, the following recommendations to the Northern Health Strategy are proposed:

a) Reduce travel barriers to working group and committee meetings by hosting them in the North. As identified through interviews and observation, many participants of the NHS have heavy workloads at their home agency. Selecting a northern meeting location may help some participants find time in their schedule to attend NHS meetings.

b) Improve role definition processes within the TACs. Findings of this report reveal that several TAC members were not clear of the role they were to play in the committee. Furthermore, confusion and conflict has occurred when committee or working group leaders place expectations upon NHS participants who are unaware of their obligations to the NHS process.

c) Establish representation from jurisdictions not actively involved in the NHS process. On several occasions, interview respondents from various components of the TAC reported that progress was thwarted by vacant seats of partner agencies that had no representative. Working with partner agencies to make sure that they have representation within various

components of the NHS will contribute towards more successful outcomes of the partnership process.
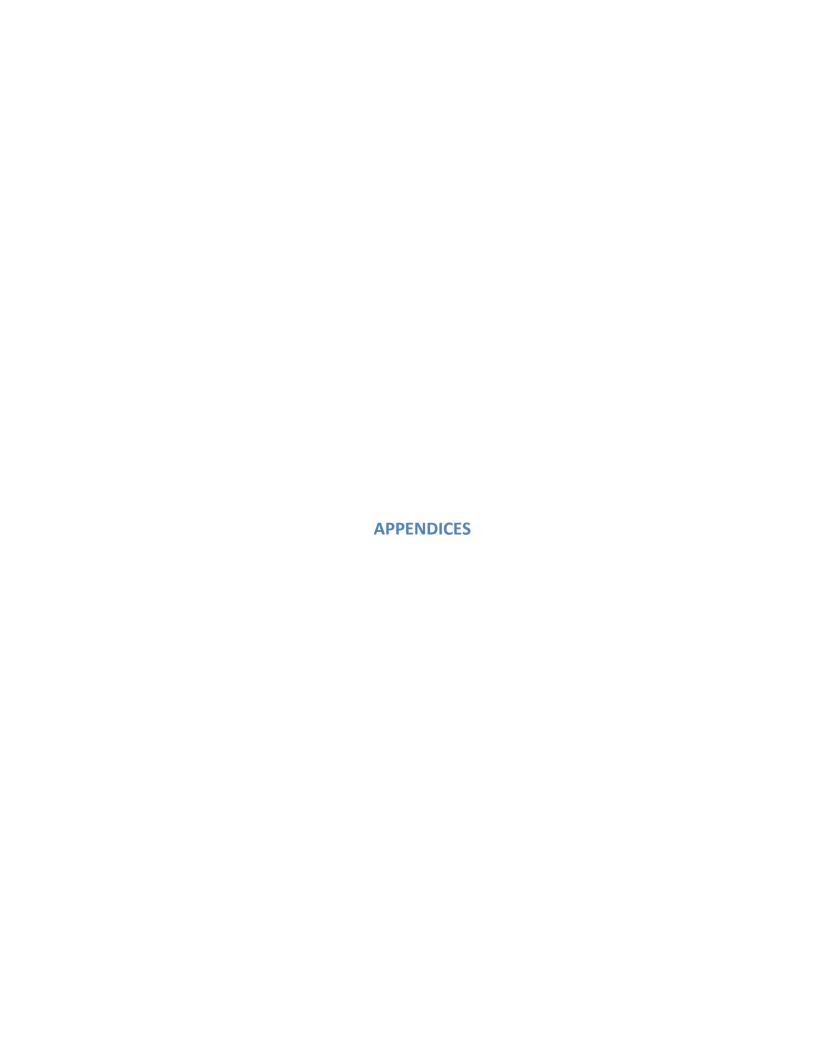
d) Identify and implement a mechanism for improving meeting attendance. Findings of this review indicate that there are several explanations for the poor, sporadic, or inconsistent attendance that stymies the efforts of NHS working group and committees (ie: travel barriers, NHS is low priority, busy schedule, participants don't feel their expertise is relevant). The NHS should endeavour to develop a mechanism for attendance improvement that addresses these multiple issues on a component-by-component basis (ie: NHLWG, NCCC, etc.).

e) Discuss with NHS participants the utility of continuing to run committees or working groups with two leaders. Interview data indicate that once TACs had a designated leader and coordinator in place they became much more task-oriented; and ultimately successful. However some respondents felt that at times the built-in efficiency of having a steady pair of committee leaders reduced the involvement of remaining committee members in the decision-making process. The NHS should examine this issue further.

f) Design and implement a strategy which sees representatives from the NHS visit various communities to monitor and assist with TAC initiatives. Interview data reveal that while most of the initiatives that TAC members embark upon are well received by northern communities, variation in capacity and understanding prevent uniform implementation of these initiatives.

g) Encourage each TAC to host special-topic forums that are initiative-driven. The successes of past forums held by TACs (ie: perinatal forum, suicide prevention forum) suggest that similar events hosted by other TACs may generate several benefits: (a) increased capacity of care providers; (b) more involvement of northern care providers and stakeholders in TAC initiatives; and (c) increased understanding of the NHS and its various objectives.

h) Utilize communication technologies already in place at many healthcare agencies. One of the more significant barriers to meeting participation was travel and time restraints. The use of Telehealth may increase participant involvement without sacrificing the human element of the TAC process (ie: visual and audio vs. audio only). If Telehealth capabilities are not in place the use of conference calling could also improve meeting attendance*.*

i) Work with leaders of partner agencies to generate a clearer understanding of what support is needed by TAC members during the implementation of certain initiatives. Feedback from NHS participants suggests that although the leadership of partner agencies are aware of the TAC process, they may not have a clear understanding of ways in which they can help in the implementation of TAC initiatives (or at the very least, ease some of the barriers stemming from within their own organization).

9.0   CONCLUSION

The findings of this report suggest that different groups within the North are willing to move beyond the status quo if it means improved access to quality health care. The means to such an end come primarily through a collaborative process that results from cooperative decisions-making within cross-jurisdictional partnerships. This evaluation examines these cross-jurisdictional partnerships and decision-making to provide a better understanding for how health system changes can generate improvements in the overall health status of all residents of northern Saskatchewan.

This report has highlighted some of the obstacles to partnership formation. However the shared desire of northern health agencies and communities to overcome the many barriers to quality healthcare in the North is driving the partnership process through these many challenges. Once partnerships form, they function as long as the members of that partnership hold the same views of the problem throughout the decision-making process. Identifying and defining these problems are members of the Northern Health Leadership Working Group. Through a process of deliberation and consensus, solutions to these problems are prioritized by the Northern Health Strategy Working Group and generated by various Technical Advisory Committees. The Northern Leadership Forum is used to report on and provide feedback from northern community leaders on the achievements and ambitions of the NHS.

Progress of the Northern Health Strategy's TACs has also been a major topic of this review. Findings from this evaluation suggest that, despite facing many challenges to progress, all five TACs included in the review have achieved some form of success. Collectively, they have increased awareness of issues relevant to the North; facilitated specialization, standardization, and knowledge transfer; and provided networking opportunities in areas and professions where such sharing opportunities have not existed previously. Overall, these contributions have increased the capacity of northern communities so that they can widen the access to quality healthcare services in the North.

APPENDICES

SPHERU

SASKATCHEWAN POPULATION HEALTH AND EVALUATION RESEARCH UNIT

NHS Working Group Members
Northern Leadership Working Group Members
Northern Health Strategy

RE: EVALUATION INTERVIEW FOR NORTHERN HEALTH STRATEGY

I am part of an evaluation team conducting a review of several components of the Northern Health Strategy (NHS). This evaluation involves collecting information from existing documents and through interviews with key participants, stakeholders and partners of the NHS. I write to ask for your participation in this review process.

In the next few weeks we plan on interviewing people on their experiences with the Northern Health Strategy. Essentially there are two types of respondents. The first are those who are in a position to be aware of the cross-jurisdictional relationships fostered by the NHS and the second are those who are on the Technical Advisory Committees within the NHS. You have received this letter because Nap Gardiner, Coordinator of the NHS, has identified you as a key informant who may be familiar with the cross-jurisdictional relationships fostered by the NHS.

If you are willing to participate in this interview process we will ask you to read, sign and return an interview consent form to us (attached). This form informs you that your involvement is voluntary and that your responses to our questions will be kept confidential and anonymous. No one outside of me and the immediate SPHERU evaluation staff will know who said what in the interviews. Following this we will need to arrange a time for me to interview you. The interview itself should take between 25 and 45 minutes. Whether they are conducted over the phone or in person, we are asking for your permission to audio tape the interview. You will be offered the opportunity to review your interview transcript.

If you are willing to be a part of this process please read and sign the interview consent form and fax a copy to (306) 953-5305. To arrange a time for an interview or if you want to ask me any questions please call me at (306) 953-8384 or email me at LSCSI@hotmail.com. Thank you. I look forward to your participation in this review.

Sincerely,

Dr. Chad Nilson
Evaluation Consultant

SASKATCHEWAN POPULATION HEALTH AND EVALUATION RESEARCH UNIT

Technical Advisory Committee Members
Northern Health Strategy

RE: EVALUATION INTERVIEW FOR NORTHERN HEALTH STRATEGY

I am part of an evaluation team conducting a review of several components of the Northern Health Strategy (NHS). This evaluation involves collecting information from existing documents and through interviews with key participants, stakeholders and partners of the NHS. I write to ask for your participation in this review process.

In the next few weeks we plan on interviewing people on their experiences with the Northern Health Strategy. Essentially there are two types of respondents. The first are those who are in a position to be aware of the cross-jurisdictional relationships fostered by the NHS and the second are those who are on the Technical Advisory Committees (TACs) within the NHS. You have received this letter because Nap Gardiner, Coordinator of the NHS, has identified you as a member of a TAC.

If you are willing to participate in this interview process we will ask you to read, sign and return an interview consent form to us (attached). This form informs you that your involvement is voluntary and that your responses to our questions will be kept confidential and anonymous. No one outside of me and the immediate SPHERU evaluation staff will know who said what in the interviews. Following this we will need to arrange a time for me to interview you. The interview itself should take between 45 and 75 minutes. Whether they are conducted over the phone or in person, we are asking for your permission to audio tape the interview. You will be offered the opportunity to review your interview transcript.

If you are willing to be a part of this process please read and sign the interview consent form and fax a copy to (306) 953-5305. To arrange a time for an interview or if you want to ask me any questions please call me at (306) 953-8384 or email me at LSCSI@hotmail.com. Thank you. I look forward to your participation in this review.

Sincerely,

Dr. Chad Nilson
Evaluation Consultant

SPHERU
SASKATCHEWAN POPULATION HEALTH AND EVALUATION RESEARCH UNIT

Interview Consent Form

Project Title: Northern Health Strategy Evaluation

Lead Researcher
Dr. Bonnie Jeffery
Faculty of Social Work & SPHERU
University of Regina
Prince Albert Campus
306-953-5311
bonnie.jeffery@uregina.ca

Researcher & Interviewer
Dr. Chad Nilson
lscsi@hotmail.com   (306) 953-8384
Prince Albert, SK.

Overview of the Project: We are contacting you to ask for your participation in an interview that will be part of the information collected to complete an evaluation for the Northern Health Strategy Working Group. This project will focus on two areas: evaluating the progress made toward the ongoing effective multi-jurisdictional partnerships and decision-making processes and evaluating progress in selected areas of the work of the Technical Advisory Committees.

Methods: The evaluation involves collecting information from existing documents and through interviews with key members of the Northern Health Strategy. We are asking for your participation in an interview where we will ask you a number of questions related to your role and work with the Northern Health Strategy. We anticipate that the interview will last no longer than 1 hour. Please be advised that you do not have to answer any questions you are not comfortable with and that you may change your answers or withdraw from the project at any time. No questions will cause undue physical or emotional stress. Your specific responses will not be identified in the final report since the interview information will be presented in an aggregate form. All interview data will be kept confidential and only the research team will be aware of your identity. You will have the opportunity to review your transcript. All materials pertaining to this interview (tapes, digital recordings, hard copies of transcripts, electronic files on disk) will be stored in the office of the lead researcher in a locked cabinet. All materials will be destroyed no later than three years after the end of this project.

If you have any question or concerns regarding the procedures of the project as they are outlined here, please contact Dr. Bonnie Jeffery at the phone number or email address above.
I have read and understood the contents of this consent form and agree to participate in this interview and this study: _____ Yes   _____ No

I have received a copy of the consent form for my files: _____ Yes   _____ No

I agree to have my interview audio taped: _____ Yes   _____ No

I give the researchers permission to use direct quotes from my interview if these quotes are seen as helpful to illustrate a particular finding and as long as these quotes do not reveal my identity: _____ Yes _____ No

_____
Participant Name (please print)

_____
Participant Signature

_____   _____
Researcher Signature   Date

I wish to have my transcript returned to me so that I may review it for omissions and errors: _____ Yes   _____ No

I understand that my address will only be used to return the transcript to me:

Name: _____

Address: _____

                 _____

PLEASE FAX THIS CONSENT FORM TO SPHERU AT (306) 953-5305

INTERVIEW GUIDE: KEY RESPONDENTS
NORTHERN HEALTH STRATEGY EVALUATION

1) What is your position within the (NHSWG, NHLWG, NLF)?

2) How long have you been involved with the NHS?

3) In your involvement with the NHS, have you experienced any cross-jurisdictional partnerships? Please explain.

4) What do you feel promotes cross-jurisdictional partnerships within the scope of the NHS?

5) In your involvement with the NHS, how do cross-jurisdictional partnerships operate?

6) Can you describe the process by which cross-jurisdictional decision-making occurs?

7) In your experience with the NHS, what do you feel leads to success in cross-jurisdictional decision-making? What leads to unsuccessful attempts at cross-jurisdictional decision-making?

8) After decisions are made, how do participants of the NHS provide information to their home communities and agencies about these decisions?

9) How are cross-jurisdictional decisions put into practice?

10) What direction do you think the partnerships and collective decision-making built within the NHS should be headed in the long term? What about the short term?

11) Do you know of any documents that may help us in our efforts to understand cross-jurisdictional partnerships and decision-making within the NHS?

**INTERVIEW GUIDE: TAC RESPONDENTS
NORTHERN HEALTH STRATEGY EVALUATION**

1) What is your position within the TAC?

2) How long have you been involved with the NHS?

3) Can you describe the working relationship between members of your TAC?

4) Can you describe the decision-making process within your TAC?

5) How do communities and other service providers learn about decisions and initiatives made within your TAC?

6) To your knowledge, what progress has your TAC made?

7) What would you say is attributable to your TAC's progress?

8) Do you feel that your TAC has contributed to the change in any particular health service delivery?

9) What shortcomings or weaknesses would you say your TAC has?

10) Do you have any suggestions for improving the way your TAC works?

11) Do you know of any documents that may help us in our efforts to understand your TAC and the decision-making processes within the NHS?

APPENDIX F

List of Documents

Note: Appendix F can be found in the printed version of this report.

**It can also be found on the SPHERU flash drive that was provided
to Northern Health Strategy along with the printed report
in a separate file named
*NHS Appendix F – List of Documents.docx***

For further information regarding this publication please contact:

Dr. Bonnie Jeffery
University of Regina
E-mail: bonnie.jeffery@uregina.ca
Phone: (306) 953-5311

For general information regarding SPHERU's research...
www.spheru.ca
or contact us:

SPHERU Regina
E-mail: spheru@uregina.ca
Phone: (306) 585-5674
Fax: (306) 585-5694

SPHERU Saskatoon
E-mail: spheru@usask.ca
Phone: (306) 966-2250
Fax: (306) 966-6487

SPHERU Prince Albert
E-mail: spherupa@uregina.ca
Phone: (306) 953-5535
Fax: (306) 953-5305

SPHERU is a bi-university, interdisciplinary research unit committed to critical population health research. The SPHERU team consists of researchers from University of Saskatchewan and University of Regina who conduct research in three main areas: northern and aboriginal health, rural health, and healthy children.

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