FINAL REPORT

Government of the Northwest Territories
Department of Health and Social Services

Evaluation and 811 Feasibility Study for Tele-Care NWT

September 29, 2006

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Letter of Transmittal

September 29, 2006

Charlotte Pecknold
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RE: Department of Health and Social Services Evaluation and 811 Feasibility Study for Tele-Care NWT - RFP #HS0350

Dear Charlotte:

Howard Research and Outcrop Communications are pleased to submit this Final Report: *Evaluation and 811 Feasibility Study for Tele-Care NWT.*

Content is based on research and evaluation activities conducted during August and September 2006.

Yours sincerely,

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Multi-jurisdictional Collaboration on Healthlines who provided access to an extensive array of reports and research on the topic of health lines.

A special thank you goes out to Charlotte Pecknold, Tele-Care NWT Project Coordinator, Department of Health & Social Services, Government of the Northwest Territories for her extensive cooperation in guiding the parameters of this study and providing data, often on short notice due the very tight deadlines for data collection and report preparation.

Table of Contents

Executive Summary

> *A basic principle of the health and social services system is that people have the responsibility to maintain their own health. This has been a clear message in all past reviews of the health and social services system. The approach to providing services over the years has created dependency on the health and social providers. This has resulted in people seeking services from the health and social services professionals prior to attempting to help themselves. People need support and tools to help break this dependency. – Action 5.1.3 Establish a 1-800 family health and social support call centre (NWT Health and Social Services Action Plan 2002 – 2005).*

Context

Telephone health advice and information advice services (often called health lines) have a legacy of some twenty years and have been utilized in many parts of the world including Canada, United States, Australia, New Zealand, United Kingdom, South Africa, Scandinavia, France, Belgium, Portugal, and Singapore. Currently, every province in Canada and the Northwest Territories has a health line. Tele-Care NWT was officially launched on May 19, 2004.

Tele-Care NWT is designed to support overall primary health care principles and strategies outlined in the *NWT Health and Social Services Action Plan 2002-2005*, especially improved services to people. A key principle guiding improved services to people is to promote personal responsibility by encouraging individuals and their families to access the health system appropriately and to learn and apply self-care when possible.

In August 2006, the Department of Health and Social Services issued a Request for Proposal to evaluate Tele-Care NWT and to investigate the feasibility of implementing an 811 line in the NWT. The telephone number 811 was reserved in 2005 by the Canadian Radio-television and Telecommunication Commission (CRTC) “for access to non-urgent health care telephone triage services.” As a system of wayfinding, 811 is an easy to remember telephone number that potentially can connect users to a variety of stand-alone or integrated services.

Part I: Evaluation of Tele-Care NWT

The evaluation followed a framework that guided data collection and analysis of five dimensions of inquiry: 1) Program Need; 2) Program Development and Implementation; 3) Access to Services; 4) Program Sustainability; and 5) Health Impacts.

Data were collected during September 2006 and involved interviews with key informants (people involved in the original design of the program), Chief Executive Officers of the Health and Social Services Authorities of the NWT, and health and social services providers. In addition community discussion groups were held and a web-based survey was issued to NWT providers of health and social services. Also, existing data were

reviewed, including the GNWT/Vendor contract, Tele-Care NWT vendor data, a previous population survey and community/provider consultation, and a northern nurse survey.

Results indicate that:

- The Department of Health and Social Services based Tele-Care NWT on a solid rationale that included a feasibility study of adopting a health and social services call centre and extensive participation in a cross-territorial and provincial collaboration on health lines funded through the national Primary Health Care Transition Fund.
- Stakeholders continue to express a need for Tele-Care NWT recognizing that the program has enhanced health information and access to non-urgent health services to larger and mid-sized communities in the North. Smaller, remote communities have made less use of the service.
- Tele-Care NWT was implemented as planned and processes and structures established to implement the program work as anticipated. Albeit at this time, the initiative is health focused and incorporates minimal social service elements.
- Quality assurance processes have been established. Call volume has grown. Ground-level support is available through a NWT-resident nurse liaison and medical advisor retained by the vendor. The GNWT contract with the vendor is being fulfilled.
- Current service is consistent and reliable. Response times exceed the service level requirements of the contract for services. Tele-Care NWT is available 24 hours a day and 7 days a week and has no toll charge. Service is bilingual and translation services are available for many other languages, including the nine official Aboriginal languages in the NWT.
- The general consensus is that enough health services are provided. However, uptake of the service is not as expected. Challenges and barriers identified to program uptake include: continuity of management with a high turnover in staff, smaller communities do not appear motivated to access the service, difficulty has been experienced in marketing to smaller communities on a regular basis, some service providers are not supportive of the service, up to 20% of northern residents do not have telephones in their homes, and awareness of the service among some communities and service providers is low.
- Those who access Tele-Care NWT are satisfied with the services they receive. Client satisfaction rates are higher than 90%. Most people who call are female. Call types tend to be about children with coughs, colds, vomiting and/or diarrhea. Calls concerning adult health issues tend to be about chest pain.
- Most providers surveyed believe the service is of value to their patients or clients. About 50% of those surveyed would say that the service reduces the work load of health services providers by reducing the number of unnecessary calls for health information and advice. Most service providers do not feel the service provides much assistance with social services issues and/or reduces the workload of social services providers.
- Call volumes have not been as large as initially anticipated. Cost per call, therefore, has been higher than initially estimated.

Part II: 811 Feasibility Study

The Howard Research and Outcrop 811 feasibility study gathered information and considered data on best practices with 3-digit numbers used as wayfinding services. It also undertook qualitative research in all eight Health and Social Services Authorities that included interviews and group discussions with management, health and social services providers and members of the general public.

Based on that research, we can report the following findings in response to the 811 feasibility framework questions.

Who needs to be engaged in the development of 811?
The range of stakeholders that need to be involved in the development of a NWT 811 line will depend on the vision, scope of services and operational requirements of the service. A broad range of stakeholders would need to be involved, such as Aboriginal organizations, professional health and social services providers, emergency services organizations, Northwestel, major user groups of NWT health and social services, and management of the eight NWT Health and Social Services Authorities.

What is the vision for 811?
There is currently no vision for a NWT 811 line, although the use of 811 in Canada has been designated by the Canadian Radio-Television and Telecommunications Commission for access to non-urgent health triage and information.

How will 811 be differentiated from 911?
Differentiation of 811 from 911 services needs to involve branding. The first requirement would be to develop a marketing and communications plan that positions 911 as an emergency services telephone line and 811 as a non-emergency health and social services telephone line.

What 811 and 911 overlap problems and/or opportunities for synergy are likely to arise?
The most common overlap problem will be the need to assist callers in determining if they are dealing with an emergency. The greatest opportunity for synergy will involve the development and use of call transfer protocols between the two services.

What health and social services will 811access?
Services to be accessed using 811 would be non-emergency in nature and would involve both health and social services concerns. The range of services would need to be determined in consultation with stakeholders. There is a general expectation that 811 would provide access to a greater range of services than are currently available through Tele-Care NWT.

How will various health line services be integrated within 811?
Integration of services within NWT 811 would likely require the use of a wayfinding “call centre.” It is expected that the call centre would use a database that includes information on all health and social services available to NWT residents.

At present 811 is being considered as a telephone-accessible service. Is it possible to use other information channels, including the Internet?
Yes, it is possible to use other communication channels, including the Internet. Other communication channels, including the Internet, could supplement the telephone services and provide NWT residents with anonymous access to health and social services information.

What audiences should 811 target?
Audiences that are currently high users of Tele-Care NWT should be the first priority target. The next priority should be low use audiences in low use regions.

How will 811 meet the needs of the diverse, Aboriginal, ethnic, language and cultural groups who are resident in the NWT?
811 would best meet the needs of NWT audiences if it provides fast, reliable and culturally sensitive translation services. NWT 811 call centre operators and those providing health and social services triage would also need to be aware of and sensitive to the NWT's unique cultural environment.

Does Clinidata have the resources to accommodate additional triage and information needs identified within the NWT?
Clinidata has the resources to meet the needs of the current Tele-Care NWT scope of service. It also has the resources to provide a number of additional services but is not staffed to meet social services needs.

How centralized will the call centre operations (811) and infrastructure need to be?
Considering the small size of the NWT population and the need to be cost effective, it would be desirable to centralize NWT 811 call centre operations and its infrastructure. However, services themselves would not need to be centralized.

What other options are there to add services?
The ability to add services is only limited by the definition of NWT 811 health and social services and the ability of the sponsor to pay for these services. Additional services could be provided by other private corporations, Non-Governmental Organizations (NGOs) or other governments.

What is the timeline for launching an 811 service?
There does not appear to be any urgency about launching a NWT 811 service since there are currently no 811 services operating in Canada. It may be best to learn from the experiences of other initiatives rather than to take on the risks and challenges of being an "early adopter."

What services and resources will need to be provided to support an 811 service?
Since there are no 811 service in operation in Canada, NWT 811 would need to look to other operating 3-digit service numbers like 211 for an answer. An 811 line would need the resources of a call centre in addition to the actual health and social services providers. It would also need protocols and standards for service similar to those developed by the Alliance of Information and Referral Systems (AIRS).

What governance structure would 811 require to operate effectively within the NWT?
The governance structure would require the creation of an Advisory Board to provide adequate representation of all key stakeholders, including the general public. Financial responsibility would be expected to remain with the funding authority.

Is provision of 811 access to all NWT residents technically possible?
811 access for all NWT residents is technically possible provided all have convenient telephone access. However, at any one time, up to 20% of NWT residents do not have access to an operating telephone in their homes.

Our 811 research findings also include the following:

- Consideration would need to be given to the role that 811 will play in relation to 211 which is already in operation as a wayfinding service in a number of major Canadian cities and currently serves approximately 46% of U.S. residents and a growing number of Canadian residents.
- Studies have shown that staged deployment of 811 has greater potential for success.
- Input from all NWT sources emphasized the belief that an 811 service should be available across the NWT without direct cost to the user.

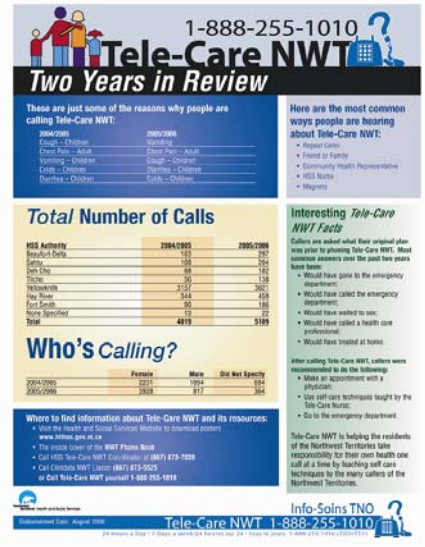
Recommendations

Following the evaluation of Tele-Care NWT and the 811 Feasibility Study, the following recommendations are offered by Howard Research and Outcrop Communications:

1. In light of the many benefits it is providing, Tele-Care NWT should continue as a primary health care strategy in the NWT.
2. Re-visit the vision for Tele-Care NWT. A clearer vision and a more precise scope of service definition will allow the NWT to engage services that more fully meet the health and social services needs of its residents.
3. More fully promote Tele-Care NWT as an essential primary community care initiative and demonstrate its application to both residents and health and social services providers.
4. Tele-Care NWT is a substantive program requiring dedicated management staff. Improve program management through increased tenure and stability in staffing and regional representation.
5. Take advantage of a unique study opportunity at the Stanton Territorial Hospital Emergency Department to collect cost-avoidance data and conduct an economic evaluation of Tele-Care NWT.
6. Focus communication programs to increase awareness and trial of Tele-Care NWT among low use regions and lower use populations, including Aboriginals, seniors and teens.
7. Identify and evaluate additional services or service enhancements that could broaden the scope of services offered through Tele-Care NWT. Discussions could begin with the current vendor (Clinidata).

8. Only the NWT's health, social and human services stakeholders can adequately address the development of a vision and scope of service for a NWT 811 line. Define a NWT 811 vision and scope of service in consultation with a wide range of NWT stakeholders.
9. Other Canadian jurisdictions and NGOs are advancing their plans for 211 services and are studying 811 service options. Initiate bi-lateral discussions with Canadian provincial governments or NGOs that have developed or are developing 811 or 211 plans.
10. An 811 Business Plan will need to be developed as a precursor to technical and costing discussions with Northwestel. Develop a full scale NWT 811 Business Plan to further develop costs and to meet the requirements of Northwestel for information to allow it to propose telephony options and estimate the cost of implementing 811 in the NWT.

Introduction



As of May 19, 2004, the Department of Health and Social Services provided the Northwest Territories with a telephone advice service (health line) named Tele-Care NWT. The current service offers access to a registered nurse and can be accessed 24/7 via a toll free number. To assess the performance of the service and its value to stakeholders, the Department issued a Request for Proposal (RFP) to evaluate the Tele-Care NWT – termed *Part 1: Evaluation of the Tele-Care NWT Program Initiative*.

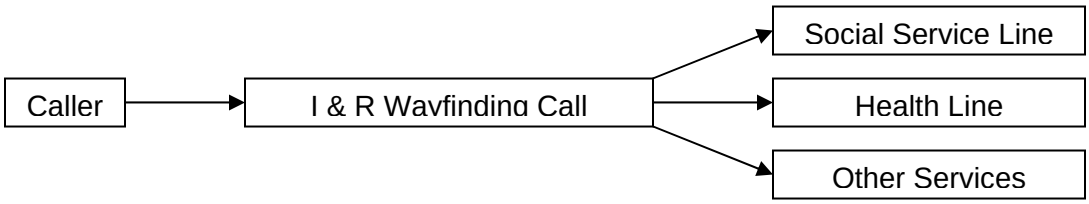
In addition, the Department recognizes that health line infrastructures have the potential to be leveraged to include more services and improved efficiencies. While the core of health line services are considered wayfinding/system navigation, health information, and symptom based nurse triage and referral, many service initiatives provide additional and unique services. For example, additional services may include:

- on-line medical dictionaries;
- links to health promotion events;
- public service announcements;
- service evaluations;
- direct links to facilities and health professionals;
- drug prescription information;
- health news;
- insurance options;
- health administrative links; regional administrative, health; environmental, and financial reports;
- scales and calculators; and
- links to allied services such as sports and fitness, mental health, social services, chiropractors and alternative medicine sites.

Often larger, more complex telephone advice services that offer additional and unique services direct callers to the appropriate service through an Information and Referral (I&R) service. It is important to differentiate the delivery of I&R from the delivery of Health & Social Services[1]. The I&R service is a call centre in and of itself that directs the caller to the service that provides specific health/social services advice and information.

[1] (2006) A Framework for the Implementation of 811 Service, Produced by Simon Lucas, Lucas & Associates For The Multi-Jurisdictional Steering Committee (MJSC).

Figure 1. Wayfinding and Health and Social Services Provision



In Canada, in July 2005, the Canadian Radio and Televison Commission (CRTC) assigned 811 for non-urgent health teletriage services, potentially enabling users easy and appropriate access to a range of services (which may include social services). As an easy to remember three-digit number, 811 could be used by callers to connect to a variety of non-urgent services. However, the technology and complexity of the infrastructure of the wayfinding system would be transparent to the caller. The caller may say “my baby is sick” and the I&R operator would connect the caller to the health line.

The adoption, then, of 811 does not necessarily imply an integration of services, however, as a system of wayfinding it can connect users to a variety of stand-alone or integrated services.

Because not a great deal is known about the influence of more and varied services on health line usage and system utilization as a whole, the Department broadened the scope of the RFP to include *Part 2: Feasibility Study*. The feasibility study is to address the viability of an 811 Health and Social Service Line in the NWT. As such, the health line may potentially include the provision of non-urgent social services.

This report is the final report outlining the frameworks and methods for both studies and the results of both investigations, including consultant recommendations. In addition, several supporting documents, including a backgrounder on 811, are located in the appendices.

PART I: Tele-Care NWT Evaluation

Evaluation Approach

Evaluation Framework

Based on the *Terms of Reference* provided in the RFP, a framework was created for the evaluation (see Appendix B). The evaluation framework was used as a foundational guide and outlined dimensions of the evaluation (access, sustainability, health impacts) and the study questions for consideration. Following discussions with the Department of Health and Social Services, additional evaluation dimensions (program need, program development and implementation) were added (See Appendix C: Revised Evaluation Framework).

What follows is a description of each dimension used to guide the evaluation of Tele-Care NWT (Program Need, Program Development and Delivery, Access to Services, Program Sustainability, and Health Impacts).

Program Need

The rationale for launching a program is most often centred on the need for the program, such as to provide a service, resolve an issue, or test a concept. The initial validity of the program is based on an assessment of the most current evidence supporting an investment in designing, developing and implementing the program. From an evaluation point of view, the dimension of program need guides an assessment of the foundational logic for the program—asking the question, "On what evidence is this program based?"

Program Development and Implementation

Delivery System – Program Development and Delivery
Program design, development, and delivery is evaluated according to program goals, program objectives, and the strategies designed and implemented to achieve expected outcomes.

Delivery System – Call Centre Efficiency
Management, implementation, and related variables are described in the literature much more frequently than they are measured. Measurement tends to focus on areas such as the impact of software and protocols/guidelines, call monitoring, call routing, training, education, and experience of nurses, job satisfaction, and communication.

Access to Services

The degree to which a telephone advice service has increased and/or improved access to health or other services can be assessed on several dimensions. Generally, access to telephone advice lines includes how often the service is utilized, when the service is accessed, who is making the calls, why they are calling, caller satisfaction with services received, wait time to receive services, and awareness of

services. In this report caller satisfaction is addressed under the dimension of sustainability.

Program Sustainability (Value to Stakeholders)

The extent to which telephone advice lines can be sustained past their introduction into service is demonstrated through their value. However, perceptions of "value" seem to rest in the question: Value to whom?

Value to the User
Caller value is generally measured as satisfaction with the information and advice provided by triage nurses, or others delivering direct service through the line. In addition, the caller's intent to follow the disposition received indicates the usefulness of the line to the caller. As well, compliance with dispositions can be extrapolated to assess health/social impact.

Value to Service Providers
Service providers may find value in telephone advice lines. Service providers value these lines if the provider perceives that telephone advice lines lessen after hours work loads, facilitate timely exchange between providers and specialist consults, have economic value to a practice, and meet the needs of their clients (patients).

Value to the Health System
The value of telephone advice lines to the health/social services system is the value perceived by those who sponsor and/or pay for the program. In Canada, the payer is generally thought of as the government (national, provincial and/or territorial). Value is measured in terms of dollars and benefits, such as increased access to primary care advice/information and support with self-care.

Health and Social Impacts

As part of a primary health care strategy (which includes social determinants of health), telephone advice lines are expected to impact population health positively through increasing the ability of the population to administer self-care (i.e. health education, improve health decision-making by consumers, etc.). An early indicator of health impact is consumer compliance with advice (caller following the advice of health line nurses).

Evaluation Methodology and Methods

Both quantitative and qualitative methodologies were used to guide methods selections for this evaluation. Specific methods included document review, interview, discussion group, survey (both random selection and self-selection), and system data analysis (vendor statistics).

The perspective of the evaluators who conducted this study considers qualitative study as an approach to understanding human experience and quantitative approaches as measuring that understanding. As such, our evaluators believe that the individual opinion

(no matter how different) sought through interview and discussion with participants is valid data and should be considered as part of the human experience associated with the program being evaluated. We use quantitative methods to assess generalizability to a broader population. We make an effort not to do qualitative study quantitatively. That is, we are more likely to use phrases like “some participants,” “the majority of participants,” and the like rather than count participant responses. We do this to make every effort to respect the individual input received by all of our participants and to provide our clients with the broadest possible overview of participant experience.

See Appendix A for a detailed account of the evaluation methodology and methods used in this evaluation.

Study Limitations

There are several limitations with a study of this type:

- All relationships that are identified in any of the statistical analysis are co-relational in nature and not causal. It is important that all relationships be viewed within the context of the qualitative data collected, including document review. In addition, telephone surveys are limited to people who have a phone and are not representative of the entire population.
- The provider survey respondents were self-selected and therefore results do not have the power of generalization to the population afforded by random sampling. In addition, the sample sizes associated with sub grouping (registered nurses, physicians, social workers) in the provider survey data were less than ideal (the margin of error is higher than 5%). As a result, some caution should be used in extrapolating findings to the entire sub group population in NWT (e.g. opinion of the doctors representing the opinion of all doctors in the NWT).
- Data were included that reflect the opinion of individuals on the perspectives of another group. This limitation is particularly relevant where providers offered perspectives on how community members perceive and value services.
- While important, qualitative discussion data represents only the views of those individuals attending the discussion. There was considerable variability in perspectives (positive/negative) among community informants representing small, Aboriginal communities. In addition, key informants, CEOs, and providers often offered different opinions concerning the uptake and value of the service. These data are qualitative and have very limited power in estimating consensus.

1.0 Need

Throughout the North, there has been a dependence on the health and social services system. This has been to a detriment of people's self-care capacity, and to the detriment of care providers who are in demand, day and night, for a variety of health and social services concerns, few of them true emergencies. The demand for access to service and information 24 hours a day creates significant challenge for the health and social services system, fraught with inadequate staffing levels which are related to a widespread nurse and social worker shortage that is expected to intensify over the next decade. This issue is shared across all three territories and the more rural and remote jurisdictions of the provinces. SOURCE: (2002) Development of a Model for a Health and Social Services Call Centre for the North Project Report.

Program Need

1.1 Rationale for Tele-Care NWT

Evaluation question: Is a rationale for Tele-Care NWT based on credible evidence?

The Department of Health and Social Services of the Northwest Territories launched Tele-Care NWT based on a need to continue the provision of 24/7 health information and non-urgent health care to northern communities while at the same time providing support to professional staff by reducing the challenge of meeting professional health and social services personnel shortages. Tele-Care NWT is designed to support[2] overall primary community care principles and strategies outlined in the *NWT Health and Social Services Action Plan 2002-2005*, especially improved services to people. A key principle guiding improved services to people is to promote personal responsibility by encouraging individuals and their families to access the health system appropriately and to learn and apply self-care when possible. The key objectives of Tele-Care NWT are to:

- Increase the ability for self-care;
- Provide support for workers;
- Decrease non-urgent after hours callouts;
- Facilitate the use of appropriate health information and advice; and
- Increase consumer health education and improve decision-making by consumers.

Selecting a telephone advice service to support primary community care was based on a solid rationale that included an awareness of the growing success of health lines, a feasibility study of adopting a health and social services call centre and extensive

[2] Action 5.1.2 involves the distribution of a self-care book to all households in the NWT; Action 5.1.3 is specific to establishing Tele-Care NWT. Both strategies are considered important and mutually supportive in improving primary community care. Tele-Care NWT nurses are made aware of the self-care book and asked to make reference to it where appropriate.

participation in a cross-territorial and provincial collaboration on health lines funded through the national Primary Health Care Transition Fund.

Telephone services such as Tele-Care NWT have a legacy of some twenty years and have been utilized in many parts of the world including Canada, United States, Australia, New Zealand, United Kingdom, South Africa, Scandinavia, France, Belgium, Portugal, and Singapore. Common success indicators across contexts have been demand and client satisfaction. Many of these lines are focused on health advice and information, however, they have the capability of incorporating community services information and directing callers to health-related services (e.g. mental health counseling).

Currently every province and the Northwest Territories have established health line services. The primary rationale for their adoption across these jurisdictions has been the perspective that health lines provide an important, strategic investment in advancing health care (particularly primary health care) through improving access to health care, increasing health literacy, and facilitating more appropriate, efficient and effective use of health resources.

As a result of the growing evidence that access to health and social services information and direct non-urgent service can be supported through professionally staffed call centres, the Northwest Territories participated in a cross-territorial project to develop a comprehensive *Model for Health and Social Services Call Centre* exploring the feasibility for a telephone advice service to support the provision of community health and social services in remote communities in the three northern territories of Yukon, the Northwest Territories and Nunavut. The Model and the recommendations of the Call Centre Advisory Committee led to the development of a Request for Proposal by the Government of the Northwest Territories (GNWT) to provide "*Telephone Advice Service to all the residents of the Northwest Territories.*"

In addition, representatives[3] from the GNWT participated in the Multi Jurisdictional Collaboration to implement Healthlines, an initiative sponsored by the Federal Government through its Primary Health Care Transition Fund (PHCTF) from 2001/2002 through 2005/2006. This $800 million fund was initiated to assist with transitional costs of implementing sustainable, large-scale, primary health care renewal initiatives.

A portion of the PHCTF funding was devoted to the evaluative aspects of health lines. Several comprehensive documents were prepared outlining the research on national and international health line development. As well, documentation was prepared to establish a broad base of supporting evidence for the adoption of health lines as a health reform strategy through advancing primary health care[4].

1.2 Current Perspectives on Need

Evaluation question: Is the program meeting the need outlined in its rationale?

[3] Representation from the GNWT changed to different individuals over the span of the Multi Jurisdictional Collaboration.
[4] Multi Jurisdictional Collaboration on Healthlines *White Paper: Improving the Sustainability of the Health Care System* and *Literature Review: Evaluative Aspects of Health Lines*.

Most key informants continue to express that Tele-Care NWT is needed to support the provision of community health and social services. There is widespread agreement among key informants, regional administrators and service providers that Tele-Care NWT has substantially enhanced health information and non-urgent health services to the larger and mid-sized communities in the North. However, key informants, regional administrators and providers are not in unanimous agreement that the current service meets the non-urgent health needs of smaller, remote communities. In addition, there is general agreement among these informants that the need for similar non-urgent social services has not been met through Tele-Care-NWT.

2.0 Development and Delivery

Program Development

2.1 Processes and Structures

Evaluation question: What processes and structures were implemented?

Tele-Care NWT is administered through the GNWT Department of Health and Social Services, Territorial Integrated Services Division. Service delivery is guided by a contract between the GNWT and Clinidata Corporation in New Brunswick. Contract management, at present, is the responsibility of the Tele-Care NWT Program Coordinator who reports to the Manager, Primary Community Services who in turn reports to the Director of Territorial Integrated Services.

To provide a network forum between the Health and Social Service Authorities and the Department of Health and Social Services, a NWT-wide Advisory Committee (Tele-Care NWT Advisory Committee) considers the nature, scope, quality and outcomes of Tele-Care NWT services and advises the Department regarding these services through reporting to the Joint Senior Management Committee (JSMC). The Tele-Care NWT Advisory Committee is considered an important body and critical in ensuring that the program has opportunities to link to stakeholders and is supported in the northern communities.

Tele-Care NWT provides key services 24 hours per day/7 days a week (24/7) facilitated through a telephone connection to a registered nurse, including:

- Health assessment;
- Advice on self-care and symptom management;
- Advice on illness prevention / healthier lifestyles;
- General health information;
- Information on the location and availability of services (including social services); and
- Connection to urgent and emergency services (faxes are sent ahead to the hospital or clinic if it has referred).

Quality control procedures are in place (see section 3.3) and the initiative is staying reasonably true to the *Model for Health and Social Services Call Centre*[5] which informed the RFP for a Telephone Advice Service (see section 2.2). Vendor reporting is regular and the Department is provided with monthly status reports (including utilization statistics).

[5] (July 2002) *Development of a Model for a Health and Social Services Call Centre for the North*. Final Report. Prepared for: The Northwest Territories Registered Nurses Association and Call Centre Advisory Committee. Prepared by Susan Ashton.

2.2 Implementation Planning

Evaluation question: Was the initiative implemented as planned?

The initial attempt to procure a vendor was unsuccessful. The complexity, cost and timelines of establishing a telephone support service were not fully anticipated. All vendor submissions were well over budget. Subsequently, additional funding was procured and a second RFP was issued.

For the most part, the Tele-Care NWT initiative has been implemented according to the concepts and recommendations outlined in the *Model for Health and Social Services Call Centre*.

1. The government proceeded with a request for proposal for a telephone nursing call centre service.
2. The project moved forward addressing primarily health concerns because social services components had not been easily integrated into existing call centre models.
3. Services to be included—health information, triage, and disease management.
4. Call centre selection requirements included cultural, linguistic, and geographic sensitivity.
5. Call centre staffed by registered nurses[6].
6. Professional integrity assured through system of practice that includes medical advisory, nursing advisory, demonstrated staff knowledge and skills, proven decision support software, risk management, and accountability framework.
7. Continuous service including regular updating of community information and health related protocols reflective of northern practice.
8. Service available to anyone with access to a telephone.
9. Initiative overseen by an Advisory Committee representing a broad range of health care and social services interests.
10. Documented transactions and the provision of performance reports.
11. Assured confidentiality and protection of privacy to callers.
12. Cross system compatibility and coordination to ensure interface with existing local services, other health lines, and hotlines.
13. Commitment to define social services components appropriate for call centre delivery.

Generally, key informants are satisfied that the Tele-Care NWT initiative has been implemented as planned. These informants expected and understood that the initial launch of Tele-Care NWT would be a telephone number available 24/7 to talk to a Registered Nurse who would be able to help with decision making in place of a local primary health care provider and could also provide information about community resources (both health and social services related). However, evaluators were reminded strongly that some of the people associated with initial planning for a service

[6] Tele-Care NWT is staffed by nurses who are registered in the Northwest Territories.

recommended that whatever service was to be established needed to be community-based reflecting the cultural diversity of the North. These dissenting views reflect a concern that the current service cannot meet the health and social services needs of many northern residents who are non-English speaking, accustomed to face-to-face communication, and have little access to telephone service. As well, these informants are disappointed that more progress has not been made in defining and delivering non-urgent social services components.

Within the service definitions of the contract signed with the vendor, reports from all informants agree that the service as described has been provided. Representatives of the GNWT indicated that the vendor is a responsible corporation that has been responsive to the GNWT demands. As well, the vendor is comfortable that the GNWT's expectations have been met. They describe Tele-Care NWT as a service that provides timely access to health care information 24/7 to members of the NWT public. Protocols are top-notch. Furthermore, the Corporation provides customized service and has a comprehensive database of NWT community assets. Relationships with the communities and the GNWT are supported through ground-level personnel in Yellowknife, specifically a nurse Liaison and a Medical Advisor.

2.3 Progressing Towards Program Goals

Evaluation question: What factors are facilitating the program progressing towards achieving its goals?

Generally, those stakeholders consulted believe Tele-Care NWT is progressing toward achieving its goals. There is an overall sense that while more progress was expected (higher call volume) within the unique setting of the NWT, more people are becoming aware of the service and more people are utilizing the line. Factors facilitating the progress of Tele-Care NWT include:

- Quality of the service: Callers receive consistent, current and accurate information and advice from a qualified health professional;
- Growth: Statistics indicate growth in both reach and utilization;
- Ground level support: The NWT-based nurse Liaison and Medical Advisor retained by the vendor facilitate an efficient and effective relationship between GNWT and the vendor; and
- Vendor responsiveness: GNWT representatives report that the vendor is approachable and amenable to many of their requests.

2.4 Sufficient Service Provision

Evaluation question: Are there enough services being provided?

A recurring service provision theme centres on the extent of non-urgent social services available through Tele-Care NWT. This adequacy question involves stakeholders' perspectives on the original intent of the program (See discussion in Section 2.2).

For some of these informants, service provision will not be sufficient unless more than just general social services information is available through the program. Others suggest that Tele-Care NWT should not be expanded to include social services information due to a belief that Tele-Care NWT is already known as a health information service. It has also been noted that social services is a complex area, and there are already a wide range of hotlines to assist with specific social services needs.

Most stakeholder groups agreed that an adequate level of non-emergency health services is provided through the current Tele-Care NWT program. However, some noted that since their community does not take advantage of the current service "why would there be a need for more?"

Others indicated that they anticipate that over time other service dimensions can be added to enhance the overall value of the program—services such as pharmacy advice, various hotlines (crisis lines), social services information, environmental health issues, mental health counseling, and emergency services for children and women. Since current call volumes are low relative to the cost of the service, an expansion of service may make the program more cost efficient.

Caution was raised by providers that enhancements to the service must be communicated to both health and social services providers so that they are able to provide consistent and accurate information to their patients and clients.

Research and discussions with the vendor reveal that the current service can be readily enhanced by connecting to services offered in other jurisdictions or through augmenting the current services with services already developed or supported through the vendor, such as:

- Poison information[7] (triage and toxic assessment) – this line goes further than regular Tele-Care triage but is not poison control as it does not give clinical advice to clinicians in hospitals (NB);
- Rabies information (NB);
- West Nile information – this line also addresses avian flu by taking calls to report dead birds); the name will change to WNV and Avian Influenza Information Line soon (NB);
- Sexually Transmitted Infection (STI) Information Line (NB);
- Gambling helpline (NB);
- Smoking Cessation Helpline (BC); and

[7] If a person calls 911 with a poison related issue, 911 will transfer the caller to Tele-Care (NB). The Tele-Care (NB) nurse will assess the situation, determine whether the exposure was in fact toxic, determine whether the patient needs to be seen by a health professional, and if so, when, where, etc. (i.e. provide telephone triage).Tele-Care (NB) nurses use tools at their disposal, including the Poisindex System (software distributed by Micromedex), to make the assessment. Tele-Care (NB) only provides poison-related triage. It does not provide clinical support to professionals (i.e. does not provide support to professionals within health centres calling with poison-related questions for their patients).

- Organ & Tissue Donor Line – this line is for health care professionals only, not the public. It is line for professionals to call to report hospital deaths (NB).

2.5 Service Issues

Evaluation question: Are there problems in the way services are being delivered?

Few service issues were reported. Current service has been continuous, consistent, and with almost no technical difficulties. The small number of service issues reported concerned isolated incidents such as a breakdown in connection with poison control and a delay in getting fax information.

However, there are some informants that expressed that while service is available, they believe the effectiveness of the service is limited. Their perceptions are that Tele-Care NWT does little to prevent unnecessary visits to a provider because, in their experience, the caller is asked to go see a nurse, doctor or Emergency Room anyway. In addition, these respondents believe the line provides a very limited range of advice, citing that Tele-Care NWT nurses have only four or five available protocols.

These views of limited protocols and the provision of little self-care advice are not supported through descriptive data. Clinidata Corporation uses the Schmitt/Thompson guidelines which incorporates 442 symptom-based nurse assessment guidelines (221 adult, 211 pediatric). While protocols are designed to be conservative (tend to error on the side of caution), monthly reports indicate that significant self-care is being recommended (30-35% of dispositions).

2.6 Challenges and Barriers to Service Provision

Evaluation question: What challenges and barriers were identified and how can they be addressed?

All stakeholder groups consulted identified challenges and barriers to providing Tele-Care NWT. Perspectives on challenges and barriers to service delivery included consistency of coordination within the Department of Health and Social Services, community outreach, cultural and demographic issues, community size, service provider support, service awareness, and technology issues.

Program Coordination
From the perspective of both the vendor and key informants, program coordination of Tele-Care NWT has posed some challenges. A couple of the interviewees termed the problem as “lack of a champion.” The management of Tele-Care NWT within the Department of Health and Social Services has been well executed. However, continuity of management has been challenging with a high turnover in staff. From the vendor’s point of view, each change in management staff requires that new people have to be brought up to speed on Tele-Care NWT operations and issues. Clinidata Corporation has attempted to provide some stability in this area by retaining a nurse Liaison and a Medical Advisor in Yellowknife. Clinidata representatives from New Brunswick also participate in the Tele-Care NWT Advisory Committee.

Community Outreach
Call volume is on the minds of most stakeholders. Reaching the communities of the NWT, especially smaller, remote and predominately Aboriginal communities is challenging for a service that depends on the medium of telephony. In the first place, actual demand for Tele-Care NWT may not be high and secondly, reaching these communities to demonstrate to residents the value of the service considerably taxes the communication and promotion budget allotted to the program. The only suggestions for meeting this challenge were to broaden the scope of services offered (e.g. STI, West Nile information, etc.) and to expand awareness (more face-to-face visits).

Cultural and Demographic Issues
There is a sense among most respondents that Tele-Care NWT has not been able to penetrate the Aboriginal communities. As well, seniors are low users of the service. While attempting to increase awareness among low users is warranted, the service itself may require strengthening to better appeal to cultural and demographic groups who do not see much value in accessing information and advice via telephone.

Community Size
A major portion of northern residents live in small communities where very limited primary care services are provided. Tele-Care NWT services are guided by protocols that may provide the nurse operator with a disposition that directs callers to a primary care provider within a 1 hour or 4 hour timeframe should the callers' presentation indicate such urgency. The disposition as provided through Tele-Care NWT may not be practical since it does not take into account the local provider's history of the caller, up-to-date services available in the community, or understanding of the unique personal needs of the caller. Therefore it is not uncommon to hear stakeholders say the current Tele-Care NWT service "does not meet our needs," and/or "does not understand us." One solution put forward by respondents was simply that representatives of Tele-Care NWT need to be on-site more. Other respondents suggested turning the regional funds allocated for Tele-Care NWT over to the regions to provide whatever health and social services enhancements the region believes best meet smaller community needs.

Service Provider Support
While not unanimous, most health services providers see some merit in Tele-Care NWT. Those providing social service are less confident that Tele-Care NWT, at least in its current configuration, is a viable option to them and their clients. Some social services personnel reportedly view the service as only a health line because nurses answer the phone. They do not view Tele-Care NWT within the broader definition of health which could include social issues as well. For many, meeting the needs of the social services community will require continued dialogue on what and how Tele-Care NWT might be of value. This would require taking time to meet with social workers and demonstrating how the advice line can assist both providers and clients. Others feel the Department of Health and Social Services will need to be more proactive in expanding the role of the program and the program's support for social services.

Service Awareness
While not a predominant challenge, informants are generally in agreement that awareness of the service among residents and health and social services providers could be greater. Reasonable efforts have been made to increase public awareness

through newspapers, posters, information for new mothers, brochures, fridge magnets, community visits, demonstrations, and service provider support. However, the messages must be regular and consistent, and this was an area many respondents felt has fallen short. The solutions proposed were almost always "more regular and consistent marketing required."

Technology Issues
Informants across all stakeholder groups are clear to point out that not everyone in the North has convenient access to reliable telephone services. That, in itself, poses a challenge for Tele-Care NWT.

2.7 The Tele-Care NWT Service?

Evaluation question: What recommendations are offered regarding the future of the Tele-Care NWT Service?

The following recommendations were offered during discussions with representatives of the vendor, Chief Executive Officers of the Health and Social Services Authorities, key informants (those representing the GNWT and/or had direct involvement in design and implementation of the program), and the public:

Vendor

- More stability in program management; and
- View Tele-Care NWT as a complementary service not a competing service.

CEO

- Tele-Care NWT fills a niche in health services delivery; requires more marketing to public and providers;
- The value of the program is not well enough understood by the public and by providers; give Tele-Care NWT more time to prove itself; and
- Reconsider the value of Tele-Care NWT to some communities and discuss options for the money dedicated to Tele-Care NWT for these communities.

Key Informants

- Provide more statistics, especially in reference to use, ER avoidance, dispositions offered;
- Tele-Care NWT should be viewed as part of the overall health system—not an add-on;
- Take time to meet with social workers and demonstrate how the line can support the provision of social services;
- Promote service sector (health and social services) knowledge sharing;
- Be very clear about the scope of services that are practical to provide through Tele-Care NWT;
- The money spent on Tele-Care NWT could be better spent on putting more providers in the field;

- Increase marketing; and
- Give the program more time to develop.

Program Delivery

2.8 Service Response Time

Evaluation question: Are the calls being answered within the time frame specified in the original contract?

Clinidata Corporation contracted to provide a Service Level of 80% of calls answered in 30 seconds or less. Vendor statistics indicate response times are typically 13 seconds and call duration 11 minutes.

2.9 Cultural Sensitivity

Evaluation question: Are the nurses who provide the Tele-Care NWT service given orientation to the standards, specifications, and cultural diversity in the North?

The vendor reports that all Tele-Care NWT nurses are provided with orientation and refresher training in cultural sensitivity. Information includes NWT health systems, geography, politics, regions, languages and specific communication issues such as types of nurse questions that are and are not welcome and pace of conversation. Clinidata Corporation aims for its Tele-Care NWT nurses to feel as though they are an actual part of the GNWT's Department of Health & Social Services.

3.0 Access

Equitable Access

3.1 Community Reach

Evaluation question: Is Tele-Care NWT accessible to all residents of the Northwest Territories?

By its very nature, Tele-Care NWT is not accessible to residents of the Northwest Territories who do not have access to telephone services. Some key informants, professional health and social service providers, and community residents reminded evaluators that the service is not practically attractive to residents who are accustomed to immediate access to a community nurse, accustomed to face-to-face interactions with health and social service professionals, and/or who do not speak English or French as their first language.

On the other hand, Tele-Care NWT is available 24 hours/7 days a week, provides immediate access to a qualified voice, is accessible in all the official languages of the North, is a free service to callers (1-800 number), and is being utilized in all regions of the Northwest Territories.

Tele-Care NWT is reaching all regions (Health and Social Services Authorities) of the North. However, percentage of call volume relative to the total Health and Social Services Authority population varies among Authorities, with Yellowknife and Hay River having the highest proportion of callers (See Table 1.).

Table 1. Total Number of Calls

HSS Authority	**Pop. Estimate**	**2004/2005**	**2005/2006**	% **of call Volume Relative to Pop. 2005/2006**
Beaufort-Delta	7088	163	297	4.19%
Sahtu	2591	108	204	7.87%
Deh Cho	3438	88	182	5.29%
Tlicho	2811	56	138	4.91%
Yellowknife	20209	3157	3621	17.92%
Hay River	3956	344	459	11.60%
Fort Smith	2514	90	186	7.40%
None Specified		13	22	
Total	**42607**	**4019**	**5109***	**11.90%**

* 12 months 2005 data + 7 months 2006 data (total calls 2005 were 3690).

Program Promotion

3.2 Promotional Success

Evaluation question: Are promotional methods being used at present successful?

A budget for marketing activity is committed for each year of the three-year implementation contract. A targeted marketing plan identifies multiple media for reaching NWT residents, including territorial and local newspapers, radio and television, flyers, brochures, pens, fridge magnets, community outreach, posters, and word of mouth. The most common mediums mentioned are “pens” and “fridge magnets.”

Providers report that they have been made aware of Tele-Care NWT through information sessions at the hospital, through the Health and Social Services Authority, advertising, television (listings channel), magnets, flyers, and posters.

When asked for suggestions to increase and/or improve public awareness, providers offered a number of ideas:

- People need more education about it;
- People need constant reminders;
- Reissue magnets;
- More written materials;
- Pamphlets – should be handed out at clinics;
- If it’s going to be a pamphlet, it needs to be one sheet and simple;
- People need something by their phones (then more apt to use it);
- Literacy is an issue in advertising; needs to be more than just written form (also radio);
- Advertise on TV, especially on the listings channel;
- Phone number should be shorter, perhaps with a jingle like those used by pizza companies;
- Handing out information to people as they check in and out of ER;
- Advertise to younger population (often scared, embarrassed);
- Promote more to seniors;
- Put it on Aboriginal language programs on CBC radio;
- Make it better known that translation service is available;
- Health Centres must be careful to stress that the number is not for emergencies; and
- Due to the apparent confusion between Tele-Care NWT and Tele-health, the line should have a name more reflective of the skill being accessed (e.g. nurse line).

According to a 2005-06 NWT population survey[8], respondents were asked to name or identify all of those things that they recalled seeing or hearing about the service. The two most common responses were: 1) had seen an advertisement (24.1%), and 2) had received something in the mail (23.3%). Females (18.2%) were most likely to recall "receiving a magnet or sticker," while males (5.6%) reported remembering a "picture of a phone."

Generally, informants from all stakeholder groups indicate that marketing seems to be more successful in the larger to medium sized communities and less successful in smaller communities. Some respondents indicate that additional marketing and communication approaches may be required.

Vendor statistics (2006) indicate that regional access varies. Residents of some regions are almost 6 times as likely as others to access Tele-Care NWT. Over the course of six months (first half of 2006), average number of calls per 1000 population in the North are 37.31.

Table 2. 2006 Call Volume Per 1000 Population

HSS Authority	Pop. Estimate	2006 Calls	Calls/1000 Pop.
Beaufort-Delta	7088	70	9.88
Sahtu	2591	40	15.44
Deh Cho	3438	33	9.60
Tlicho	2811	39	13.87
Yellowknife	20209	763	37.76
Hay River	3956	155	25.52
Fort Smith	2514	42	16.71
Total	**42607**	**1142**	**37.31**

In the 2005 survey of northern nurses [9], respondents suggested that those encouraging patients in northern communities to access Tele-Care NWT should do so with the cultural context of the community in mind. Some of their responses were:

"There should be more community-oriented nurses to take the calls."

"Culturally, people in remote communities have been used to having the health centre nurse. They do not willingly try to make first contact with an anonymous stranger."

[8] Data taken from the NWT Population Survey sponsored by the Multi Jurisdictional Collaboration on Healthlines. *Non-User Study (February 2006).*
[9] Nurse Recruitment and Retention Survey 2005 - NWT http://www.rnantnu.ca/documents/2005_nwt_surveyresults.pdf.

Program Quality

3.3 Vendor Quality Assurance Standards

Evaluation question: Are the quality assurance standards provided by Clinidata Corporation effective in improving services based on the needs of the individuals of the NWT?

At the primary level of quality control (currency and accuracy of protocols available to the call centre nurse), Clinidata Corporation deploys Schmitt/Thompson clinical guidelines processed within LVM System's decision support software. Guidelines are peer reviewed regularly. In addition, Clinidata Corporation engages a Medical Advisor (physician) practicing in the Northwest Territories to review guidelines as well as a nurse Liaison to coordinate NWT implementation. Without reservation, the Medical Advisor states confidence in the guidelines, guideline review system and resulting modifications to guidelines. The protocols are reviewed line-by-line and "Canadianized" where required. Any immediate concerns about the guidelines are addressed promptly, usually within 24 hours. Other key informants are unanimous in agreeing that the information and advice provided by call centre registered nurses is safe, current, and accurate.

It is less clear at the secondary level of formative quality control that Clinidata is able to modify and adapt call centre operations to better meet all the needs of callers across the NWT. As has been and will continue to be re-iterated in this report, the current services provided through Tele-Care NWT have limitations in meeting both non-urgent health and social service needs of residents in all northern communities, especially those communities that are small, remote, or have significant proportions of their population who do not access telephones and/or whose first language is not English or French.

Meeting the multiple language needs of the North is handled through a Winnipeg-based service, CanTalk Canada, which is able to connect call centre callers (NWT residents) to an appropriate translator. In this way Clinidata meets their contractual obligations to provide service in English and French and access to interpreting services of the official Aboriginal languages of the NWT (Chipewyan, Cree, Tlicho/Dogrib, French, Gwich'in, Inuktitut, Inuinnaktun, Inuvialuktun, North Slavey and South Slavey.) However, the three-way call established between the caller, nurse, and translator can take time, diminishing the effectiveness of the service from a caller's perspective. Furthermore, evaluators were told by community members and professional service providers that some of these languages do not have words for medical and health terms used in providing health and social services information and advice[10]. Thus the information exchange between the caller, nurse, and translator may be less than clear, causing some frustration on the part of the caller.

Community information is reasonably current. The Clinidata Corporation database was populated by a professional librarian who initially contacted community services, social services, and health services agencies for inclusion. The database was then revised in 2005. A number of NWT centres for health care (such as clinics, hospitals) inform the

[10] For example, medical description of body parts. During face-to-face communication the patient is able to point to the body part.

vendor of any changes regarding hours of operation, closures, and on-call staff. This information is then immediately updated on Tele-Care NWT nurses' screens. However, challenges remain regarding community changes that are not reported.

Program Demand

3.4 Population Awareness

Evaluation question: Who (residents) is aware of Tele-Care NWT?

Awareness of Tele-Care NWT among residents of the NWT is growing. Informants from all stakeholder groups suspect awareness of the service is greater in larger communities than smaller communities and that the non-Aboriginal population of NWT is more aware than the Aboriginal population.

According to a 2005-06 NWT population survey[11], approximately sixty-five percent (64.3%) of respondents had heard of Tele-Care NWT / Info-Soins TNO. Differences were found among demographical groups. Those who were aware of the service were more often:

- Female than males (ratio:1.3/1);
- Married or common law than single (ratio:1.3/1);
- With children residing in their household than without children (ratio:1.2/1); and
- Living in a large or medium sized community than a small community (ratio:1.6/1).[12]

Again, the majority of key informants and CEOs interviewed believe awareness is a function of marketing and communication. They suggest that two messages should be dominant—one, that Tele-Care NWT provides access to experienced, well-trained, qualified health professionals and two, that Tele-Care NWT provides information and advice on issues beyond medical issues.

A 2005 survey of Northern Nurses[13] reports that the majority of nurse respondents (71%; N=120) "felt that the people in their community were aware of the Tele-Care NWT service." Again, the majority of respondents (61%; N=101) "felt that people in their communities were accessing/using the service." However, they emphasized that greater awareness/utilization of Tele-Care NWT services would result if "more hands on sessions" were held in the communities. Also, they suggested "periodic public campaigns" were necessary due to the transient nature of the population—new people coming to the North need to be made aware of the service.

[11] Data taken from the NWT Population Survey sponsored by the Multi Jurisdictional Collaboration on Healthlines. *Non-User Study (February 2006).*
[12] Large (Yellowknife), Medium (Fort Smith, Hay River and Inuvik), Small (All other communities).
[13] Nurse Recruitment and Retention Survey 2005 – NWT. http://www.rnantnu.ca/documents/2005_nwt_surveyresults.pdf.

3.5 Caller Demographics

Evaluation question: Who (residents) calls Tele-Care NWT?

A reasonable number of demographic and use characteristics are being documented by the vendor. Annual reports indicate that most calls are made by females.

According to the population survey statistics, almost thirty-three percent (32.7%) of those individuals interviewed, who were aware of Tele-Care NWT, had used Tele-Care NWT / Info-Soins TNO. Those individuals who had used the service were more often:

- Married or common law than single (ratio:2.5/1);
- Female than male (ratio:2.9/1);
- With children in the home than without children in the home (ratio:1.6/1);
- Non-seniors than seniors (ratio:2.3/1); and
- Living in a large community than either a medium-sized community or small community (ratio:1.9/1 and 1.6/1).

3.6 Reasons People Call

Evaluation question: Why do residents call Tele-Care NWT?

Vendor reports indicate that calls are typically about:

- Cough – children;
- Chest Pain – adult;
- Vomiting – children;
- Colds – children; and
- Diarrhea – children.

Population survey statistics indicate that the top three reasons for future use identified by respondents were:

- To call a nurse for symptom related advice (65.4%);
- To get information about health services in their community (23.9%); and
- For medical information as needed (17.5%).

3.7 Reasons People Do Not Call

Evaluation question: Why do residents not call Tele-Care NWT?

Stakeholders have a number of perspectives as to why people of the NWT do not use the service:

- Many people prefer face-to-face contact, a factor that may be affected by the age of the patient;
- People tend to identify "resource people" in the community to whom they can go with questions. Some segments of the population, for example, smaller, remote or Aboriginal communities, may be accustomed to use their local health centres and prefer to do so rather than call Tele-Care NWT;
- Unlike larger centres such as Yellowknife (where people may be more conditioned to use services like Tele-Care NWT), in small communities, people are accustomed to face-to-face contact with health care providers whom they may already know and trust;
- People are not accustomed to the concept of "self-care" to the same degree that they are accustomed to health care as an external service delivered by health professionals;
- The system to develop Tele-Care NWT did not collaborate with Aboriginal groups as partners. Rather it developed the system separately then made it available to the entire NWT. Some Aboriginal communities may feel that service is not attuned to their needs;
- In smaller communities another 24/7 health service is redundant. Most small communities have 24/7 access to a nurse on call;
- The program is new. Tele-Care NWT needs five years to prove itself. People in the North have experienced services "come and go." It will require time for people to trust that the service is part of their health system;
- A number of NWT residents are uncomfortable communicating in English, and translation services are not overly convenient;
- Trying to implement behavioural change in a community is a very slow process. A new way of providing service will take time to catch on; and
- There is more to the language issue than were realized. English speaking does not mean English fluency. Health terms are often misunderstood by people whose first language is not English.

Individuals who participated in the population survey but had not yet used Tele-Care NWT / Info-Soins TNO were asked if they would "consider using Tele-Care NWT in the future." Over eighty percent (82.0%) reported they would consider using it in the future, while less than two percent (1.5%) were unsure about future use. However, it should be noted the large majority (77.7%) of respondents did not think they would have a use for the service.

4.0 Value

Value to Residents of NWT

4.1 Caller Satisfaction

Evaluation question: Are the residents of the Northwest Territories satisfied with service that they are receiving and how do we know that?

While not unanimous, the large majority of key informants, CEOs and providers consulted report that NWT residents who use Tele-Care NWT are satisfied with the service. However, generally, these perceptions are grounded in anecdotal evidence. When asked for examples of the feedback they are receiving they provided the following:

- Increased, easy, direct access to health care (particularly in communities that are not well-staffed);
- Competent provider;
- Good information;
- Consistent, evidence-based information;
- Comforting and supporting to people looking for answers;
- Available 24/7 to everyone in the NWT;
- Available from the comfort of home;
- Self help;
- Confidential. Anonymous;
- Access to other links or services;
- Toll free;
- Timely manner—"Somebody to talk to and listen right off the bat;" and
- Increases access to health care, especially when there are staff shortages.

Those who are not receiving positive feedback about the service say they are hearing that the caller is referred to the nurse or doctor anyway. In smaller communities, the nurse is available 24/7—"so why bother?" Also, a common theme reported is that residents are frustrated by the large number of initial questions asked when they call the service. A few providers indicate that people sometimes call Tele-Care NWT then come to them to verify the information.

According to population survey statistics, those interviewees who had used Tele-Care NWT / Info-Soins TNO were asked a series of questions related to their experience with the health line. The majority (94.3%) reported that they received the information they were looking for when they contacted Tele-Care NWT / Info-Soins TNO.

When participants were asked about their level of satisfaction, again, the majority (96.6%) indicated they were satisfied with the service they had been provided. Furthermore, almost all (98.9%) of those individuals who reported using Tele-Care NWT / Info-Soins TNO indicated they would call the health line again. Intent to use the health line again was consistent across all demographic groupings (gender, age, marital status, and children in the household).

Value to Providers of Health and Social Services

4.2 Provider Understanding and Support

Evaluation question: Do the health and social services providers of the NWT understand and support the Tele-Care NWT Line?

For the most part, health and social service providers of the NWT are aware of Tele-Care NWT and understand what primary service it offers. If there is a lack of understanding, it tends to centre on the extent to which the service is capable of supporting the social services sector.

The Tele-Care NWT Provider Survey conducted in September 2006 indicates that 92.6% of respondents were aware of Tele-Care NWT. A little over half (56.4%) of providers are aware of patients or clients that have used the service and 51% have advised patients or clients to use the service. When asked if they had ever called the service, 26.9% indicated that they had. Of those who had personal experience with the service, most (78.6%) had called to obtain advice and 40% indicated that they wanted to see how it worked (professional curiosity).

Provider support for Tele-Care NWT varies widely. In one setting (health), the organization has set up a speed dial to Tele-Care NWT and encourages their patients to use the service at every opportunity. They claim the service is becoming more important to them because they are recognizing the impact of Tele-Care NWT on reducing the number of non-acute, less serious cases to which they have to attend. Nurses who are supportive of the service say it takes a load off at night. The calls they do receive are more appropriate and people wait to see them during the day. However, in another instance, staff question the efficacy of the service and wonder whether Tele-Care NWT may actually be sending more patients their way rather than diverting them. These staff report that they have intimate knowledge of the community and its health needs and that more often than not Tele-Care NWT recommends that the patient see the local nurse anyway.

The perspective among social service providers varies as well. Some informants point out that earlier in the initiative, social services providers were “resistant,” but they appear more accepting now. Others continue to question the value of the service to the social services provision. However, the majority of informants tend to think that the service should be re-examined with extensive input from the social services sector. There is a sense from these providers that Tele-Care NWT does have some current value to their sector but that improving that value would require a much clearer articulation of what information is currently available and what potential information and services could be added.

4.3 Provider Patient Referral

Evaluation question: Are health and social service providers in the NWT referring their patients to Tele-Care NWT in between visits?

According to most regional health and social service administration, front-line workers have reportedly mentioned Tele-Care NWT to clients and found the service to be useful to meet basic needs that clients can address at home (rather than going to a hospital or clinic). Key informants suggest that nurses and new staff have to be continually reminded to inform patients that they can access this service, especially during staff shortages. However, there are reports that in some communities during periods of staff shortages, people have gone door-to-door promoting Tele-Care NWT.

Generally, key informants and regional administrators suggest that most members of the public hear about Tele-Care NWT from health providers, not from social workers, although some social workers interviewed say they readily give out the toll free number to their clients. According to the provider survey, registered nurses / nurse practitioners are most likely to provide the Tele-Care NWT number to the public and medical doctors are least likely (see Table 3.).

Table 3. Recommending Tele-Care NWT to Patients or Clients

Provider Type	YES	NO	Not Sure
Registered Nurse / Nurse Practitioner	76.9%	20.5%	2.6%
Health Related	50.0%	45.5%	4.5%
Social Worker/Social Work Related	41.7%	58.3%	0.0%
Medical Doctor	25.0%	60.0%	15.0%

Tele-Care NWT Provider Survey (September 2006)

4.4 Provider Workload Relief

Evaluation question: Do the health and social service professionals feel any sense of relief with having the Tele-Care NWT Line in place as a means to direct individuals with health and social issues after clinic hours?

According to the provider survey (see Table 4.), providers tend to agree that Tele-Care NWT provides some work load relief for health services providers and tend to disagree that Tele-Care NWT provides work load relief to social services providers.

However, when asked if their own work load was reduced by the introduction of Tele-Care NWT, providers tend to disagree.

Table 4. Workload Responses to Provider Survey

Tele-Care NWT reduces the work load of health services providers			
Provider Type	**Agree**	**Disagree**	**Neutral***
Registered Nurse / Nurse Practitioner	45.0%	32.5%	22.5%
Health Related	58.5%	12.5%	29.0%
Medical Doctor	35.0%	45.0%	20.0%
Social Worker/Social Work Related	54.2%	25.0%	20.8%
Tele-Care NWT reduces the work load of social services providers			
Provider Type	**Agree**	**Disagree**	**Neutral***
Registered Nurse / Nurse Practitioner	16.2%	37.8%	46.0%
Health Related	36.0%	4.0%	60.0%
Medical Doctor	20.0%	40.0%	40.0%
Social Worker/Social Work Related	26.0%	61.0%	13.0%
Tele-Care NWT reduces my work load			
Provider Type	**Agree**	**Disagree**	**Neutral***
Registered Nurse / Nurse Practitioner	18.0%	59.0%	23.0%
Health Related	18.0%	40.0%	44.0%
Medical Doctor	10.0%	60.0%	30.0%
Social Worker/Social Work Related	4.3%	47.8%	47.9%

* Respondents were asked to rate their agreement (scale of 1-5) with statements. Neutral was interpreted as a rating of 3, neither agree nor disagree (don't know/not sure).

The nurse survey[14] indicates that a majority of nurse respondents (67%; N=97) felt that Tele-Care NWT had no impact on nurses' workload (i.e. reduced call backs, reduced time with patient who have used the service, etc.)—25% felt it had a positive/somewhat positive impact.

4.5 Provider Access to Services

Evaluation question: Do the nurses, doctors or other health professionals currently or would they consider calling Tele-Care NWT themselves in order to receive information regarding best practice standards?

Service providers do call Tele-Care NWT (see Table 5). However, they typically call for personal advice on a personal health issue, not to receive information on best practice standards.

[14] Nurse Recruitment and Retention Survey 2005 – NWT.

Table 5. Personally Accessed Tele-Care NWT

Provider Type	YES	NO
Health Related	50.0%	50.0%
Social Worker/Social Work Related	29.2%	70.8%
Registered Nurse / Nurse Practitioner	25.0%	75.0%
Medical Doctor	9.1%	90.9%

Tele-Care NWT Provider Survey (September 2006)

Value to the NWT Health and Social Services System

4.6 Advancing Primary Health Care

Evaluation question: Is Tele-Care NWT supporting the broader program of primary health care in the NWT?

The value of Tele-Care NWT ultimately rests in the initiative's ability to support the broader program of primary health care in the NWT. On an immediate level, Tele-Care NWT is valued in terms of a successful strategy as part of the *NWT Health and Social Services Action Plan 2002 – 2005 (Action 5.1.3 Establish a 1-800 family health and social support call centre)*. Key informants and regional administration agree that the line has been established. Statistics confirm that service has been continuous and meeting the terms of reference of the contract between the GNWT and Clinidata Corporation. From the perspective of the Department, Tele-Care NWT fits in with the primary community care initiative. The NWT is increasing its use of nurse practitioners, as in some instances a referral to a nurse practitioner is more appropriate than to a physician. This service can facilitate that kind of process. As such, it has become one of the key components of primary community care.

According to some providers, the link between *Action 5.1.2 All households in the NWT will receive a self-care book and 5.1.3 Establish a 1-800 family health and social support call centre* does not appear to have been made in number of communities. Where community informants did mention the self-care book, they were impressed with the material in the book.

Action 5.1.2 involves the distribution of a self-care book to all households in the NWT; Action 5.1.3 is specific to establishing Tele-Care NWT, a telephone advice line. Both strategies are considered important and mutually supportive in improving primary community care. Tele-Care NWT nurses are made aware of the self-care book and asked to make reference to it where appropriate

4.7 Cost and Benefit

Evaluation question: Is Tele-Care NWT cost beneficial?

The value of Tele-Care NWT to the GNWT will first be considered against the contract for services. Currently call volumes are below initial expectations[15].

Table 6. 6 Month Call Volume Statistics

Tele-Care NWT Monthly Statistics	**NWT**
April 2006	
Forecast based on Contract	1445
Forecast based on Experience	566
Actual Call Volume	393
May 2006	
Forecast based on Contract	1730
Forecast based on Experience	678
Actual Call Volume	390
June 2006	
Forecast based on Contract	1787
Forecast based on Experience	700
Actual Call Volume	365
July 2006	
Forecast based on Contract	1962
Forecast based on Experience	663
Actual Call Volume	397
August 2006	
Forecast based on Contract	1920
Forecast based on Experience	752
Actual Call Volume	363
September 2006	
Forecast based on Contract	1654
Forecast based on Experience	648
Actual Call Volume	486

Current figures suggest that call volume is considerably less than originally expected.

[15] Estimates based on southern Canada experiences.

Service and marketing costs[16] to the GNWT are on average $56,822.16 per month of the contract. At original estimates for call volume[17], cost per call was estimated at $45.05 per call. Call volume between April 04 and July 06 was 9128 calls. Cost per call over the same time period was $174.30. Call volume has settled in at approximately 380 callers per month. Cost per call at a 400/month estimated call volume is $142.05.

For a number of reasons, it is well established that delivery of health and social services to northern residents is proportionately higher than delivery of services in southern Canada. Initial call volumes were estimated on service volumes experienced in southern jurisdictions. There was no northern comparator at the time.

The value of Tele-Care NWT should not only be considered relative to its proportional costs with other jurisdictions but be considered in light of the benefits the program is providing. The question then becomes what resources are the GNWT prepared to commit to offer a program that:

- Is currently offered almost universally across Canada;
- Has a better than 90% client satisfaction rate;
- Is receiving support from both health and social services providers (albeit not unanimously);
- Is increasing its reach into northern communities;
- Has reportedly reduced the number of non-urgent requests received by some health providers;
- Is promoting self-care; and
- Is increasing access to health information and primary care advice to residents of the NWT.

[16] This does not include the initial implementation cost of $108,341.00.
[17] Call volumes were based on Clinidata experiences with volumes in southern Canada.

5.0 Impact

Health Impact

5.1 Following Advice Given by the Tele-Care NWT Nurse

Evaluation question: Do Callers comply with advice received from Tele-Care NWT nurses?

Results of the Population Survey indicate that the majority of respondents (96.6%) indicated they had followed the advice they were given by the Tele-Care NWT nurse. Response patterns across the demographics were consistent, and no differences were found to be statistically significant.

Table 7. Following Advice

	TOTAL	AGE		MARITAL STATUS		CHILDREN		GENDER	
	(N=87)	Senior (n=16)	Non-Senior (n=71)	Single (n=10)	Not Single (n=77)	Children (n=57)	No Children (n=30)	Male (n=13)	Female (n=74)
Yes	96.6%	93.8%	97.2%	100.0%	96.1%	98.2%	93.3%	92.3%	97.3%
No	3.4%	6.2%	2.8%	0.0%	3.9%	1.8%	6.7%	7.7%	2.7%
Don't Know	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

* One respondent refused to indicate marital status

When providers of health and social services were asked their opinion as to the impact of Tele-Care NWT on patients and clients, most providers agreed that Tele-Care NWT provided greatest benefit to people seeking assistance/advice to assist with physical health problems. Provider responses were as follows:

Table 8. Provider Perspectives on Tele-Care NWT Impact

Question	Agree	Disagree	Neutral
Helps clients find appropriate health and social services resources.	41.5%	20.6%%	37.9%
Provides valuable assistance to people experiencing physical health problems.	47.9%	19.6%	32.5%
Provides valuable assistance to people experiencing mental health and addiction problems.	23.6%	32.8%	43.6%
Provides valuable assistance to people experiencing social problems.	21.6%	35.2%	43.2%
Helps people to learn how to better manage their own physical health, social, and/or mental health-related problems	32.8%	24.7%	42.5%
Users of Tele-Care NWT are likely to make changes to their physical health, social, and/or mental health behaviour after receiving advice from Tele-Care NWT service.	17.9%	39.2%	42.9%
Tele-Care NWT can help prevent more serious physical health, social, and/or mental health and addiction problems with early intervention.	31.0%	26.8%	42.2

It is difficult to determine the exact intent of respondents who provided a neutral response (neither agreed nor disagreed with statements provided). Neutral responses could be interpreted as “I don’t know or I am not sure” or as “I am not interested.”

PART II: 811 Feasibility Study

811 Feasibility Study Methods

Focus of 811 Feasibility Research

The Northwest Territories is assessing the feasibility of establishing an 811 health and social services telephone line for residents of the NWT. This study will provide information to assist the GNWT in determining the long-term scope, feasibility and appropriateness of such a service.

To provide decision making information in relation to an 811 service, Howard Research and Outcrop have studied similar systems and gathered initial input from NWT stakeholders by:

- Gathering information on 3-digit telephone information access systems like 211 and 811 to identify best practices;
- Conducting interviews and holding discussions across the NWT to assess the appropriateness and potential scope of a NWT 811 system with providers of health and social services in all NWT Health and Social Services regions, management of Health and Social Services Authorities and members of the general public;
- Gathering information on going forward plans for 811 and 211 health and social service triage and information services in other Canadian jurisdictions; and
- Gathering information on the planning decisions that will need to be taken to determine cost options for an 811 service in the NWT.

In addition, a framework developed for the intergovernmental Multi-Jurisdictional Steering Committee and completed in early 2006 was used by Howard Research and Outcrop for this study (*A Framework for the Implementation of 811 Service*[18]). The framework provides information and options to assist jurisdictions that are assessing the feasibility of an 811 system.

The need to include 211 information in the 811 Feasibility Research

Because there are no 811 systems in operation as non-urgent telephone triage services, Howard Research and Outcrop expanded the parameters of this feasibility study to include a review of the planning for and implementing of 211 services, with particular emphasis on western Canada. 211 services have a great many similarities with any potential 811 service. Studies associated with 211 services provide a template for the planning that will need to be done before any final decision on instituting an 811 service can be taken by the NWT.

[18] Framework for the Multi-Jurisdictional Steering Committee, produced by Lucas & Associates, Final Report 27 Feb 2006.

What is 811?

At the present time, 811 is more an approved idea than a reality. There are currently no 811 services operating in Canada. 811 was reserved in 2005 by the Canadian Radio-television and Telecommunication Commission (CRTC) "for access to non-urgent health care telephone triage services."[19]

The intention to use 811 as a health care triage service is unique to Canada. In the United States, 811 has been reserved for information on the location of buried cables and pipelines.

What is 211?

211 has been in use in North America since June 12, 1997. It was first introduced in Atlanta, Georgia as a community resources information and referral service. At present, 211 services are available to 46% of US citizens.

In 2001, the CRTC assigned 211 as a "toll free service that will supply information and referrals about community, social, health and government services."[20] Two national bodies, the United Way of Canada-Centraide Canada and the Inform Canada Federation have provided leadership to 211 initiatives in Canada. The goal established for Canada's 211 initiative is to ensure that one-third of Canadians in at least five provinces have access to 211 by 2008 and that access to 211 is extended to all Canadians by 2011.[21] 211 service is currently available in Toronto, Calgary, Edmonton, the Niagara area of Ontario and Simcoe County, Ontario. British Columbia is in the advanced stages of planning to provide 211 access across the entire province.[22]

[19] Telecom Decision CRTC 2005-39, Ottawa 6 July 2005.
[20] Telecom Decision CRTC 2001-475, Ottawa 9 August 2001.
[21] BC211 Final Report and Business Plan, November 2005.
[22] BC211 Final Report and Business Plan, prepared by IBM Consulting Services, November 2005.

811 Feasibility Study Dimensions of Inquiry/Results

1.0 Stakeholder Engagement

The 811 feasibility study included consultations and discussion with many of the key NWT stakeholders who would need to be involved in planning or implementing an 811 service.

1.1 Stakeholder Representation

Feasibility question: Who needs to be engaged in the development of 811?

If an 811 service is ultimately introduced in the NWT, there would be a need for ongoing stakeholder engagement. The range of stakeholders that would need to be involved in ongoing 811 operations would be determined by the vision that the NWT adopts, the scope of 811 services and the 811 operational requirements. Key planning stakeholders may include:

- The management of the eight NWT Health and Social Services Authorities;
- Professional health and social services providers in each Authority or Agency;
- NGO providers of services funded by the GNWT Department of Health and Social Services;
- Regional and territorial organizations with an expressed interest in the provision of health and social services to NWT residents;
- Aboriginal organizations;
- Major users of NWT health and social services including seniors' organizations;
- Youth organizations;
- Emergency services organizations;
- Northwestel and cellular telephone service providers; and
- Members of the general public who are not aligned in a significant way with the stakeholders identified above.

Ongoing stakeholder engagement will be needed to address the following:

- The vision and scope of 811 services in the NWT;
- The desired degree of integration or overlap with other potential NWT N11 services such as 911;
- The role that 811 would play in the Primary Health Care System;
- The principles of the NWT Integrated Service Delivery Model (ISDM);
- Regional and cultural differences within the NWT;
- Priorities of Health and Social Services Authorities and Agencies;

- Language services need to support delivery of the 811 service; and
- Advisory stakeholder groups.

2.0 Vision and Scope of a NWT 811 Service

There needs to be a clear vision for NWT 811. That vision cannot be developed in isolation from other dimensions of health care in the NWT, and it is important that the NWT 811 vision is directly aligned with both the NWT's Primary Community Care system and overall with the NWT's ISDM.

Once the vision is created, the next step will be to identify the services that are needed to bring the vision into reality. It is important to remember that NWT 811 will not likely deliver the service. Instead, using a call centre, 811 would guide callers to the services that best meet their needs.

2.1 Vision

Feasibility question: What is the Vision for 811?

There is currently no 811 vision statement in the Northwest Territories or elsewhere in Canada.

To address this deficiency, a vision statement will need to be developed and approved through a stakeholder engagement process that includes service providers, those who will use the service and those who will fund the service.

If developed, an 811 vision needs to consider:

- The CRTC ruling that designated 811 for non-urgent health care telephone triage services in Canada;
- Dialogue with NWT stakeholders, providers and funders about 811 vision and scope of services;
- The unique cultural, social, linguistic and geographic nature of the NWT;
- 811 vision statements developed for other 811 jurisdictions; and
- Potentially overlapping vision and scope of service between 811 and 211 (nationally and regionally).

A discussion of the vision for 811 needs to begin with a review of the CRTC (Canadian Radio and Television Commission) decision on 811 and its implication for 811 services across Canada.

811 Designation by the CRTC
The CRTC (Canadian Radio and Television Commission) decision on 811 (Telecom Decision, CRTC 2005-39, 5 July, 2005)[23] sets out expectations and makes rulings with respect to the introduction of 811 services in Canada.

The CRTC ruling was triggered by an application from Alberta Health and Wellness (August 24, 2004) to have 311 designated for "non-commercial use across Canada for access to first level health care triage services (teletriage services)." However, since an earlier application to the CRTC to assign 311 for non-emergency municipal government services had received a favourable ruling, the CRTC invited Alberta Health and Wellness to apply for another N11 number. On November 26, 2004 Alberta amended its application to apply for any available N11, but preferably 811.

At the end of the review process, the CRTC issued an order reserving 811 for non-urgent health care telephone triage. The telephone companies were given between 30 days and two years to vacate any 811 line which was being used for telephone repair services. Northwestel was asked to vacate 811 by June 2006, which it has done.

The CRTC designation of 811 also addressed a number of implementation issues. It ruled that each province or territory that wished to implement 811 service provide a minimum of six months notice to its telephone service provider (TSP). On cost recovery, the CRTC directed the TSPs to assume, on an incremental basis, the cost of basic switch modifications and network changes necessary for the implementation of 811 service. It also ruled that cost recovery for supporting the 811 service should not be charged as a component on carriers' bills, as is presently done for 911 cost recovery. The CRTC also determined that the callers should bear the cost of 811 calls placed from wireless networks and from pay telephones.

See Appendix J for a more extended discussion of the CRTC ruling.

Developing an 811 Vision in Canada
Our research has not been able to find an approved 811 vision statement from any Canadian jurisdiction. However, this is not surprising considering how recently the 811 number was designated for non-urgent health care telephone triage services.

In anticipation of the need to develop an 811 vision, much has been done to examine 811 issues. In this regard, our research team is indebted to the information presented in *A Framework for the Implementation of 811 Service*[24] produced for the Multi-Jurisdictional Steering Committee (MJSC).

Potential Overlaps in 811 and 211 Visions and Scope of Service
If 811 and 211 services are delivered independently, this could lead to confusion for callers. It could also result in a duplication of infrastructure and increased overall costs. However, there need not be confusion and competition. The two services (811and 211) could develop with a planned degree of overlap and share a common infrastructure. It will be important to define the vision and scope of each before 811 is launched.

[24] A Framework for the Implementation of 811 Service, Lucas & Associates, Final Report, 27 Feb 2006.

3.0 Overlap with 911 Services

911 services are not currently available in the NWT. However, this may change in the near future since the City of Yellowknife is preparing an application to the CRTC to provide 911 services to Yellowknife.

911 services are defined as fire, police and medical emergency services. 911 is not intended to provide non-emergency services or referrals. Traditionally 911 services were delivered only over land lines. However, the expansion of wireless services has created a need for Enhanced 911 services referred to as E911 services. While these are part of 911 in larger southern cities, current 911 plans in Yellowknife are expected to provide only the basic service.

Where 911 is not available, some callers may try to use 811 as both an emergency and a non-emergency services telephone line because the caller may be unable to determine whether their situation is an emergency or not. Where 911 is in operation, the 811 call centre operator could simply transfer calls to 911 if an emergency exists. However, it is not expected that 911 operators would provide a transfer back to 811, although this may be possible.

3.1 N11 Service Differentiation

Feasibility question: How will 811 be differentiated from 911?

Differentiation should be introduced primarily through distinctive branding of each service. Because the NWT population will eventually include some communities that have 911 services and some who do not, it would be risky to define 811 in too narrow a fashion. In any case, separate branding and communication strategies will be needed for both 911 and 811.

It may be desirable to brand 911 services as “911 Emergency.” The 811 service would also need appropriate branding. It may be best to brand 811 by adding the words health and social services – as in “811 Health and Social Services.” Before selecting any branding, it is highly desirable that the brand label be tested with a sample of NWT audiences. This could be accomplished most easily by focus groups or a professionally developed survey.

Our community research, as part of this project, suggests that most people believe that NWT residents will quickly learn which services they can expect to access using different 3-digit telephone numbers. Because the services are accessed in a voice form rather than a written form, it may be desirable to do most promotion through broadcast messaging. Television PSAs that include dramatizations of appropriate examples could be effective public education tools. Prompts like “fridge magnets” should continue to be used.

Since 811 (or 211) may be used across the entire NWT, it may be best to play down the non-urgent or non-emergency scope of 811 services. For those who don’t know how to

access emergency services, 811 triage should still be available to put them in touch with the service that they need – whether it is an emergency service or not. To do this efficiently, 811 operators would need to be able to transfer calls directly to an emergency services line without asking the caller to call another number.

3.2 Overlap and Synergy

Feasibility question: What 811 and 911 overlap problems and/or opportunities for synergy are likely to arise?

The most likely overlap problem will be the inability of many callers to distinguish between emergency and non-emergency situations or to know which to call if both are available. Education will be needed to make it clear that the emergencies involved are police, fire and potentially life-threatening or extreme health emergencies.

Different kinds of service responses will be involved with 911 and 811. In the case of 911 calls the most frequent requests are to dispatch fire, police or emergency health services to attend to the emergency. However, in the case of 811, the caller is most likely to be seeking help to determine how they can address a non-emergency concern – either by using self-care and support or by accessing a wide range of other health and social services. The key to synergy will be the establishment of wayfinding protocols for both services that are consistent with the primary purpose of each.

Opportunities to synergize are more likely to involve call transfers from 811 to 911 rather than 911 to 811. To reinforce the emergency branding, it will be desirable that 911 operators not try to provide telephone triage or connection to non-emergency services. However, 811 service operators should be trained to promptly refer genuine emergencies directly to 911 where emergency services are available or to alternative telephone numbers where these resources are not locally available.

4.0 Service Integration

Integration of the delivery of 811 services needs to take into account the professional skills that are required to meet the varied health and social services needs of callers. While integration of service delivery by telephone will be challenging, there are excellent opportunities to integrate an information resources database.

4.1 811 Health Services Access

Feasibility question: What health and social services will 811 access?

If 811 services are offered in the NWT, it appears likely that the 811 number would be used to facilitate access to both non-emergency health service and non-emergency social services. The scope of the services to be provided by each would need to be determined within the NWT since a definition of non-urgent health services was not provided by the CRTC in its 811 ruling. This would appear to leave it up to each jurisdiction to establish its own list of available services.

In our community research and consultations with NWT community members, health care professionals and Health and Social Services Authority management, Howard Research and Outcrop observed that there is strong support for the provision of both health and social services triage and information though a free, telephone-accessible service. Identifying the scope of 811 services needs to be determined in consultation with stakeholders.

It should be noted that public perception of what constitutes a social service may be different or broader than the scope of social services provided through the Department of Health and Social Services. Some NWT residents see government programs like income support, public housing and day care subsidies as social services. However, these are delivered through the Department of Education, Culture and Employment, not the Department of Health and Social Services. Cooperative development of information access programs will likely be needed among government departments

In other Canadian jurisdictions, early indications are that an 811 implementation strategy may be to simply change the health line access number from a toll free line to 811 without re-defining the service. This has the potential to bring some consistency where there are different names for similar triage and health information services. However, it is potentially a very limiting strategy and is not recommended to the NWT by Howard Research and Outcrop.

Across Canada health teletriage services are currently provided using a variety of names, including:

- NurseLine – British Columbia
- Health Link – Alberta
- Healthline – Saskatchewan
- Health Links – Manitoba
- Telehealth – Ontario
- Info Santé – Quebec
- Tele-Care – New Brunswick
- Tele-Care – NWT

In the course of a transition to 811, there is the possibility of adding new services. As more new 811 services are added, it may be necessary to use a two-tier approach in which a call centre provides wayfinding and a second level of service connects the caller to government and NGO services that address the caller's needs.

However, the wayfinding concept is also central to 211. In order to assess the most appropriate solution for the NWT (811, 211 or no change), an assessment of the optimum long term service model needs to be explored with stakeholders – particularly those in other jurisdictions who are moving forward with 211 services.

811 plans will also need to consider ongoing financial sustainability and the mix of resources that need to be made available to meet the expectations of residents and the

Department of Health and Social Services. It would be very unwise to initiate an 811 service without recognizing that it will entail a long term commitment.

Ultimately it may be necessary for the NWT to choose between an 811 or a 211 call centre. With a population of only 42,000, the NWT is not in a position to operate and staff its own call centre on a cost effective basis. And, since it is estimated that a cost effective call centre operation needs to have a population base of approximately one million people, a NWT wayfinding call centre will likely need to be operated as a satellite of some larger call centre outside the territory. Satellite call centre options that could be explored include the Calgary 211 call centre, the Edmonton 211 call centre and the soon to be established BC211 call centre.

4.2 Integrated Service Delivery within 811

Feasibility question: How will various health line services be integrated within 811?

It is very unlikely that all of the services required by an 811 system can be provided by a single organization or agency. As noted above, 811 will likely require a two-tier process within which different professionals provide specialized services. This may be similar to the 211 process where a trained professional identifies the caller's primary need and the service most likely to meet that need. Once that has been accomplished the caller can be "handed-off" directly (if possible) to those who can work with the caller to provide the service.

In order to provide NWT residents with improved and cost effective access to expanded telephone accessible health and social services, it may be desirable to identify high quality providers of low volume services in other jurisdictions. For example, BC already operates a Pharmacist Network and may add a Dial-a-Dietician service. It may be feasible to contract low volume services like these from multiple vendors while maintaining the present health line vendor.

While 811 health and social services may be provided by different organizations, there are excellent opportunities to benefit from the creation of a common database. The 211 Canada Taxonomy project, already initiated in Ontario, could provide the NWT with information on appropriate database architecture and term definitions.

5.0 Internet Delivery Channels

The Internet could provide NWT residents with increased access to health services and social services information. This would be in line with the increased use of the Internet to access health information.

A 2005 Statistics Canada survey released August 15, 2006 reports that 58% of rural and small town residents of Canada accessed the Internet in 2005 for personal non-business reasons. It was also reported in the same study that 58% of all Canadians who used the Internet for non-business reasons in 2005 were searching for medical or health-related

information.[25] These results strongly suggest that the Internet is a powerful way to provide access for Canadians seeking health-related information. Since the NWT has a lower percentage of Internet users, the health-related use in the NWT may be reduced but could still be significant.

5.1 Possibility for Other Information Channels

Feasibility question: At present 811 is being considered as a telephone-accessible service. Is it possible to use other information channels, including the Internet?

Considering the increasing use northerners make of the Internet, it would be entirely appropriate to make additional health and social services information available over the Internet. To increase awareness that information is available on the Internet, there should be ongoing promotion of this fact to NWT residents and cross promotion with other 811 messaging. The use of Meta Tags[26] would be encouraged to increase the ease with which NWT residents find the site using search engines.

To attract repeat traffic from NWT residents, it will be desirable to provide information tailored to the needs of northern audiences. This will likely require a degree of "northernization" of language and terms, including placing greater emphasis on health and social services issues that are common to the North. Northern examples should be used as much as possible. It will also be desirable to simplify and "plain language" information summaries about NWT services.

To retain credibility, it will be particularly important not to overstate the scope or extent of services available through 811. Where services are not consistently available, it is important not to suggest that are easily accessible. It will also be very important to monitor database information regularly to ensure that the site is as up-to-date as possible. When it is ready to be launched, it is recommended that Internet information be offered on a separate web site with an easy-to-remember name. The Department of Health and Social Services web site may not be the best place to host this information. The language and structure of the Health and Social Services web site requires some knowledge of bureaucratic terms and organizational structure that is not part of the average northerner's experience – particularly those living in smaller communities.

Consideration should also be given to the fact that the web site would operate as a portal rather than a wayfinding service. As a portal, the site needs to be functionally intuitive – planned from the user's perspective and needs rather than one of organizational structure. Unlike a wayfinding approach, where a caller can be helped to find the best choice, an Internet site puts the responsibility for choice on the user.

[25] Statistics Canada, Canadian Internet Survey Use (News Release), August 15, 2006
[26] Meta Tags provide information about a given web page to search engines. They are a search optimization tool that usually gives the site a high ranking on search engines, increasing the ease with which web users will find the site.

6.0 Priority Audiences/Cultural & Language Considerations

6.1 Target Audiences

Feasibility question: What audiences should 811 target?

Our consultations in all regions across the NWT suggest that the prime users of the Tele-Care NWT service are currently pregnant women, women with young children or those who are caring for older family members in their homes. Since there is already a receptive audience within these target groups, a continued effort should be made to address the health and social service information needs of those audiences and to expand services that they most need or request. This targeting will help focus communication and promotion programs. Generic mass media advertising is likely to be much less effective than innovative communication and promotion programs targeting specific audiences.

To build a large constituency for 811 services, a special effort should be made to promote 811 services with both current users and audiences that may not currently use Tele-Care NWT services. The most likely low use audience with significant growth potential is NWT youth who are learning to take greater responsibility for their own choices. Targeting youth would be an excellent opportunity to take advantage of Internet delivered information and services. The site could also encourage youth to use the 811 line to confidentially discuss the information they have accessed over the Internet.

6.2 Meeting Diverse Needs

Feasibility question: How will 811 meet the needs of the diverse Aboriginal, ethnic, language and cultural groups who are resident in the NWT?

One of the challenges of delivering health and social services in the NWT is the need to communicate across a population that includes nine Aboriginal languages, other languages spoken by immigrant populations, as well as English and French.

It is important to let NWT residents know that the 811 service can be offered in translation to these language groups. Our research in all regions of the NWT confirmed that many NWT residents, including those who have used Tele-Care NWT, are not aware of the translation services that are available. Since translation into languages other than French and the NWT's Aboriginal languages was only mentioned once in the course of our consultations, it is unlikely that non-English speaking immigrant groups are aware that their needs could be met through the Tele-Care NWT service (or an 811 service).

Cultural orientation to the NWT should be a priority for all who deliver telephone services. We received many suggestions as to how to remedy this perceived deficiency. They included tours for service providers or the construction of a community resources page for each NWT community that could show an aerial view of the community[27],

[27] The NWT Statistics Branch has both photos and community profiles available on the Internet at http://www.stats.gov.nt.ca/Infrastructure/Profiles.html.

population data and a list of all health, social service and self-care resources that can be accessed in the community. Another suggestion was for the development of a 15-20 minute orientation video that would include some communities from each of the health regions. Once developed, the video would become part of the orientation of all new call centre staff.

7.0 811 Delivery Approach

The 811 delivery approach will be strongly influenced by the vision and scope of 811 discussed in Section 2.0 of this report. Delivery will also need to consider the resources that are best able to meet the needs of current and potential target audiences. Whether this is provided through one vendor or several will depend on the ability of vendors to deliver the services required.

7.1 Current Vendor Support

Feasibility question: Does Clinidata have the resources to accommodate additional triage and information needs identified within the NWT?

The evaluation portion of this report has determined that Clinidata has the ability to respond to medical questions using the services of Registered Nurses working in the company's call centre. What is not clear is whether Clinidata could deliver all of the additional services that may be required by an expanded scope-of-service 811 line. Services like "poison information" and "STI information" are currently offered by Clinidata in New Brunswick and could possibly be added to the services provided to the NWT. Once a scope of service has been established for 811 it will be possible to determine how many of the additional services Clinidata could provide. However, it may be unrealistic to expect Clinidata to also handle social service inquiries, crisis lines and social services such as mental health and addictions.

7.2 Centralization and Infrastructure

Feasibility question: How centralized will the call centre operations (811) and infrastructure need to be?

Considering the need for consistent service delivery and the small size of the NWT population, it would likely be desirable to centralize the operations of the call centre that provides the initial response.

The scope of 811 services will be a critical factor in determining whether the same call centre should also provide direct services or simply act as a wayfinding and referral agency. In any case, the call centre should be centralized, but the services do not need to be. It should also be possible to contract separate vendors for services that require different skills or different professional training.

The technical infrastructure and the database development and maintenance should be centralized. These should be common to all call centre responders.

7.3 Potential for Additional Services

Feasibility question: What other options are there to add services?

The options to add services are limited only by the expectations/needs of the public, the definition of health and social services and the ability of the 811 sponsor to pay for the services that meet those needs.

From an effectiveness and reliability perspective, it will likely be best to add specific services in small increments. Services that are very specific are more likely to be better understood by the public. For example, it is easier to understand the services provided by a “Pharmacist Line” than a “healthy living” or “wellness” line. The more specific the service the more likely it is to be understood and used.

The ways in which the GNWT can deliver the chosen services needs to consider the options for wayfinding services available. It is almost certain these services will come from outside the NWT and make use of operating models and staffing arrangements developed in southern Canada.

Currently the Tele-Care NWT health line services are effectively delivered from a call centre in New Brunswick. Additional resources to meet enhanced 811 services may be delivered through Clinidata if it offers these services, or through services that are based in cities like Edmonton or in provinces like British Columbia. Service delivery may come from private corporations, NGOs or be delivered directly by governments.

Beyond the scope of service, the most important consideration before offering an 811 service will be to determine how effectively it can contribute to meeting the health, social, cultural and linguistic needs of the people of the Northwest Territories.

8.0 Staged Deployment

Staged deployment is intended to optimize the sequencing and type of launch that various services require. It will allow for services to be added in small increments and for service additions to be optimized. This can impact how the service delivery is perceived and allow problems to be fixed one at a time rather than across the board. In the end, staged deployment allows for lessons learned at each step to be applied to the next steps as the service grows to meet the 811 vision and scope of service.

8.1 Timelines

Feasibility question: What is the timeline for the launching of an 811 service?

There does not appear to be any urgency about launching an 811 service in the NWT. As there are no 811 services currently operating in Canada, it may be best to learn from the experience of others rather than being an “early adopter” and taking on all the risks and challenges of being the first to make an 811 service available.

Detailed planning for the launch of a new service like 811 will be essential. Simon Lucas in his report to the Multi-Jurisdictional Steering Committee has developed an 811 framework that will be very useful in 811 planning. He suggests that deployment of 811 needs to be broken down into six phases. There would need to be satisfactory plans for all six before the service is launched.

- Concept Development: Understanding the environment in which one will operate and defining the initial vision and scope of service.
- Solution Planning: This is a step-by-step process that involves technology planning, marketing planning and deployment planning.
- Plan Approval: The plan needs to provide ongoing support of the governance structure and a realistic timeline.
- Implementation: Following approval, detailed planning is the next step, including securing the needed services and completing the infrastructure development.
- Development and Evaluation: There is need to plan for building awareness, increasing trial and encouraging repeat use. There is also a need to review the scope and determine if additional services are needed. This may be best done by a formal Progress Evaluation.
- Sustainment: Ongoing communication and promotion programs are essential as well as securing long-term funding commitments that ensure sustainability.

The time and effort required to launch a NWT 811 service will depend on the scope of service. A staged approach will reduce the risks associated with the service launch.

8.2 Resource Requirements

Feasibility question: What services and resources will need to be provided to support an 811 service?

Since there are no 811 services in operation in North America, Howard Research and Outcrop looked to proven N11 models like 211 to identify services, resources and standards that may apply to an 811 service.

211 operating standards in Canada and the United States are based on the established *Standards for Professional Information and Referral* published by the Alliance of Information and Referral (AIRS). While accreditation and certification are specific to 211, it is possible that acceptance of these (or similar) standards will become the norm for all 811 operators. In any case, some standards will be required. Since the NWT will likely be outsourcing its 811 services, it will be important to set standards for suppliers of call centre wayfinding services, such as:

- Ability to deliver 24-hour coverage, year-round;
- Accredited or have a clear written plan for becoming accredited;
- Use of Certified (Specially Trained) Referral Specialists;
- Cooperative relationships with agencies and NGOs that provide services and with vendors who deliver specialized services;

- Has a means of tracking call volume, abandoned calls, average speed of answering and average call length;
- Has a computerized database with client collection capability;
- Uses the Taxonomy of Human Services being developed by Canada 211;
- Has the resources for public education and promotion;
- Has TTY (Text Telephony) and multi-language accessibility either on-site or through dependable access to interpreters; and
- Ensures quality of service and caller satisfaction through appropriate follow-up.

In addition, considerable attention must be paid to technology planning in order to ensure efficiency and reliability. Key questions to be resolved include:

- Call steering – automated vs. voice or a combination of the two? This decision has important IT consequences.
- Call handling – How will the call be handled (by people or technology) and what equipment will the primary Call Centre require?
- Telecom network – How will 811 be accessed? Can radio, satellite or VoIP calls be handled? What about "strapped" phones in the NWT?
- Who pays for 811 calls outside the Service Provider's area? Or access to resources outside the caller's area?
- Call decision on "applications" needed to support 811 service. The scope of service will drive the application requirements. How will these applications be supported?
- Decision on the type of wayfinding system to triage the caller's initial need for services.

9.0 Governance

Governance should provide a formal decision making process as well as mechanisms to ensure long term accountability and transparency. The degree to which 811 governance provides for ongoing stakeholder input will be important in determining additions or deletion of services, staged system deployment, cultural and regional input and ongoing review and evaluation.

9.1 Governance Structure

Feasibility question: What governance structure would 811 require to operate effectively within the NWT?

An appropriate and effective governance structure for an 811 service in the NWT will vary considerably based on the vision and scope of service determined by stakeholders and supported by the funders.

Stakeholder engagement in ongoing governance will need to take the following factors into account:

- Definitions of health and social services within the NWT;
- Scope of 811 service;
- Extent of integration with other current or future N11 services;
- Need for regional public (ordinary citizen) involvement;
- Role of the Health and Social Services Authorities;
- Role of First Nations Governments and Aboriginal organizations;
- Extent of integration into Primary Health Care and the GNWT's Integrated Service Delivery Model (ISDM);
- Extent of inter-jurisdictional cooperation or need to access specific services; and
- The political agenda with regard to public access to human services, including health and social services.

During the NWT 811 concept development phase a working group could be formed to ensure adequate stakeholder participation is taken into account. Its role should be advisory. Once the NWT 811 service is ready for implementation, the working group should be replaced by a publicly appointed Advisory Board that includes adequate stakeholder representation. Financial responsibility and the final decision on selection of service providers should remain with the funding authority – most likely the Department of Health and Social Services of the GNWT.

10.0 Technical Implications

10.1 Reaching All NWT Residents

Feasibility question: Is the provision of 811 access to all NWT residents technically possible?

It will not be possible to provide 811 access to all NWT residents unless all residents have 24/7 access to a telephone to can connect to 811. However, it is technically possible to introduce 811 service across the NWT.

Currently, as many as 20 per cent of NWT residents do not have access to telephone service in their homes at any one time. Some simply have not had a telephone installed. Others may experience periods of time in which access is denied by Northwestel for failure to keep payments for services current. Some may also have a wireless service that is only available in the home if the wireless telephone subscriber is on the premises.

To address this deficiency, some Band/Settlement/Hamlet offices provide telephone and Internet access to residents who do not have access to a telephone or the Internet at home. Where this is provided, it is only available during normal business hours and not 24/7.

If the initial use of 811 is simply to change the current Tele-Care NWT toll-free access number to a 3-digit number, the service would be accessible to the same number of residents who could previously access the toll-free line. However, if 811 is to offer broadened or enhanced services this would require the use of a call centre. The call centre would then connect callers to resources in different locations. This raises the issue of who pays if toll charges are involved. If a person in a small community accesses the call centre, and is then connected to a service in a different community, long distance toll charges may apply.

Many NGOs and information service providers are unable to absorb the cost of long distance toll charges which would then have to be assumed by the caller. This may discourage residents from accepting referral services. In some cases the caller would also be unable to connect to the service if their telephone did not have long distance access. This restriction in the North is commonly referred to as a having a “strapped” telephone. However, even a strapped phone could access 811.

So long as these issues are satisfactorily addressed, the “technical” aspects of 811 are more easily resolvable. These would include designing a system in cooperation with the telephone service provider, obtaining the appropriate hardware and software (applications) for a call centre, building and maintaining the database, tracking calls and routing the calls to the services most appropriate to the callers needs. Provisions would also need to be made for data management and security, the data network and the design and operation and maintenance of a web site, if one is intended to supplement the services available through the call centre.

Two technology cost modeling examples, based on BC211 planning, are included in Appendix E.

11.0 Critical Success Factors

11.1 Critical Success Factors to be Resolved

Feasibility question: If a decision is taken to proceed with 811 in the NWT, what are the critical success factors that must be resolved before the 811 service can be successfully implemented?

We are indebted to Lucas & Associates for its development of 12 critical success factors that need to be successfully addressed in the introduction of an 811 service.

11.1.1 The scope of service must be clearly defined.
Since 811 is part of the delivery of health care, it is essential to align 811 with the NWT’s primary health care ISDM model.

11.1.2 The appropriate stakeholders must be engaged.
To maximize potential 811 strategic benefits, stakeholder engagement is essential. At the same time, it is essential that any conflicting stakeholder views about 811 services are resolved or minimized.

11.1.3 The 811 delivery model must be clear and supported by both the provider of the service and 811 stakeholders. Issues of centralized/decentralized services need to be clarified at the outset.

11.1.4 811 must be integrated into the Primary Health Care System.
This will make a significant difference in the long-term usefulness of the service. The delivery of health services needs to be addressed separately from the provision of information and referral services.

11.1.5 Delivery of the 811 service should be staged to reduce risk of failure.
There is much to lose in proceeding too rapidly. A soft launch or a phased rollout by regions will increase potential for success and provide greater regional relevance.

11.1.6 The right technology must be selected and must work.
While this might seem obvious, it is absolutely critical to success. This includes call steering and call handling, the voice and data networks, the IT hardware, the operating systems and the applications needed to support the service. It also includes the development and maintenance of an appropriate and integrated 811 web site. Attention also needs to be paid to seeking solution arising around call routing, wireless telephones and issues like “strapped” fixed lines.

11.1.7 Knowledge Management solutions are required.
The key issues are accurate and up-to-date provider databases, medical knowledge management, call information and call history.

11.1.8 Effective Privacy and Data Security procedures in place.
Compliance with Privacy Regulations is essential for legal and public relations reasons. Appropriate policies and training must be developed and implemented.

11.1.9 Marketing and Branding must be right from the beginning.
A communication plan appropriate to the NWT must be developed to meet our unique northern challenges. Branding must clearly distinguish 811 from other N11 services. Language and promotions must be relevant, accurate and consistent. A multi-dimensional communication plan needs to be developed, implemented and reassessed annually.

11.1.10 There must be enough trained staff to answer calls.
Staffing must be adequate to meet anticipated needs. As awareness is increased it is likely that call volumes will increase. Non-medical staff that may provide wayfinding need special training and resources.

11.1.11 There must be effective plans to handle public emergencies.
Emergency planning needs to be concerned with the delivery of additional services in the event of a public emergency. This will be particularly critical is the emergency is of a health nature. During the SARS outbreak in Toronto, the 211 service was very valuable but was also swamped at times.

11.1.12 The focus must remain on the customer.
This should provide the focal point for the resolution of conflicting views or priorities. Ongoing program evaluation will be an important tool to assess satisfaction with the service among the general population.

Consultant
Comments and Recommendations

Going Forward with Tele-Care NWT and 811

Howard Research and Outcrop Communications make the following recommendations with respect to the Tele-Care NWT Evaluation and 811 Feasibility studies.

Evaluation Study Recommendations

Recommendation # 1 Continue the Program

Continue the Tele-Care NWT program

Telephone advice services (particularly health lines) are fast becoming a universal offering across Canada. Currently all provinces and the NWT have health lines supporting their primary care agendas. The continuation of Tele-Care NWT is recommended in light of the benefits the program is providing. Statistical and anecdotal evidence suggest that Tele-Care NWT is:

- Making progress with generating awareness and use in all regions of the NWT;
- Has a better than 90% client satisfaction rate;
- Providing an after-hours solution for community residents with non-urgent health care issues;
- Reportedly reducing the need for health professionals in some communities to attend to non-urgent inquiries;
- Assisting callers in attending to self-care of their health needs;
- Allaying callers anxiety concerning health issues (e.g. should I see a physician, call the Health Centre or go to the Emergency Department); and
- Receiving a reasonable degree of support from Health and Social Services Authorities and health and social services providers.

On the other hand, the NWT is a unique environment (cultural, linguistic, geographical and political), and Tele-Care NWT has not been successful in meeting initial call volume targets or been able to make as much progress in small communities as it has made in large communities like Yellowknife and Hay River.

The program requires more time to adjust to the unique circumstances of the North and to generate awareness, trial and use by more residents. In addition, support from health and social services providers needs to be strengthened. Aside from registered nurses and nurse practitioners, more than 50% of health and social services providers surveyed for this study are not recommending[28] the Tele-Care NWT service to patients and clients.

[28] Not recommending the Tele-Care number does not mean that they are opposed to the service; it means that they are not actively supporting it.

Recommendation # 2 Increase Clarity of Service Vision and Scope

Increase the clarity of the Tele-Care NWT Vision and Scope of Service definition

The Health and Social Services Action Plan 2002-2005 identified the need "to establish a toll-free call centre for NWT residents to improve access to information and advice from health and social services professionals on a 24-hour basis."

Subsequently the GNWT's Department of Health and Social Services (HSS) issued an RFP for the provision of these services. Ultimately Clinidata, a national firm with Canadian and U.S. experience was selected and contracted to provide the Tele-Care NWT service.

The scope of service and vision of Tele-Care NWT is currently defined by the contract between GNWT and Clinidata. While it would appear that the original intent for a toll-free call centre was to include access to non emergency health and social service information, the current Tele-Care NWT service primarily provides health triage and information services. These health triage services are supplemented by a limited capacity to make referrals for other human and social services.

A clearer vision, and a more precise scope of service definition, will allow the NWT to engage services that more fully meet the health and social services needs of its residents.

For example:

- Clearly define role of Tele-Care NWT within Primary Community Care and the ISDM implementation;
- Add non-urgent social services to the overall scope of service for Tele-Care NWT; and
- Work with stakeholders (including providers and community) to develop a Vision and Scope of Service for a NWT N11 capability.

Recommendation # 3 Promote Tele-Care NWT

Promote Tele-Care NWT as an essential primary community care initiative and demonstrate its application to both residents and health and social services providers.

Primary health care[29] is differentiated from primary care by providing a more holistic, inclusive perspective on health. Primary health care advances the position that health is impacted by several determinants, including cultural and social factors (e.g. family, education, mental health, spiritual health). This broader perspective includes sustaining

[29] In the NWT, primary health care is referred to as primary community care.

a system of health through improving public access to needed health services and information (24/7), increasing consumer health and determinates of health knowledge and changing help seeking behaviour, broadening the system of health surveillance, and positively impacting the health of individuals and populations.

Promoting Tele-Care NWT is more than marketing another government service. It is pro-actively linking the service to a broader health and social services strategy.

Tele-Care NWT can and should play a role in improving primary health care in the North.

Recommendation # 4 Improve Management Stability

Improve program management through increased tenure and stability in staffing and regional representation.

Tele-Care NWT is a substantive program and has important implications in advancing primary health care in the NWT. Improved tenure and stability in staffing and regional representation would enhance the program and provide a better environment in which to promote its value to residents and the health and social services community.

Since its inception there have been a number of changes in the staff assigned to management and coordination of the program as well as frequent turnover in Advisory Committee membership. Frequent staff and membership turnover makes it difficult to maintaining the consistency and continuity required to promote the program and demonstrate to stakeholders. Time is also lost in orienting new Health and Social Services staff adding an additional burden to the vendor representatives. This reduces time available for stakeholder consultation and program refinement.

Without dedicated staff to coordinate ongoing Tele-Care NWT promotion and education within the Health and Social Services Authorities and among health and social service providers, Tele-Care NWT is unlikely to achieve its full potential as an important strategy in advancing primary health care in the NWT.

Recommendation # 5 Conduct an Economic Evaluation

Take advantage of a unique study opportunity at the Stanton Territorial Hospital Emergency Department to collect cost-avoidance data and conduct an economic evaluation of Tele-Care NWT.

There is a dearth of economic studies on health lines. The savings incurred by health lines is their ability to substitute for more costly forms of care and information provision in a system where demand for health care services is continually increasing. However, the data linking health line dispositions, actions of the caller, and a service such as the Emergency Department have been difficult to establish for multiple reasons – mostly that of tracking the caller. The Stanton Territorial Hospital Emergency Department has recently established significant support for recommendation and use of Tele-Care NWT by Emergency Department staff. It is advising approximately 6-10 patients per day to seek service from Tele-Care NWT rather than having the patient utilize emergency

services at the hospital. Data such as these and those collected by the vendor should prove promising in assessing some of the economic impact of Tele-Care NWT.

Recommendation # 6 Focus Communication Programs

Develop and implement communication and promotion programs intended to increase awareness and trial of Tele-Care NWT in low use regions and among lower use populations including Aboriginals, seniors and teens.

Tele-Care NWT vendor data show significant variations in the use, among specific NWT populations. Highest use of the service is among NWT women. In 2005/2006 women were almost five times as likely to use the service as men. Use of the service by men dropped 27% over the previous year.

Data identifying Tele-Care NWT clients by age indicate that only 1.1 % of clients were over 65. However, because data is collected by age of client rather than age of caller, we are not able to determine the use of the health line by specific age groups. Anecdotal evidence gathered during the 2006 evaluation of Tele-Care NWT suggests that use of Tele-Care NWT is low among both teens (13-19) and by seniors (55 and over). Sixty percent of calls were from repeat callers.

Regional data show a 27% increase between 2004-2005 and 2005-2006 in Tele-Care NWT use in all regions. However, there are significant regional differences in use. Frequency of use in Yellowknife was four times greater than use in any of the Beaufort-Delta, the Dehcho or the Tlicho areas that in 2005-2006 had the lowest use per thousand residents. The use of Tele-Care NWT is much greater in the NWT's two largest communities than in the 30 smaller communities. The City of Yellowknife accounted for 70.9% of all Tele-Care NWT use in 2005-2006 but according to the NWT Statistic Branch has only 48% of the population. When the populations of Yellowknife and Hay River are added together, they accounted for 79.9% of all use.

To address these issues:

- Focus promotion activities primarily on smaller NWT communities and populations like seniors and teens who have lower use of Tele-Care NWT;
- Continue giving away prompt tools like pens, fridge magnets or small stickers for medicine cabinets or cupboards;
- Make greater use of audio and visual communication message tools in smaller communities – including community radio and DVD presentations of success stories for use in smaller communities and Health Centres;
- At the same time, reduce use of newspaper advertising. Work directly with seniors and youth organizations to increase awareness and trial of Tele-Care NWT; and
- Keep messaging simple. Keep it client-focused. Use a public service description like "Tele-Care NWT can answer your health questions – day or night, any day of the week." Reinforce the message delivery with examples of client/nurse dialogue.

Recommendation # 7 Identify Service Options

Identify and evaluate additional services or service enhancements that could broaden the current scope of services offered through Tele-Care NWT.

Current call volumes are much lower than those anticipated at the launch of Tele-Care NWT. Also call volume is lower than forecasts made by the vendor following some experience offering services in the NWT. The addition of social services and further health services to the current roster of services offered through Tele-Care NWT may increase call volume and improve the cost to benefit ratio of the service.

Clinidata has indicated that some additional health-related services are accessible by them. Information should be obtained on these services to assess the appropriateness of using them within Tele-Care NWT. Data on the cost of these services to the client as well as Clinidata's experience in delivering them to remote or rural areas should be gathered and assessed.

811 Feasibility Recommendations

Recommendation # 8 Define the NWT 811 Vision and Scope

Define a NWT 811 vision and scope of service in consultation with a wide range of NWT stakeholders.

Only NWT health, social and human services stakeholders can properly address the development of a vision and scope of service for a NWT 811 (or other N11 service like 211) wayfinding and triage line. The key stakeholders should include:

- The Department of Health and Social Services;
- The Health and Social Services Authorities and Agencies;
- Aboriginal Governments and Aboriginal organizations with an expressed interest in primary health care;
- NWT NGOs with an interest in the health, social and human services provided to their NWT client group or advocacy on similar issues;
- Other GNWT departments with an interest in programs and services that the public may perceive as related to health, social and human services (e.g. Education Culture and Employment, Justice, MACA);
- Representative members of Aboriginal and immigrant language and cultural groups; and
- Members of the general public that represent a variety of demographic interests (e.g. seniors, youth, young mothers).

It is recommended that a visioning conference (possibly a two-day event) be held in a smaller NWT community. The selection of a smaller community could be used to emphasize the commitment to make the service relevant to people living in smaller communities. Participants would be engaged in visioning, scope of service definition, governance and services delivery recommendations.

Representatives of other Canadian jurisdictions that are planning for or operating 211 or 811 systems should be invited to present information to participants on the first day of the conference. The second day could then be devoted to roughing out a vision and scope of service to be refined by the Department of Health and circulated to participants for comment before being finalized by a working group charged with developing a full scale Business Plan for NWT 811 (see Recommendation # 10).

Recommendation # 9 Initiate Bi-lateral Discussions

Initiate bi-lateral discussions with Canadian provincial governments or NGOs that have developed or are developing similar 811 (or 211) initiatives.

Examine options to deliver NWT 811 services as a regional add-on to larger full scale provincial 811 or 211 programs. Informal offers have been made by both the United Ways of British Columbia and the BC211 project lead for the Government of British Columbia to explore the possibility of providing the NWT with either an 811 or 211 service. Other jurisdictions, including Alberta, are studying the possibility of a provincial or regional 811 system.

The assessment of being an “add-on” to a system in another jurisdiction should include consideration not only for the system database, technical requirements and scope of service, but also for the degree to which call centres in other jurisdictions will have the capacity to address the issues of remote and Aboriginal communities in the NWT.

Recommendation # 10 Develop a NWT 811 Business Plan

Develop a full scale NWT 811 Business Plan to meet the requirements of Northwestel for information to allow it to propose telephony options and estimate their costs for a NWT 811 service.

The BC211 Business Plan developed by IBM Consulting provides an excellent template for the development of a NWT 811 Business Plan. A key part of this will be the development of telephony costs. This will require extended discussions with Northwestel who has made it clear that their company will not be able to provide information on 811 telephony options until the proponents of an 811 (or 211) system can describe exactly what kinds of services would be delivered across the NWT. Northwestel has also indicated that it will need to know the full extent of the services that are expected to be available to residents in all 32 NWT communities, who will pay for them, whether the services will require a digital as opposed to analog systems and a list of other estimating requirements.

As part of planning, there will likely be a need to explore the option of simply replacing the toll-free Tele-Care NWT number with 811. We would not recommend making such a decision until the NWT 811 option has been fully examined through the development of a full scale Business Plan. If at that time 811 has been demonstrated to be feasible for the NWT, the use of 811 should be delayed until the first tier of a NWT 811 service can be introduced. If a full scale NWT 811 service proves to be impractical or unsustainable, then consideration may be given to the number change option.

Appendix A: Evaluation Methodology and Methods

Howard Research and Outcrop will be deploying both qualitative and quantitative methodologies in conducting the evaluation and feasibility study. In addition, specific study methods (data gathering approaches and data analysis) will overlap between the two studies.

Document Review

Several documents have been procured for review. They will serve as context for the evaluation and assist in the development of an N11 *Background Document* that will outline the concept of N11, current practices in applying N11, and issues associated with actual deployment. We anticipate a good deal of the 811 feasibility study will be based on the current state of the science surrounding N11.

Primary Tele-Care NWT Data Documents:

- Low/Non User Study (Dale Howard)
- Clinidata Statistical Monthly Reports (Clinidata Corporation)
- Raw Data (Clinidata Corporation)
- Nurse Recruitment and Retention Survey – NWT Survey Results Report 2005 (Registered Nurses Association of the Northwest Territories and Nunavut)
- Nurse Recruitment and Retention Survey – NWT Survey Results Report 2005 (Registered Nurses Association of the Northwest Territories and Nunavut) – Raw Data
- Development of a Model For a Health and Social Services Call Centre for the North (Susan Ashton)
- RFP For the Provision of a Telephone Advice Service (2003) (GNWT Department of Health and Social Services)
- Select Contract Information from Contract between the GNWT and Clinidata Corporation (GNWT Department of Health and Social Services)
- Tele-Care NWT Statistical Monthly Summaries (04/05 – 05/06 Comparison, April & May)
- Appendix A – Tele-Care NWT Results-based Management and Accountability Framework
- Appendix B - STATISTICAL SUMMARY FOR TELE-CARE NWT FISCAL YEAR 04/05 TO 05/06
- NWT Help Directory
- NWT Primary Community Care Framework – 2002
- The NWT Health and Social Services System Action Plan 2002-2005
- 211: Advancing the Provincial Consolidated System: Final Report – 211 Ontario Phase 2 Tools and Resources
- http://en.wikipedia.org/wiki/8-1-1 (N11 information)
- IP Telephony Interview
- A Framework for the Implementation of 811 Service (Simon Lucas)
- BC211: Final Report and Business Plan Providing 211 to all British Columbia (IBM)
- Appendix: Continuous Quality Improvement Plan Elements

- (Adapted from the Crowfoot Village Family Practice Nurse Telecare Project)
- Appendix: Evaluation Framework Work Plan (from Development of a Model for a Health and Social Services Call Centre for the North: Evaluation Framework Workplan)
- Integrated Service Delivery Model for the NWT Health and Social Services System: A Detailed Description (2004)
- Integrated Service Delivery Model for the NWT Health and Social Services System: A Plain Language Summary (2004)
- Shaping Our Future – A Strategic Plan for Health and Wellness (1998)
- Shaping Our Future – A Strategic Plan for Health and Wellness (Summary)
- 211: Towards a Pan Canadian, Bilingual Taxonomy for 211
- Tele-Care NWT: A Year in Review (May 2005)
- Tele-Care NWT April/May 2005 (Source: Tele-Care NWT Administrative Statistics and NWT Bureau of Statistics)
- Tele-Care NWT June/July 2005 (Source: Tele-Care NWT Administrative Statistics and NWT Bureau of Statistics)
- Tele-Care Statistical Summary Fiscal Year 04/05 – Fiscal Year 05/06
- Tele-Care NWT Statistical Summary April 2006
- Tele-Care NWT Statistical Summary May 2006
- Tele-Care NWT Statistical Summary June 2006
- Tele-Care NWT Statistical Summary July 2006

Clinidata:

- Clinidata: Tele-Care NWT Export Map
- Clinidata: Telephone Advice Service Report for the Northwest Territories Department of Health and Social Services (Monthly reports from June 2005 to July 2006)
- NWT Table Code Description
- NWT Tele-Care How Heard Setup List – By How Heard Id

Primary 811 Data Documents:

- Telecom Decision CRTC 2005-39, Ottawa July 6, 2005, Canadian Radio-television and Telecommunications Commission
- A Framework for the Implementation of 811 Service, Simon Lucas for the Multi-Jurisdictional Steering Committee, Final Report, February 27, 2006
- Alberta Health and Wellness' request for code 8-1-1 for non-urgent health triage services, Telecom Decision, CRTC 2005-39, 6 July 2005
- 811 Disconnected as Northwestel Contact Number, Northwestel News Release, June 16, 2006
- Standards for Professional Information and Referral Systems, 4th Edition, AIRS, October 2002

- 211 Plan Underway With Province and United Way Funding, BC Ministry of Labour and Citizen's Services News Release, April 8, 2006
- 211 Canada, Newsletter, July 21, 2006
- Making Connections: 2005 Canadian Community Information and Referral Conference, Vancouver – October 24 and 25, 2005
- Toward a pan Canadian, bilingual Taxonomy for 211, Ontario 211, Deborah Woods, 2/5/2006
- New 3-digit information numbers, San Francisco Chronicle, November 6, 2002
- N11 Codes, Canadian Numbering Administrator, undated
- The Future of N11 Service Codes, telecom jungle musings, March 19, 2005
- FCC Designates 811 as Nationwide Number to Protect Pipelines, Utilities from Excavation Damage, Federal Communications Commission, Washington, D.C., March 10, 2005
- The Support Network, Edmonton's Distress and Information Centre, Annual Reports 2000, 2001, 2002, 2003, 2004
- Inform Canada, Canadian Alliance of Information and Referral Systems (AIRS) Canadian Affiliate, Project and Contact Information, March 17, 2006
- BC211 Initiative, Information Brochure, July 26, 2006
- Welcome to BC211, 2006
- BC211 Final Report and Business Plan: Providing 211 to all British Columbia, December 2005
- Deloitte Cost-Benefit Study, United Way of Canada – Centraide Canada 211 Business Case, July 2005
- Reference Architecture and 211 Operating Model, Deloitte & Touche LLP, 2005
- Know the Facts, 211 Manitoba
- 211 Edmonton, The Support Network, 2002
- Help Is Just Three Digits Away, United Way of New York City, 2001
- County of Los Angeles – 211 System, July 2005
- 211, Get Connected, Get Answers, 211 of South Central Georgia

Contact Information:

- Important Numbers Contact List (August 2006)
- Master Social Work List – Revised July 2006
- Northwest Territory Chief Executive Officers Contact List (August 2006)
- NWT Nursing Leadership Network List
- Physician List
- Organization Chart for the Department of Health and Social Services
- Organization Chart for the HSS System
- Help Lines in the Northwest Territories (2 lists)
- Tele-Care NWT Advisory Committee Contact List 2006/2007

Key Informant Interview

Key informants are people who have had a major role in the design, development, and implementation of the Tele-Care NWT program, as well as senior administration responsible for program delivery. In addition, they will include interviews with telephone company representatives and administration/management personnel of services already in operation.

While the initial number of contacts slated for this activity was small (4-6), it became apparent that an expanded scope of contacts is required. We project 12 – 15 interviews will be administered (either in person or via teleconference) over the course of the study. In the case of 811, some site visits are required. Currently 8 interviews have been conducted with Tele-Care NWT informants and 3 interviewing sessions with key 811 and 211 personnel located in Vancouver and Victoria were visited.

See Appendix F for Data Collection Instruments for interview protocols.

Key Informants were selected in consultation with the Project Manager and representatives of the Advisory Committee. Contact lists were provided by the Project Manager:

- Tele-Care NWT Advisory Committee Contact List
- NWT Authority Chief Executive Officers
- Important Numbers Contact List

Contacts for N11 informants were researched by the consultants.

Community/Regional Discussion (focus group)

Community consultation is important to this evaluation. Focus groups, interviews with regional Health and Social Services Authority staff, primary health care providers, community leaders and NGOs (if present), have been scheduled for:

- Beaufort-Delta Health and Social Services Authority
- Fort Smith Health and Social Services Authority
- Hay River Health and Social Services Authority
- Sahtu Health and Social Services Authority
- Stanton Territorial Health and Social Services Authority
- Tlicho Community Services Agency
- Yellowknife Health and Social Services Authority

Data collected by Howard Research (late 2005) in the community of Fort Simpson is considered still valid as input from residents and providers in the Deh Cho Health and Social Services Authority.

See Appendix G for initial schedule of travel to communities.

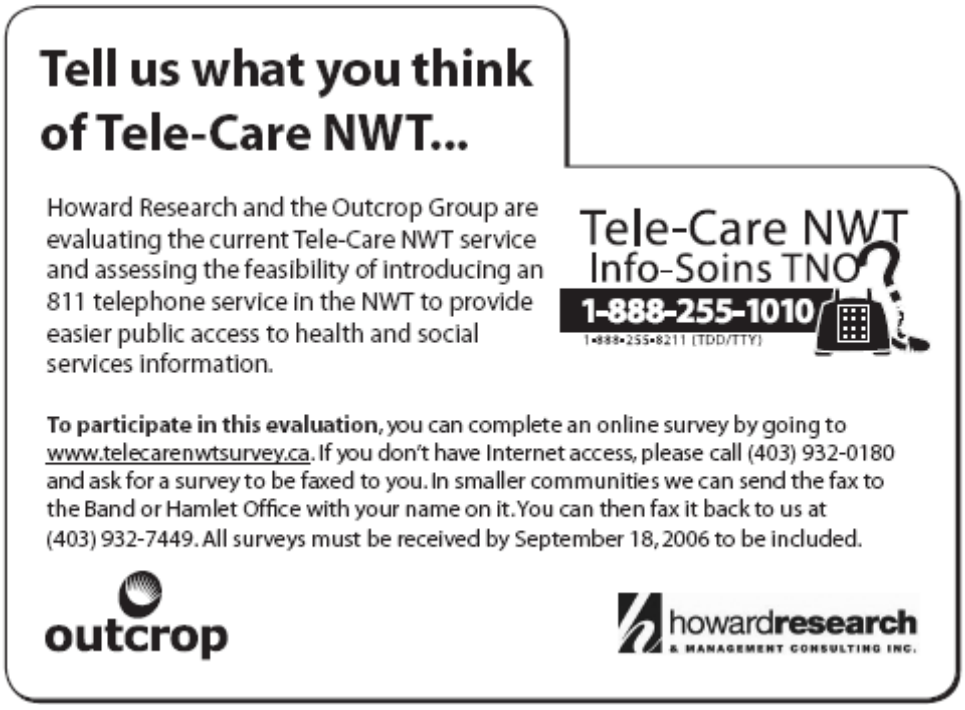
Two research teams are being deployed for this exercise. Howard Research provides one team and Outcrop Communications Group provides the other. Each team includes a facilitator/interviewer and recorder/note taker. Each data gathering opportunity will be used to discuss Tele-Care NWT and the concept of 811—its implications for stakeholder engagement, scope of service, integration of health and social services, delivery channels, and target audiences.

Primarily due to vacation times and seasonal absences of residents from the communities, visits to regional centres are scheduled for the first two weeks of September. This research and data gathering phase will be completed by September 15, 2006 to enable the consultants to use the data in completing the evaluation and the feasibility report by September 29, 2006.

See Appendix F for Data Collection Instruments for discussion protocols.

Community Survey

A web-based/fax community survey was developed for collecting general feedback from residents of NWT communities. The access coordinates were provided by newspaper advertisements. Surveys were made available to the public on August 30/06 with an access window of approximately two weeks.



A web-link (www.telecaresurvey.ca) was created by Outcrop to access the following surveys (English and French options) hosted by Howard Research:

http://www.snap-surveys.com/howard_research/TeleCareNWT/

http://www.snap-surveys.com/howard_research/TeleCareNWT_FR/

See Appendix F for Data Collection Instruments for survey forms.

Population Survey

During the months of October 2005 thru to December 2005, Howard Research conducted a variety of data collection activities in the Northwest Territories. These activities included:

- Population-based telephone survey
- Remote Primary Health Care Professionals focus groups
- Remote Youth focus groups
- Remote Community focus groups
- Youth in-person surveys
- Community in-person surveys

Jurisdictional approval was granted for all survey questions before survey administration commenced.

Data from these reports will be reviewed to augment the evaluation.

The following were the population survey parameters:

- telephone survey administered to a random sample of the territorial population
- sample drawn from a publicly available electronic listing of residential telephone numbers
- random digit dialing approach used
- Interviewers completed surveys with 414 Northwest Territories residents; 167 males (40.3%) and 247 females (59.7%)
- overall response rate was 61.6%
- survey results tabulated, cleaned, and analyzed using SPSS[30]
- frequencies and cross-tabulations were carried out in order to assess differences between various segments of the population. These included age, marital status, children, and gender. Coding frames were prepared for open-ended questions.
- results reported by group and thematized into the following four categories:

    1. Awareness/Use
    2. Satisfaction
    3. Access to Health Information
    4. Future Directions

Regional location was also retrieved for the majority of respondents allowing for a re-analysis of themes relative to large, medium, and small communities.

[30] SPSS 11.5 for Windows was used.

Health and Social Services Survey

A web-based/fax survey has been designed for health and social services providers. Both evaluation and 811 feasibility questions are incorporated. Due to extremely tight timelines the survey will be distributed to a convenience sample of providers.

See Appendix F for Data Collection Instruments for survey forms.

In addition, through cooperation of the Department further data is available on nurses' perspective of Tele-Care NWT. These perspectives are reported in a study *Nurse Recruitment and Retention Survey – NWT Survey Results Report 2005*, courtesy of Bernard Hogan, PhD., Principal Consultant, Northern Research + Evaluation.

> *Paper copies of the survey were sent out to all current NWT members of the RNANT/NU in mid December, 2005. Nurses had approximately 1 month to complete the survey in one of three ways: they could fill out the paper copy and return it by regular mail; they could fax it back to the RNANT/NU; or they could fill out the survey online. Reminder notices were also sent out to the entire membership in late December 2005, which helped to improve the response rate. Overall, 594 surveys were sent out, and 259 were returned complete – for an overall response rate of 44% (and a confidence level of +/- 5%, 19 times out of 20).*

Results and the SPSS file are available to the consultants and will be used to augment provider data collected through the provider survey and focus group.

System Statistics

With cooperation from the Department, all system data (Clinidata Corporation) have been made available to the consulting statistician. These data will be examined to assess performance contract obligations of the vendor to the Department.

Cost Modeling

Outcrop Communications, with assistance from Howard Research, will conduct a financial analysis on available data gathered through the data collection strategies outlined above. For the most part these analyses will consider financial implications of instituting N11 options and outline a costing model specific to the Northwest Territories.

Reporting

There are three reporting requirements for this project outlines in the RFP (pp 13-14)—Interim Report, Final Report, and on-going (weekly) Status Reports.

This interim report includes:

- A detailed description of the evaluation approach and methods
- A feasibility study framework for the proposed 811 Health and Social Services Line, which includes a comprehensive and detailed description of the intended results, processes and structures

Final Report

A comprehensive Final Report will include the Interim Report (as an appendix) plus:

- An executive summary
- Results of the evaluation
- Results of the feasibility study
- Conclusions (i.e. to the evaluation questions and to the feasibility questions)
- Recommendations, including specific structures and processes (as data available indicate)

Status Reports

Weekly project status reports are being submitted/conducted by telephone or e-mail. Meeting notes for each teleconference are recorded.

Appendix B: Evaluation Framework

1.0 DIMENSION OF INQUIRY: Access Evaluating Access The degree to which a health line has increased and/or improved access to health services can be assessed on several dimensions. Generally, access to health lines is about how often the service is utilized, when the service is accessed, who is making the calls, why they are calling, caller satisfaction with services received, wait time to receive services, and awareness of services.
Evaluation Questions
1.1 Is Tele-Care NWT accessible to all residents of the Northwest Territories? 1.2 Are promotional methods being used at present successful? 1.3 Are the quality assurance standards provided by Clinidata Corporation effective in improving service based on the needs of the individuals of the NWT?
1.4 What is the demand for Tele-Care NWT services? *1.5 Who (residents) aware of Tele-Care NWT?* *1.6 Who (residents) calls Tele-Care NWT?* *1.7 Why do residents call Tele-Care NWT?* *1.8 Why do residents not call Tele-Care NWT?*

2.0 DIMENSION OF INQUIRY: Sustainability

Evaluating Sustainability
The extent to which health lines demonstrate their "value" seems to rest in the question: to whom?

Value to the User
Caller value is generally measured as satisfaction with the information and advice provided by triage nurses. In addition, the caller's intent to follow the disposition received indicates the usefulness of the line.

Value to Service Providers
Service providers may find value in health lines. Service providers value health lines if the provider perceives that health lines lessen after hours work loads for service, facilitate timely exchange between providers and specialist consults, or have economic value to a practice.

Delivery System – Call Centre Efficiency
Management, implementation, and related variables are described in the literature much more frequently than they are measured. Measurement tends to focus on areas such as the impact of software and protocols/guidelines, call monitoring, call routing, training, education, and experience of nurses, job satisfaction, and communication.

Delivery System – Program Development and Delivery
Program design, development, and delivery is evaluated according to program goals, program objectives, and the strategies designed and implemented to achieve expected outcomes. For Tele-Care NWT the key objectives are to:

Increase the ability for self care;
Provide support for workers;
Decrease non-urgent after hour call outs;
Facilitate the use of appropriate health and social services by consumers
Improve public access; and
Increase consumer health education and improve decision making by consumers

Evaluation Questions

Value to Users

2.1 Are the residents of the Northwest Territories satisfied with service that they are receiving and how do we know that?

Value to Service Providers

2.2 Do the health and social service providers of the NWT understand and support the Tele-Care NWT Line?

2.3 Are health and social service providers in the NWT referring their patients to Tele-Care NWT in between visits?

2.4 Do the health and social service professionals feel any sense of relief with having the Tele-Care NWT Line in place as a means to direct individuals with health and social issues after clinic hours?

2.5 Do the nurses, doctors or other health professionals currently or would they

consider calling Tele-Care NWT themselves in order to receive information regarding best practice standards?

Delivery System – Call Centre Efficiency

2.6 Are the calls being answered within the time frame specified in the original contract?

2.7 Are the nurses who provide the Tele-Care NWT service given an orientation to the standards, specifications, and cultural diversity in the North?

Delivery System - Program Development and Delivery

2.8 What processes and structures were implemented?

2.9 Was the initiative implemented as planned?

2.10 What factors are facilitating the program progressing towards achieving its goals?

2.11 Are there enough services being provided?

2.12 Are there problems in the way service is being delivered?

2.13 What challenges and barriers were identified and how can they be addressed?

2.14 What recommendations are offered regarding the future of the Tele-Care NWT service?

3.0 DIMENSION OF INQUIRY: Health Impacts

Evaluating Health Impacts
Evidence that health lines have positive health impacts is largely associated with indicators that the right people are receiving the right service at the right time, and that the caller follows the advice received.

Evaluation Questions

1.1 Do callers comply with advice received from Tele-Care NWT nurses?

Appendix C: Evaluation Framework (Revised)

1.0 DIMENSION OF INQUIRY: Need

Evaluating Need

The rationale for the development and implementation of a health line is an indicator of prudent investment. Rationale is based on the experiences of others (success of other health line initiatives or primary needs assessment).

Evaluation Questions

1.1 Is a rationale for Tele-Care NWT based on credible evidence?

1.2 Is the program meeting the need outlined in the rationale?

2.0 DIMENSION OF INQUIRY: Program Development and Implementation

Evaluating Program Development and Implementation
The?

Delivery System – Program Development and Delivery
Program design, development, and delivery is evaluated according to program goals, program objectives, and the strategies designed and implemented to achieve expected outcomes. For Tele-Care NWT the key objectives are to:

Increase the ability for self care;
Provide support for workers;
Decrease non-urgent after hour call outs;
Facilitate the use of appropriate health and social services by consumers
Improve public access; and
Increase consumer health education and improve decision making by consumers

Delivery System – Call Centre Efficiency
Management, implementation, and related variables are described in the literature much more frequently than they are measured. Measurement tends to focus on areas such as the impact of software and protocols/guidelines, call monitoring, call routing, training, education, and experience of nurses, job satisfaction, and communication.

Evaluation Questions

Delivery System - Program Development and Delivery

2.1 What processes and structures were implemented?

2.2 Was the initiative implemented as planned?

2.3 What factors are facilitating the program progressing towards achieving its goals?

2.4 Are there enough services being provided?

2.5 Are there problems in the way service is being delivered?

2.6 What challenges and barriers were identified and how can they be addressed?

2.7 What recommendations are offered regarding the future of the Tele-Care NWT service?

Delivery System – Call Centre Efficiency

2.8 Are the calls being answered within the time frame specified in the original contract?

2.9 Are the nurses who provide the Tele-Care NWT service given an orientation to the standards, specifications, and cultural diversity in the North?

3.0 DIMENSION OF INQUIRY: Access

Evaluating Access

The degree to which a health line has increased and/or improved access to health services can be assessed on several dimensions. Generally, access to health lines is about how often the service is utilized, when the service is accessed, who is making the calls, why they are calling, caller satisfaction with services received, wait time to receive services, and awareness of services.

Evaluation Questions

3.1 Is Tele-Care NWT accessible to all residents of the Northwest Territories?

3.2 Are promotional methods being used at present successful?

3.3 Are the quality assurance standards provided by Clinidata Corporation effective in improving service based on the needs of the individuals of the NWT?

3.4 Who (residents) is aware of Tele-Care NWT?

3.5 Who (residents) calls Tele-Care NWT?

3.6 Why do residents call Tele-Care NWT?

3.7 Why do residents not call Tele-Care NWT?

4.0 DIMENSION OF INQUIRY: Sustainability

Evaluating Sustainability
The extent to which health lines demonstrate their "value" seems to rest in the question: to whom?

Value to the User
Caller value is generally measured as satisfaction with the information and advice provided by triage nurses. In addition, callers intent to follow the disposition received indicates the usefulness of the line.

Value to Service Providers
Service providers may find value in health lines. Service providers value health lines if the provider perceives that health lines lessen after hours work loads for service, facilitate timely exchange between providers and specialist consults, or have economic value to a practice.

Value to the System
Those who pay for the health line will require some evidence that the investment is providing sufficient benefit for the cost of the service. Value may be measured in economic terms, however the value of human service programs can also be considered in terms of non-economic benefits.

Evaluation Questions

Value to Residents of the NWT

4.1 Are the residents of the Northwest Territories satisfied with service that they are receiving and how do we know that?

Value to Providers of Health and Social Services

4.2 Do the health and social service providers of the NWT understand and support the Tele-Care NWT Line?

4.3 Are health and social service providers in the NWT referring their patients to Tele-Care NWT in between visits?

4.4 Do the health and social service professionals feel any sense of relief with having the Tele-Care NWT Line in place as a means to direct individuals with health and social issues after clinic hours?

4.5 Do the nurses, doctors or other health professionals currently or would they consider calling Tele-Care NWT themselves in order to receive information regarding best practice standards?

Value to NWT Health and Social Services

4.6 Is Tele-Care NWT supporting the broader program of primary health care in NWT?

4.7 Is Tele-Care NWT cost beneficial?

5.0 DIMENSION OF INQUIRY: Health Impacts Evaluating Health Impacts Evidence that health lines have positive health impacts is largely associated with indicators that the right people are receiving the right service at the right time, and that the caller follows the advice received.
Evaluation Questions
5.1 Do callers comply with advice received from Tele-Care NWT nurses?

Appendix D: 811 Feasibility Framework

1.0 DIMENSION OF INQUIRY: Stakeholder Engagement
Evaluation Questions
1.1 Who needs to be engaged in the development of 811?

2.0 DIMENSION OF INQUIRY: Scope of 811 Service
Evaluation Questions
2.1 What is the vision for 811 service?

3.0 DIMENSION OF INQUIRY: Overlap with other N11 Services
Evaluation Questions
3.1 How will 811 be differentiated from 911?
3.2 What are the problems that will arise due to overlap?
3.3 Are there opportunities to synergize?

4.0 DIMENSION OF INQUIRY: Integration with other Health and Social Services Within the Northwest Territories
Evaluation Questions
4.1 What health services will 811 access?
4.2 How will Health Line Services be integrated under 811?

5.0 DIMENSION OF INQUIRY: Delivery Channels
Evaluation Questions
5.1 811 at present is being thought of as a telephone service, however, is it possible for other channels to be used, i.e. the internet?

6.0 DIMENSION OF INQUIRY: Target Cultures / Languages
Evaluation Questions
6.1 What segments of the public should 811 target?
6.2 How will all of the diversities of the Northwest Territories be served by this line?

7.0 DIMENSION OF INQUIRY: Delivery Approach
Evaluation Questions
7.1 Is Clinidata capable of further accommodating the needs identified for the NWT?
7.2 How centralized will the operations and infrastructure be?
7.3 What are the options for different services?

8.0 DIMENSION OF INQUIRY: Staged Deployment
Evaluation Questions
8.1 What is the timeline for launching 811?
8.2 What services and functions are provided when?

9.0 DIMENSION OF INQUIRY: Governance
Evaluation Questions
9.1 What is the formal governance structure for 811 Service?

10.0 DIMENSION OF INQUIRY: Technical Implications

Evaluation Questions

10.1 Is the implementation of 811 technically possible for all residents in all regions, in all communities of the Northwest Territories?

10.2 Would Clinidata Corporation technically be able to contract out the work for the services that are required and be able to handle the call volume for the Northwest Territories?

Appendix E: Comparisons of N11 Models and N11 Technology Costs

Virtually all N11 services that provide a wide variety of services use a call centre (first tier/level) to help people to find their way to the service that best meets their needs. The service itself (provided at a second tier/level) is then delivered by professionals or specially trained volunteers.

In a few instances, where most of the services can be delivered by a single centralized delivery service, the need for a first tier/level call centre is eliminated allowing the service to operate with service providers also providing wayfinding to a limited number of services that are not offered directly by the professionals who are answering the telephone line.

In 2005, BC211 contracted IBM Business Consulting Services to develop a BC211 Business Plan that explored technology and operating costs for a province-wide system. While IBM developed four options, only two of them have any relevance to the NWT.

The BC211 Option #1 was costed to provide for one centralized 211 service for BC. The estimated technology costs to set up the call centre would be approximately $450,000. Annual operating costs in BC would be approximately $3 million.

The BC211 Option #2 would provide for a central call centre and one regional call centre. Estimates of technology costs for this service with two centres would be about $575,000. Annual operating costs would be approximately $4 million to cover all British Columbia. Additional costs of adding a remote call centre, connected to the central call centre, would be about $275,000. This assumes that no remotely developed and maintained database would be needed.

These projected numbers assume annual call volumes to the BC211 call centres of approximately 450,000. With these volumes, IBM projected that cost per call in BC would be $15.68 in year 1, dropping to $8.35 in year 5.

It is very important to note that none of the costs outlined above include costs for triage, advice or specific information services. The options in this Appendix are for call centre set-up, operations and referral costs only.

This information would suggest that for the NWT an independent call centre would very expensive on a per capita basis. If we assumed that the NWT operated the call centre 24/7 there would be, compared to BC, significant reductions in staff required, facilities rental and database maintenance.

Without a full study, there is no way to accurately project how much that would reduce the NWT's costs. However, based on our reading of the IBM study, it is possible that the annual operating cost of a separate NWT call centre could be between $400,000 and $800,000. That cost would be $9.52 per resident and depending on call volumes would be about $60 to $70 per call to simply provide wayfinding to connect the caller to the service that would best meet their need. The cost of the advice and information services

to the caller, whether delivered through the current vendor, additional new services or a combination of vendors, would be additional.

These figures would suggest that before the NWT invest in an 811 call centre of its own, that it fully explore all available options in two areas: 1) establishing 811 services through collaboration with neighbouring jurisdictions (cost sharing); 2) purchasing 811 services from an existing 811 service (when an 811 becomes available in a Canadian jurisdiction).

Appendix F: Instruments and Protocols

Evaluation of Tele-Care NWT & 811 Feasibility Options

Information for Interviewees & Group Discussion Participants

Howard Research and the Outcrop Group have been contracted by the GNWT's Department of Health and Social Services to evaluate the Tele-Care NWT program and to assess the feasibility of introducing an 811 system in the NWT.

Currently, NWT residents can access Tele-Care NWT's non-emergency health services by dialing 1-888-255-1010. The service is free, available 24/7 and provides callers with an opportunity to talk directly to a registered nurse about health issues or to access a wide range of information on health subjects. The service is promoted across the NWT by the Department of Health and Social Services as "Your family health and support line."

An 811 system, if installed in the NWT, could allow callers to access non-emergency health and social services information and advice by calling an easy-to-remember three digit number. 811 is part of a group of N11 numbers designated for special purposes across Canada. Perhaps the two best know N11 numbers are 911 for emergencies and 411 for telephone information. The 811 number is being considered because the Canadian government (through the CRTC) has designated 811 for non-emergency health services information. Other designated numbers in Canada are 211 for community, health and social services information, 311 for municipal government services information and 511 for transportation and weather information services. Currently only 911 and 411 are in widespread use in Canada.

To gather input from key informants, community residents and professional health and social services staff our research teams will be conducting interviews and holding group discussions in seven NWT communities. We will also be including input from many other communities using teleconferences organized through the NWT's eight Regional Heath and Social Services Authorities.

Yellowknife, NT
August 25, 2006

Howard Research (403) 932-0180
The Outcrop Group (867) 766-6705

Key Informant Interview Protocol

The Department of Health and Social Services, Government of the Northwest Territories has contracted Howard Research & Management Consulting Inc. and the Outcrop Group to evaluate Tele-Care NWT and to conduct a feasibility study for the adoption of a three digit number (e.g. 811) for community access to non-urgent tele-health information and for community and social service information.

PART 1: Tele-Care NWT (1-888-255-1010)
Tele-Care NWT is a family health and support line funded by the GNWT for territory-wide use by NWT residents. It is a free, confidential telephone service that can be used to get information or non-emergency health advice from a nurse. It offers round-the-clock access to:

- Help people to take care of themselves;
- Make use of the "Do I Need to See the Nurse/Doctor?" book;
- Identify situations where emergency care is needed;
- Recommend when a caller should contact their nurse, social worker or doctor; or
- Suggest when talking to someone else in their community may help

1. Were you involved in implementing Tele-Care NWT (e.g. needs analysis, planning, delivery, monitoring, etc.)? If so, was the initiative implemented as planned?

2. Overall, has Tele-Care NWT met your expectations for service to individuals residing in NWT?

   How has Tele-Care NWT met your expectations?
   In what ways has Tele-Care NWT not met your expectations?

3. What aspects of Tele-Care NWT are working well?

4. What factors would you consider key (most important) in assisting Tele-Care NWT in achieving its goals?

5. To your knowledge were there/are there any challenges/barriers in launching Tele-Care NWT? If yes, please elaborate.

6. Have these challenges/barriers been resolved?

7. Do you see further challenges/barriers to sustaining Tele-Care NWT? If yes, please elaborate.

8. What value do you feel Tele-Care NWT is to residents of NWT?

9. What value do you feel Tele-Care NWT is to health providers in NWT?

10. What value do you feel Tele-Care NWT is to social service providers in NWT?

11. What expectations do you have for Tele-Care moving forward?

PART 2: 811 Feasibility

Three digit numbers (or N11 numbers) have been available for 5 years or so. The most common are 911 for fire, police and ambulance service and 411 for directory assistance. The CRTC has also approved 211 for community and social services information, 311 for municipal enquiries, and 811 for non-urgent tele-health information.

1. What advantages do you see for the NWT adopting one or more of these N11 numbers beyond 911 and 411? We are aware that the NWT does not yet have 911 (emergency service).

2. What disadvantages do you see for the NWT adopting one or more of these N11 numbers beyond 911 and 411?

3. Do you foresee any issues with developing N11 (i.e. 811 or 211) in the NWT before adopting 911?

4. If N11 (i.e. 811) were to be adopted by the NWT, who needs to be engaged in that development?

5. What segments of the NWT population should be targeted for use of N11 (i.e. 811)?

6. If both health information and social service information cannot be integrated under ONE number (i.e. 811), what issues do you foresee in requiring a 211 number (social services information) in addition to an 811 (non-urgent health information)?

7. How critical is it for the NWT to have N11 service beyond 911 and 411?

8. When would you foresee the NWT instituting an N11 service beyond 911 and 411?

Focus Group/Interview Questions (Professional Provider)

The Department of Health and Social Services, Government of the Northwest Territories has contracted Howard Research & Management Consulting Inc. and the Outcrop Group to evaluate Tele-Care NWT and to conduct a feasibility study for the adoption of a three digit number (e.g. 811) for community access to non-urgent tele-health information and for community and social service information.

Tele-Care NWT (1-888-255-1010)

Tele-Care NWT is a family health and support line funded by the GNWT for territory-wide use by NWT residents. It is a free, confidential telephone service that can be used to get information or non-emergency health advice from a nurse. It offers round-the-clock access to:

- Help people to take care of themselves;
- Make use of the "Do I Need to See the Nurse/Doctor?" book;
- Identify situations where emergency care is needed;
- Recommend when a caller should contact their nurse, social worker or doctor; or
- Suggest when talking to someone else in their community may help

1. How familiar are you with Tele-Care NWT?
2. When did you first become aware of Tele-Care NWT?
3. Are you aware of any of the people to whom you provide services having used Tele-Care NWT?
4. Do you refer the people to whom you provide services to use Tele-Care NWT? IF YES, who do you refer to use Tele-Care NWT?
5. Have you ever called Tele-Care NWT for personal reasons (you or your family needed information or care)? (yes) (no) – IF YES, what did you think of the service?
6. Have you ever called Tele-Care NWT for professional reasons (for example: looking for health and/or social services resources or information, just curious about the service)? (yes) (no) – IF YES, what did you think of the service?
7. Is Tele-Care NWT needed in the North? WHY? WHY NOT?
8. What value do you think Tele-Care NWT provides to people of the North.
9. What barriers do people have in using Tele-Care NWT?

811 Feasibility

Three digit numbers (or N11 numbers) have been available for 5 years or so. The most common are 911 for fire, police and ambulance service and 411 for directory assistance. The CRTC has also approved 211 for community and social services information, 311 for municipal enquiries, and 811 for non-urgent tele-health information.

1. What advantages do you see for the NWT adopting one or more of these N11 numbers beyond 911 and 411 (we are aware that the NWT does not yet have 911 (emergency service)?

2. What disadvantages do you see for the NWT adopting one or more of these N11 numbers beyond 911 and 411?

3. Do you foresee any issues with developing N11 (i.e. 811 or 211) in the NWT before adopting 911?

4. If N11 (i.e. 811) were to be adopted by the NWT, who needs to be engaged in that development?

5. What segments of the NWT population should be targeted for use of N11 (i.e. 811)?

6. If both health information and social service information cannot be integrated under ONE number (i.e. 811), what issues do you foresee in requiring a 211 number (social services information) in addition to an 811 (non-urgent health information)?

7. How critical is it for the NWT to have N11 service beyond 911 and 411?

8. When would you foresee the NWT instituting an N11 service beyond 911 and 411?

Tele-Care NWT Vendor Interview Protocol

The Department of Health and Social Services, Government of the Northwest Territories has contracted Howard Research & Management Consulting Inc. and the Outcrop Group to evaluate Tele-Care NWT and to conduct a feasibility study for the adoption of a three digit number (e.g. 811) for community access to non-urgent tele-health information and for community and social service information.

Tele-Care NWT (1-888-255-1010)

Tele-Care NWT is a family health and support line funded by the GNWT for territory-wide use by NWT residents. It is a free, confidential telephone service that can be used to get information or non-emergency health advice from a nurse. It offers round-the-clock access to:

- Help people to take care of themselves;
- Make use of the "Do I Need to See the Nurse/Doctor?" book;
- Identify situations where emergency care is needed;
- Recommend when a caller should contact their nurse, social worker or doctor; or
- Suggest when talking to someone else in their community may help

1. Overall, do you believe Clinidata met the GNWT's expectations in delivering the Tele-Care NWT service? If so, how? If not, how?

2. What aspects of the Tele-Care NWT service are working best in helping the program progress towards achieving its primary health care goals?

3. Are you aware of any challenges/barriers in implementing the Tele-Care NWT? If yes, please elaborate.

4. To the best of your knowledge, have these challenges/barriers been successfully addressed?

5. Do you see any unresolved or new challenges/barriers to sustaining Tele-Care NWT? If yes, please elaborate.

6. How would you describe the working relationship between GNWT and Clinidata?

811 Feasibility

Three digit numbers (or N11 numbers) have been available for a number of years. The most common are 911 for fire, police and ambulance service and 411 for directory assistance. The federal CRTC has also approved 211 for community and social services information, 311 for municipal enquiries, 511 for transportation and weather and 811 for non-urgent tele-health information.

1. What impact do you think adopting an N11 number for the non-emergency health services in the NWT would have on the current services delivered by Clinidata?

2. If the 811 line handled calls about social services what impact do you think this would have on Clinidata? On callers?

3. Would a health and social services line better meet the needs of most NWT residents?

4. Are there other services that callers might expect Clinidata to be able to access?

5. Do you foresee issues developing around the use of an N11 (i.e. 811 or 211) in the NWT?

Tele-Care NWT Survey
(All Health & Social Service Providers)
Health & Social Service Providers Survey

On behalf of the Department of Health and Social Services, Government of the Northwest Territories, we are asking you to take a few moments and complete this survey as part of the Department's evaluation of Tele-Care NWT.

Following completion, please FAX the survey to Howard Research at 403-932-7499 OR complete an ON-LINE survey by connecting to:
http://www.snap-surveys.com/howard_research/TeleCareNWT-Provider
Surveys must be received by September 18, 2006 to be included in the summarized results in the Evaluation Report.

Your participation in this survey will assist the Department to enhance and improve Tele-Care NWT service. If you have any questions as to the validity of this survey please do not hesitate to call 867-873-7039

Survey Administration:

Howard Research and Management Consulting Inc.

Contact: Dale Howard, PhD.

403-932-0180

Participation is voluntary. All data will be aggregated with all personal identifiers removed.

SURVEY QUESTIONS – Please √ or X circle your responses

1. Prior to receiving this survey, had you ever heard of Tele-Care NWT?
   O Yes **O** No

IF NO-GO TO QUESTION 7

2. When did you first become aware of Tele-Care NWT?
   O Last 1 to 12 months
   O One to 2 years ago
   O Over 2 years ago
   O Cannot recall

3. Are you aware of any of the people to whom you provide services using Tele-Care NWT?
   O Yes **O** No

4. Do you advise the people to whom you provide services to use Tele-Care NWT?
   O Yes **O** No

IF NO – GO TO QUESTION 6

5. In what circumstances have you advised people to use Tele-Care NWT (e.g. type of patient/client, type of health or social concern)?
   _____
   _____
   _____

6. Have you ever called Tele-Care NWT, yourself?
   O Yes **O** No

IF YES for what reason (CHECK ALL THAT APPLY)
- **O** For personal advice
- **O** To see how it worked (professional curiosity)
- **O** To find an appropriate health or social services resource for which to refer a patient
- **O** To check for a public health advisory
- **O** Other _____

7. Tele-Care NWT is a family health and support line funded by the GNWT for territory-wide use by NWT residents. It is a free, confidential telephone service that can be used to get information or non-emergency health advice from a nurse. It offers round-the-clock access to:
   - Help people to take care of themselves;
   - Make use of the "Do I Need to See the Nurse/Doctor?" book;
   - Identify situations where emergency care is needed;
   - Recommend when a caller should contact their nurse, social worker or doctor; or
   - Suggest when talking to someone else in their community may help

   On a scale of 1 to 5, where **1 is strongly disagree**, and **5 is strongly agree**, please indicate your opinion with regard to each of the following statements:

   a) Tele-Care NWT is a supportive tool in meeting the work load demands of health services providers.
   (Strongly Disagree) **O** 1 **O** 2 **O** 3 **O** 4 **O** 5 (Strongly Agree)

   b) Tele-Care NWT is a supportive tool in meeting the work load demands of social services providers.
   (Strongly Disagree) **O** 1 **O** 2 **O** 3 **O** 4 **O** 5 (Strongly Agree)

   c) Tele-Care NWT is a supportive tool in meeting my work load demands.
   (Strongly Disagree) **O** 1 **O** 2 **O** 3 **O** 4 **O** 5 (Strongly Agree)

   d) Tele-Care NWT helps clients find appropriate health and social services resources.
   (Strongly Disagree) **O** 1 **O** 2 **O** 3 **O** 4 **O** 5 (Strongly Agree)

   e) Tele-Care NWT provides valuable assistance to people experiencing physical health problems.
   (Strongly Disagree) **O** 1 **O** 2 **O** 3 **O** 4 **O** 5 (Strongly Agree)

   f) Tele-Care NWT provides valuable assistance to people experiencing mental health and addiction problems.
   (Strongly Disagree) **O** 1 **O** 2 **O** 3 **O** 4 **O** 5 (Strongly Agree)

   g) Tele-Care NWT provides valuable assistance to people experiencing social problems.
   (Strongly Disagree) **O** 1 **O** 2 **O** 3 **O** 4 **O** 5 (Strongly Agree)

   h) Tele-Care NWT helps people to learn how to better manage their own physical health, social, and/or mental health-related problems.
   (Strongly Disagree) **O** 1 **O** 2 **O** 3 **O** 4 **O** 5 (Strongly Agree)

i) Users of Tele-Care NWT are likely to make changes to their physical health, social, and/or mental health behaviour after receiving advice from Tele-Care NWT service.
(Strongly Disagree) **O** 1 **O** 2 **O** 3 **O** 4 **O** 5 (Strongly Agree)

j) Tele-Care NWT can help prevent more serious physical health, social, and/or mental health and addiction problems with early intervention.
(Strongly Disagree) **O** 1 **O** 2 **O** 3 **O** 4 **O** 5 (Strongly Agree)

k) Tele-Care NWT can be used by health and social service providers to obtain professional information.
(Strongly Disagree) **O** 1 **O** 2 **O** 3 **O** 4 **O** 5 (Strongly Agree)

7. Please indicate below which items best describe you and your practice:

a. Practicing as a:
O registered nurse/nurse practitioner
O social worker
O mental health/addictions counsellor
O community wellness worker
O medical doctor
O Other (specify) _____

b. Practicing:
O Less than 2
O 2 to 5 years
O 5 to 10 years
O 11-15 years
O More than 15 years

c. Practicing in the North
O Less than two years
O 2 to 5 years
O 5-10 years
O11-15 years
O More than 15 years

d. Currently employed as a health or social services provider:
O Full-time **O** Part-time **O** Other _____

c. Location of Practice (community) _____

8. If you have further comments about Tele-Care NWT, we would be happy to hear them. Comments (use back of page if you require more room for comments):

Thank you for your participation!

Tele-Care NWT & 811 Feasibility
Public Survey

On behalf of the Department of Health and Social Services, Government of the Northwest Territories, we are asking you to take a few moments to complete this survey. Your information will help to improve access to health and social services information. If you have any questions about the validity of this survey, please call 867-873-7039.

The survey can be completed online or you can print out the survey and fax it back to us at 403-932-7499. Completed surveys must be received by September 18, 2006 to be included in this study. The survey is anonymous.

Please circle your answers, check the appropriate boxes and fill in blanks as necessary.

Tele-Care NWT Survey

1. Have you ever used Tele-Care NWT? YES NO

If YES GO TO 3

2. Why Not? Check ALL THAT APPLY
   - 2.a Did not know the service existed
   - 2.b Heard negative comments about the service
   - 2.c Don't like to talk about my health over the telephone
   - 2.d Get my health information and advice somewhere else
   - 2.d Other _____

GO TO 7

3. Did Tele-Care give you the health information and advice you needed? Yes No
4. Were you satisfied with the Tele-Care NWT service you got? Yes No
5. Did you follow the advice you were given? Yes No
6. Will you call Tele-Care NWT again? Yes No

811 Telephone Line Survey

(The 811number is not currently in service in the NWT. These questions are intended to see if people think an 811 health and social programs information line would be a good idea.)

7. What do you think of an 811 number to access both health information and social programs information line?

7.a Good idea, and I would like to see it happen

2.b Bad idea, and would not like to see it happen

2.c I'm not sure, I don't know enough about it

2.d Other reasons

_____

Please help us with some additional information:

I am Male _____ Female _____

I am 24 years old – or less _____
25 – 34 _____
35 – 45 _____
45 – 54 _____
55 + _____

I am Single _____ Married _____ Common Law _____

Divorced or Separated _____ Widow or Widower _____

I have (Check all that apply)

No children living at home

Newborn to age 2 at home

Children age 3 to 6 at home

Children age 7 to 12 at home

Children age 13 to 18 at home

Dependants older than 18 at home

Elderly dependants at home

My first language is English _____ French _____ Another language _____

Please tell us the name of the community where you live.

_____

Thanks very much. All replies to this survey are confidential.

Appendix G: Proposed Consultation Scheduling

Tele-Care NWT and 811 Project
Community Visits
Interview and Group Discussions Schedule

Fort Smith (September 5)
(Local coordinator Louise Scott 872-6257)

Fort Smith (pop. 2514 - 2004 est.) is the southernmost community in the NWT. The Fort Smith Health and Social Services Authority administers community health and social services.

The Authority is governed by six members plus a chairperson. The Town of Fort Smith, Salt River First Nations and Métis Nation Local 50 each have two representatives on the Board.

All meetings, except for Aurora College, will be at the hospital.

10:00 AM	Dana Rasiah, FSHSSA CEO
11:00 AM	Staff Discussion at the Fort Smith Hospital (7-8 persons)
Afternoon	Scott Shelton, Student Wellness Coordinator, Aurora College
7:00 PM	Community Discussion Group (8-10 participants) -- Participants to be paid $50 each

Norman Wells (September 6-7)
(Local coordinator Wanda Allen 587-3651)

The Sahtu Health and Social Services Authority encompasses the central Mackenzie Valley area (pop. 2591 – 2004 est.). The Authority came into existence April 1, 2005 and is headquartered in Norman Wells (pop. 848 – 2004 est.).

Sept 6 - Afternoon	Teleconference with staff from the various Sahtu Health Centres
Sept 6 - Afternoon	Meeting with Norman Wells-based SHSSA staff
Sept 6 - 7:00 PM	Community Discussion Group (8 participants) Participants will not be paid
Sept 7 – 10:00 AM	Chad Fehr, CEO or Colin Eddie, Director Health & Social Services

Hay River (September 6-8)
(Local coordinator Brenda Elderkin 874-7129)

Hay River (pop. 3,876 – 2004 est.) is the largest community south of Great Slave Lake. It administers a range of community health and social services for Hay River, K'atlodeeche, West Point and Enterprise.

Sept 6 - PM	Terry Villeneuve in Fort Resolution (she is a Board member of the Native Women's Association of the NWT). Get maps for all locations from Louise Scott at the hospital.
Sept 7 – 10:00 AM	West Point First Nation (meet with Wendy Cayen)
Sept 7 – 1:00 PM	Paul Viera, HRHSSA CEO (in his office at the hospital)
Sept 7 – 2:00 PM	Staff Discussion (in Hospital Executive Board Room – 5 persons – Clinic, Social Services, Home Care, Emergency, Patient Care)
Sept 7 – Afternoon	Still trying to arrange an NGO interview at Soaring Eagle Friendship Centre if possible.
Sept 8 – Evening	Unsuccessful in getting a discussion group together yet. Preparation for major trade fair (September 18-20) and other local community meetings are said to be competing. We will make one more effort to pull a group together for September 8. Alternatively our local coordinator of arrangements has said she would arrange to have the Public Survey at the trade show and they would try to get people to fill it out. Apparently the Authority has a booth there.
Sept 8 – 9:30 AM	K'atlodeeche First Nation (Jennifer LaFleur, Director of Health)

Inuvik (September 7-8)
(Local coordinator Stella Van Rensburg 777-8193)

The Beaufort-Delta Health and Social Services Authority is based in Inuvik (pop. 3,586 – 2004 est.) and includes the NWT's second largest hospital. It provides health and social services to eight communities with a total population of 7,088 (2004 est.).

Sept 7 – 2:30 PM	Staff teleconference with representation from Inuvik Hospital and all other Health Centres. Location: Inuvik Regional Hospital Small Boardroom.
Sept 7 – 7:00 PM	Community Discussion Group (approx. 12 persons) Location: Ingamo Hall Board Room. Participants will not be paid. Karen Mitchell, Native Women's Association Board member will also participate.

Sept 8 – 9:00 AM	Senior Management Meeting (approx 15 participants - including medical as well as administrative personnel) Location: Large Inuvik Hospital Board Room.

Fort Simpson (September 11)
(Local coordinator Lauren Muir 695-3815)

The Deh Cho Health and Social Services Authority is located in the southwest corner of the NWT. Fort Simpson (pop.1269 – 2004 est.) is the largest community in the Deh Cho (pop. 3,478 – 2004 est.). The Authority has 13 members including the Chair. Fort Simpson has three representatives with all of the remaining communities having one representative on the Board.

Fort Simpson would prefer that we use the data gathered in Fall 2005 by Howard Research. They agreed to a teleconference with representatives from smaller community Health Centres. Fort Liard, Fort Providence and Fort Simpson are currently too busy to participate in the staff teleconference. A community person from Wrigley will also speak with us by telephone.

Sept 11 – 8:45 AM	Telephone interview with DCHSSA CEO Kathy Tsetso
Sept 11 – 1:30 PM	Staff teleconference with representatives from Jean Marie River, Trout Lake, Nahanni Butte, Wrigley and Fort Simpson-based Lauren Muir (ISDM Implementation Coordinator) online.

Yellowknife (September 12-15
(Local coordinator YHSSA "Health" Ruth Robertson 920-6113)
(Local coordinator YHSSA "Social Services" Les Harrison 873-7901)
(Local coordinator STHA "Hospital" Heather Chang 669-4101)

There are two Authorities headquartered in Yellowknife (pop.19,056 – 2004 est. and current estimate of approximately 22,000). The YHSSA serves Yellowknife, Lutselk'e, Fort Resolution N'dilo and Dettah. The Stanton Territorial Authority provides serves to residents across the entire territory and operates the NWT's largest hospital.

Sept 12 – AM	Meeting with some Yellowknife "health services" staff.
Sept 12 – AM	Meeting with YHSSA CEO Greg Cummings
Sept 12 – 7:00 PM	Community Discussion Group in the Status of Women Board Room in the NorthwesTel Tower. Approximately 10 persons expected. Participants will need to be paid $50 each. Participants are drawn mainly from clients or staff of five organizations – Status of Women Council of the NWT, Women's Centre, Native Women's Association of the NWT, YWCA (Transition Housing) and YK Seniors' Society.

Sept 14 – 9:00 AM	Participation in the monthly Yellowknife "social services" staff meeting hosted by Les Harrison. Meeting location is the large second floor Board Room in the Jan Stirling Building. Discussion may be limited to 30 minutes.
Sept 14 – 10:00 AM	Meeting with Stanton Territorial Authority CEO Sylvia Haener (her office 3rd Floor rear elevator at the hospital)
Sept 14 – 2:00 PM	Stanton Territorial Hospital staff including emergency, psychiatry, nursing and other hospital health service personnel. One hour and 15 minutes has been allocated for this meeting.
Sept 14 – 7:00 PM	Community Discussion Group in the Status of Women Board Room in the NorthwesTel Tower. Approximately 10 persons expected. Participants will need to be paid $50 each. Participants are drawn mainly from clients or staff of five organizations – Status of Women Council of the NWT, Women's Centre, Native Women's Association of the NWT, YWCA (Transition Housing) and YK Seniors' Society.

Behchoko (September 13)
(Local coordinator Joe Beaverho 392-3039)

The Tlicho Community Services Agency, headquartered in Behchoko (pop. 1,895 – 2004 est.) is an extension of the self-governing Tlicho First Nations. The Agency provides services to residents in the four Tlicho communities (pop. 2,811 – 2004 EST.). The "Agency" is the only one in the NWT that combines the functions of health and education. It is governed by a five-member Board consisting of a chair and one representative from each community.

Sept 13 – AM	Meeting with either Jim Martin (Agency CEO) or Anna Beals (Director of Health and Social Services)
Sept 13 – 2:00 PM	Staff discussion. May be limited availability due to staff shortages and vacancies.
Sept 13 – 6:00 PM	Community discussion following an informal community meal in the courthouse space in the main services building. Approximately 75 persons are expected to attend. Meeting portion would begin about 7:00 PM.

Appendix H: Provider Survey Data Tables

Tele-Care NWT Provider Survey (September 2006)

Question 1: Prior to receiving this survey, had you ever heard of Tele-Care NWT?

	Registered Nurse / Nurse Practitioner (n = 40)	Medical Doctor (n = 21)	Health Related (n = 25)	Social Worker / Social Work Related (n = 25)
Yes	97.5%	95.2%	84.0%	88.0%
No	2.5%	0.0%	16.0%	4.0%
Don't Know / Not Sure	0.0%	4.8%	0.0%	8.0%

Question 2: When did you first become aware of Tele-Care NWT?

	Registered Nurse / Nurse Practitioner (n = 38)	Medical Doctor (n = 20)	Health Related (n = 21)	Social Worker / Social Work Related (n = 22)
Last 1 to 12 months	7.9%	20.0%	9.5%	36.4%
One to 2 years ago	28.9%	50.0%	42.9%	27.3%
Over 2 years ago	57.9%	30.0%	33.3%	27.3%
Cannot recall	5.3%	0.0%	14.3%	9.1%

Question 3: Are you aware of the people to whom you provide services using Tele-Care NWT?

	Registered Nurse / Nurse Practitioner (n = 39)	Medical Doctor (n = 22)	Health Related (n = 22)	Social Worker / Social Work Related (n = 23)
Yes	71.8%	68.2%	50.0%	34.8%
No	23.1%	27.3%	40.9%	52.2%
Don't Know / Not Sure	5.1%	4.5%	9.1%	13.0%

Question 4: Do you advise the people to whom you provide services to use Tele-Care NWT?

	Registered Nurse / Nurse Practitioner (n = 39)	Medical Doctor (n = 20)	Health Related (n = 22)	Social Worker / Social Work Related (n = 24)
Yes	76.9%	25.0%	50.0%	41.7%
No	20.5%	60.0%	45.5%	58.3%
Don't Know / Not Sure	2.6%	15.0%	4.5%	0.0%

Question 5: In what circumstances have you advised people to use Tele-Care NWT (e.g. type of patient/client, type of health or social concern)?

	Registered Nurse / Nurse Practitioner (n = 29)	Medical Doctor (n = 4)	Health Related (n = 10)	Social Worker / Social Work Related (n = 9)
After hours / On call / Answering machine	20.7%	0.0%	0.0%	11.1%
Referral of parents / children	20.7%	0.0%	10.0%	33.3%
General referral of patients/clients/public	31.0%	25.0%	20.0%	33.3%
Referral re: symptoms/condition/concerns	13.8%	25.0%	30.0%	11.1%
Other	13.8%	50.0%	40.0%	11.1%

Question 6: Have you ever called Tele-Care NWT yourself?

	Registered Nurse / Nurse Practitioner (n = 40)	Medical Doctor (n = 22)	Health Related (n = 22)	Social Worker / Social Work Related (n = 24)
Yes	25.0%	9.1%	50.0%	29.2%
No	75.0%	86.4%	50.0%	70.8%
Don't Know / Not Sure	0.0%	4.5%	0.0%	0.0%

If YES, for what reasons (CHECK ALL THAT APPLY):

	Registered Nurse / Nurse Practitioner (n = 10)	Medical Doctor (n = 2)	Health Related (n = 11)	Social Worker / Social Work Related (n = 7)
For personal advice	60.0%	0.0%	81.8%	85.7%
To see how it worked (professional curiosity)	30.0%	100.0%	27.3%	28.6%
To find an appropriate health or social services resource for which to refer a patient	30.0%	0.0%	0.0%	0.0%
To check for a public health advisory	10.0%	0.0%	9.1%	14.3%
Other	30.0%	0.0%	27.3%	0.0%

Question 7a: On a scale of 1 to 5, where 1 is strongly disagree and 5 is strongly agree, please indicate your opinion with regard to each of the following statement: Tele-Care NWT is a supportive tool in meeting the work load demands of health services providers.

	Registered Nurse / Nurse Practitioner (n = 40)	Medical Doctor (n = 20)	Health Related (n = 24)	Social Worker / Social Work Related (n = 24)
Strongly Disagree (1)	15.0%	5.0%	0.0%	4.2%
Disagree (2)	17.5%	40.0%	12.5%	20.8%
Neutral (3)	22.5%	20.0%	29.2%	20.8%
Agree (4)	22.5%	30.0%	29.2%	41.7%
Strongly Agree (5)	22.5%	5.0%	29.2%	12.5%

Question 7b: On a scale of 1 to 5, where 1 is strongly disagree and 5 is strongly agree, please indicate your opinion with regard to each of the following statement: Tele-Care NWT is a supportive tool in meeting the work load demands of social service providers.

	Registered Nurse / Nurse Practitioner (n =37)	Medical Doctor (n = 20)	Health Related (n = 25)	Social Worker / Social Work Related (n = 23)
Strongly Disagree (1)	24.3%	5.0%	0.0%	21.7%
Disagree (2)	13.5%	35.0%	4.0%	39.1%
Neutral (3)	45.9%	40.0%	60.0%	13.0%
Agree (4)	10.8%	20.0%	32.0%	21.7%
Strongly Agree (5)	5.4%	0.0%	4.0%	4.3%

Question 7c: On a scale of 1 to 5, where 1 is strongly disagree and 5 is strongly agree, please indicate your opinion with regard to each of the following statement: Tele-Care NWT is a supportive tool in meeting my work load demands.

	Registered Nurse / Nurse Practitioner (n = 39)	Medical Doctor (n = 20)	Health Related (n = 25)	Social Worker / Social Work Related (n = 23)
Strongly Disagree (1)	30.8%	25.0%	28.0%	43.5%
Disagree (2)	28.2%	35.0%	12.0%	4.3%
Neutral (3)	23.1%	30.0%	44.0%	47.8%
Agree (4)	7.7%	10.0%	12.0%	4.3%
Strongly Agree (5)	10.3%	0.0%	4.0%	0.0%

Question 7d: On a scale of 1 to 5, where 1 is strongly disagree and 5 is strongly agree, please indicate your opinion with regard to each of the following statement: Tele-Care NWT helps clients find appropriate health and social services resources.

	Registered Nurse / Nurse Practitioner (n = 39)	Medical Doctor (n = 20)	Health Related (n = 25)	Social Worker / Social Work Related (n = 24)
Strongly Disagree (1)	20.5%	5.0%	0.0%	12.5%
Disagree (2)	7.7%	25.0%	0.0%	12.5%
Neutral (3)	30.8%	45.0%	44.0%	41.7%
Agree (4)	28.2%	25.0%	36.0%	20.8%
Strongly Agree (5)	12.8%	0.0%	20.0%	12.5%

Question 7e: On a scale of 1 to 5, where 1 is strongly disagree and 5 is strongly agree, please indicate your opinion with regard to each of the following statement: Tele-Care NWT provides valuable assistance to people experiencing physical health problems.

	Registered Nurse / Nurse Practitioner (n = 40)	Medical Doctor (n = 20)	Health Related (n = 25)	Social Worker / Social Work Related (n = 24)
Strongly Disagree (1)	12.5%	10.0%	0.0%	4.2%
Disagree (2)	15.0%	25.0%	8.0%	8.3%
Neutral (3)	27.5%	45.0%	28.0%	33.3%
Agree (4)	25.0%	20.0%	28.0%	29.2%
Strongly Agree (5)	20.0%	0.0%	36.0%	25.0%

Question 7f: On a scale of 1 to 5, where 1 is strongly disagree and 5 is strongly agree, please indicate your opinion with regard to each of the following statement: Tele-Care NWT provides valuable assistance to people experiencing mental health and addiction problems.

	Registered Nurse / Nurse Practitioner (n = 36)	Medical Doctor (n = 19)	Health Related (n = 25)	Social Worker / Social Work Related (n = 23)
Strongly Disagree (1)	22.2%	26.3%	4.0%	17.4%
Disagree (2)	27.8%	5.3%	4.0%	21.7%
Neutral (3)	36.1%	63.2%	56.0%	34.8%
Agree (4)	11.1%	5.3%	28.0%	13.0%
Strongly Agree (5)	2.8%	0.0%	8.0%	13.0%

Question 7g: On a scale of 1 to 5, where 1 is strongly disagree and 5 is strongly agree, please indicate your opinion with regard to each of the following statement: Tele-Care NWT provides valuable assistance to people experiencing social problems.

	Registered Nurse / Nurse Practitioner (n = 37)	Medical Doctor (n = 19)	Health Related (n = 25)	Social Worker / Social Work Related (n = 23)
Strongly Disagree (1)	18.9%	5.3%	4.0%	21.7%
Disagree (2)	32.4%	26.3%	8.0%	26.1%
Neutral (3)	37.8%	52.6%	56.0%	34.8%
Agree (4)	8.1%	15.8%	24.0%	13.0%
Strongly Agree (5)	2.7%	0.0%	8.0%	4.3%

Question 7h: On a scale of 1 to 5, where 1 is strongly disagree and 5 is strongly agree, please indicate your opinion with regard to each of the following statement: Tele-Care NWT helps people learn how to better manage their own physical health, social, and/or mental health-related problems.

	Registered Nurse / Nurse Practitioner (n = 38)	Medical Doctor (n = 20)	Health Related (n = 24)	Social Worker / Social Work Related (n = 24)
Strongly Disagree (1)	10.5%	25.0%	0.0%	8.3%
Disagree (2)	18.4%	15.0%	12.5%	12.5%
Neutral (3)	39.5%	45.0%	41.7%	54.2%
Agree (4)	23.7%	15.0%	20.8%	16.7%
Strongly Agree (5)	7.9%	0.0%	25.0%	8.3%

Question 7i: On a scale of 1 to 5, where 1 is strongly disagree and 5 is strongly agree, please indicate your opinion with regard to each of the following statement: Users of Tele-Care NWT are likely to make changes to their physical health, social and/or mental health behaviour after receiving advice from the Tele-Care NWT service.

	Registered Nurse / Nurse Practitioner (n = 38)	Medical Doctor (n = 19)	Health Related (n = 24)	Social Worker / Social Work Related (n = 24)
Strongly Disagree (1)	21.1%	31.6%	12.5%	20.8%
Disagree (2)	21.1%	21.1%	20.8%	12.5%
Neutral (3)	42.1%	36.8%	50.0%	45.8%
Agree (4)	10.5%	10.5%	12.5%	16.7%
Strongly Agree (5)	5.3%	0.0%	4.2%	4.2%

Question 7j: On a scale of 1 to 5, where 1 is strongly disagree and 5 is strongly agree, please indicate your opinion with regard to each of the following statement: Tele-Care NWT can help prevent more serious physical health, social, and/or mental health and addiction problems with early intervention.

	Registered Nurse / Nurse Practitioner (n = 39)	Medical Doctor (n = 20)	Health Related (n = 25)	Social Worker / Social Work Related (n = 24)
Strongly Disagree (1)	7.7%	20.0%	4.0%	12.5%
Disagree (2)	20.5%	10.0%	24.0%	8.3%
Neutral (3)	41.0%	60.0%	44.0%	37.5%
Agree (4)	25.6%	10.0%	16.0%	20.8%
Strongly Agree (5)	5.1%	0.0%	12.0%	20.8%

Question 7k: On a scale of 1 to 5, where 1 is strongly disagree and 5 is strongly agree, please indicate your opinion with regard to each of the following statement: Tele-Care NWT can be used by health and social service providers to obtain professional information.

	Registered Nurse / Nurse Practitioner (n = 41)	Medical Doctor (n = 20)	Health Related (n = 24)	Social Worker / Social Work Related (n = 24)
Strongly Disagree (1)	22.0%	20.0%	4.2%	20.8%
Disagree (2)	24.4%	30.0%	16.7%	4.2%
Neutral (3)	24.4%	35.0%	45.8%	33.3%
Agree (4)	12.2%	15.0%	29.2%	16.7%
Strongly Agree (5)	17.1%	0.0%	4.2%	25.0%

Part 2: Question 7a: Please indicate below which items best describe you and your practice: Practicing as a:

	%
Register Nurse / Nurse Practitioner	33.1%
Medical Doctor	17.7%
Health related	20.2%
Social Worker / Social Work related	20.2%
Unknown	8.9%

Question 7b: Please indicate below which items best describe you and your practice: Practicing:

	Registered Nurse / Nurse Practitioner (n = 40)	Medical Doctor (n = 22)	Health Related (n = 24)	Social Worker / Social Work Related (n = 24)
Less than 2 years	2.5%	0.0%	0.0%	25.0%
2 to 5 years	10.0%	22.7%	33.3%	16.7%
6 to 10 years	15.0%	4.5%	12.5%	25.0%
11 to 15 years	7.5%	18.2%	8.3%	8.3%
More than 15 years	65.0%	54.5%	45.8%	25.0%

Question 7c: Please indicate below which items best describe you and your practice: Practicing in the North:

	Registered Nurse / Nurse Practitioner (n = 41)	Medical Doctor (n = 22)	Health Related (n = 23)	Social Worker / Social Work Related (n = 25)
Less than 2 years	9.8%	0.0%	0.0%	24.0%
2 to 5 years	24.4%	40.9%	43.5%	36.0%
6 to 10 years	26.8%	9.1%	13.0%	16.0%
11 to 15 years	7.3%	27.3%	13.0%	8.0%
More than 15 years	31.7%	22.7%	30.4%	16.0%

Question 7d: Please indicate below which items best describe you and your practice: Currently employed as a health or social services provider:

	Registered Nurse / Nurse Practitioner (n = 38)	Medical Doctor (n = 22)	Health Related (n = 25)	Social Worker / Social Work Related (n = 25)
Full-time	63.2%	95.5%	84.0%	92.0%
Part-time	21.1%	4.5%	4.0%	4.0%
Other	15.8%	0.0%	12.0%	4.0%

Question 7e: Please indicate below which items best describe you and your practice:
Location of practice (community):

	%
Aklavik	.8%
Behchoko	2.4%
Fort Liard	1.6%
Fort McPherson	.8%
Fort Providence	1.6%
Fort Resolution	1.6%
Fort Simpson	6.5%
Fort Smith	8.1%
Gameti	.8%
Hay River	8.1%
Inuvik	2.4%
Lutselk'e	.8%
Norman Wells	4.0%
Sahtu	.8%
Tuktoyaktuk	.8%
Tulita	.8%
Whati	2.4%
Yellowknife	50.0%
Did not specify	5.6%

Question 8: If you have further comments about Tele-Care NWT, we would be happy to hear them.

	Registered Nurse / Nurse Practitioner (n = 41)	Medical Doctor (n = 22)	Health Related (n = 25)	Social Worker / Social Work Related (n = 25)
Valuable service overall	12.2%	4.5%	12.0%	12.0%
Tele-Care generally refers callers elsewhere	12.2%	0.0%	0.0%	4.0%
Public unaware or confused about service / Needs more promotion	7.3%	4.5%	4.0%	16.0%
Other	9.8%	13.6%	0.0%	12.0%
No Comment	58.5%	77.3%	84.0%	56.0%

Appendix I: Glossary of Terms

211	The 3-digit number assigned by the CRTC for national access to non-emergency health and human service referral and information
211 NIC	211 National Implementation Committee made up of Information and Referral Agencies and United Ways across Canada – will take on responsibility for national 211 standards and licensing
811	The 3-digit number assigned by the CRTC for national access to non-urgent health triage and information (no services currently in operation in Canada)
911	The 3-digit number used to access emergency services like police, fire and ambulance (currently not in operation in the NWT)
AIRS	The Alliance of Information & Referral Systems is a membership-based organization serving information and referral interests in Canada and the United States
BC211	A cooperative project of the United Ways of BC, community Information and Referral Agencies across the province and the Government of British Columbia planning the introduction of a province-wide 211 system.
Call Centre	A location where live operators take calls
Call Router	A call router sends live calls directly to the appropriate telephone number or extension
Canada 211	A national organization, with representation from all provinces, that is coordinating national aspects of the establishment of 211 systems in Canada
CIRS	Certified Information & Referral Specialist (through AIRS)
CRS	Certified Resource Specialist (through AIRS)
CRTC	Canadian Radio-television and Telecommunications Commission regulates all Canadian broadcasting and telecommunications activities and enforced rules it creates to carry out its policies
DB	Database
GNWT	Government of the Northwest Territories
Taxonomy	A taxonomy is a classification system that allows the user to index and access community resources based on the services provided and the target populations they serve. It provides a structure for the information in the database and tells users what is in the system and how to find it.
IP Telephony	Internet Protocol Telephony based Contact (Call) Centre solutions combine data and voice technologies to facilitate geographically independent multimedia customer interactions
I&R	Information and Referral organizations – created to help people access critical services such as shelter, childcare, jobs, mental health support, emergency food, health care and other similar services
IRA	Information and Referral Agency (a standards organization for Information and Referral organizations)
ISDM	Integrated Service Delivery Model for delivery of Primary Health Care within the NWT
MJSC	Multi-Jurisdictional Steering Committee

N11	The term used to refer to 3-digit dialing telephone numbers – 211, 311, 411, 511, 611, 811 and 911
NGO	Non-Governmental Organization
Portal	A way of providing a person with easy access to a wide range of services from a variety of sources – usually over the Internet. In many cases a portal has a specific subject or geographic focus. Choices on entering the portal are intended to be either intuitive or based on access to an Internet-based Search Engine (such as Google or Yahoo).
PSA	Public Service Announcement – often a professionally produced 30 or 60 second radio or television message that may be paid or may be run as a public service by the radio or television station.
PSTN	Public Switched Telephone Network is the concentration of the world's public-switched telephone networks. PSTN is now almost entirely digital and includes mobile as well as fixed telephones.
Telco	A telephone service provider
TSP	Telephone Service Provider
VoIP	Voice over Internet Protocol (also called IP Telephony, Internet Telephony) is the routing of conversations over the Internet or any IP-based network
WAN	Wide area network service is a computer network covering a broad geographic area
Wayfinding	A term that is applied to the process that connects a person from the need to access a service or location to the provision of that service or access. When the service is delivered over the telephone it commonly assumes that a live operator will triage the caller's needs and facilitate that process

Appendix J: Telecom Decision CRTC 2005-39

Ottawa, 6 July 2005

Alberta Health and Wellness' request for code 8-1-1 for non-urgent health teletriage services

Reference: 8665-A83-200409492 and 8698-C12-200415928

In this Decision, the Commission approves an application from Alberta Health and Wellness requesting the assignment of an N-1-1 code, specifically 8-1-1, for access to non-urgent health care telephone triage services.

The application

1. The Commission received an application from Alberta Health and Wellness, on behalf of the provincial and territorial Deputy Ministers of Health (Alberta Health and Wellness), dated 24 August 2004, filed pursuant to Part VII of the *CRTC Telecommunications Rules of Procedure.* Alberta Health and Wellness requested that the Commission assign the 3-1-1 code for non-commercial use across Canada for access to first level health care telephone triage services (teletriage services).

2. Alberta Health and Wellness stated that teletriage service has been identified by all provincial and territorial Deputy Ministers of Health as an important component in primary care restructuring and reform. Teletriage service, as a component of primary care systems, would improve access to primary health care services, the quality and efficiency of those services, and the results for patients who use those services.

3. In *Assignment of 311 for non-emergency municipal government services,* Telecom Decision CRTC 2004-71, 5 November 2004 (Decision 2004-71), the Commission approved the assignment of the 3-1-1 code for access to non-emergency municipal government services.

4. Concurrent with the release of Decision 2004-71, on 5 November 2004, Commission staff issued a letter announcing that the 5-1-1 and 8-1-1 resources were available for reassignment and invited the applicant to amend its application to request an available three digit code (N-1-1), given that the 3-1-1 resource was no longer available.

5. On 26 November 2004, the Commission received an amended application from Alberta Health and Wellness dated 19 November 2004, requesting any available N-1-1, but preferably, 8-1-1.

The process

6. On 30 November 2004, two staff letters were issued. The first letter established the process to be followed in respect of Alberta Health and Wellness' amended

application. The second letter recognized that some Canadian carriers were making use of 8-1-1, and that therefore those carriers were requested to file proposals for vacating the 8-1-1 resource.

7. On 6 December, 10 December and 15 December 2004, the Commission received letters from Saskatchewan Telecommunications (SaskTel); Aliant Mobility and Bell Mobility; and TELUS Communications Inc. and TELE-MOBILE Company which does business as TELUS Mobility (TELUS), respectively. All parties indicated that 8-1-1 was in use to various degrees in their networks and requested more time to assess the consequences of any reclamation of those codes and to propose remedial actions.

8. On 24 December 2004, in reply to a number of submissions from potentially affected carriers, the process was amended to extend the comment cycle from 14 January 2005 to 28 January 2005 and reply comments from 28 January 2005 to 11 February 2005. Parties were reminded, to develop and file by 28 January 2005, proposals for vacating the 8-1-1 resource.

9. The Commission received proposals for vacating 8-1-1 on 28 January 2005 from Aliant Telecom Inc. and Aliant Mobility (Aliant Telecom); Bell Mobility Inc. on behalf of itself, NMI Mobility Inc., Télébec Mobility, a division of Télébec, société en commandite, and NorthernTel Mobility, a division of NorthernTel, Limited Partnership (Bell Mobility et al.); MTS Allstream Inc. (MTS Allstream); SaskTel; TBayTel; and TELUS.

10. The Commission received comments on Alberta Health and Wellness' application, dated 28 January 2005 from Aliant Telecom; Bell Canada; Bell Mobility et al.; Canadian Wireless Telecommunications Association (CWTA); MTS Allstream; Rogers Wireless Inc. (RWI); SaskTel; TBayTel; and TELUS.

11. Alberta Health and Wellness submitted reply comments on 11 February 2005.

12. United Way of Canada and 211 Canada Steering Committee (211 CSC) filed comments on 18 and 25 February 2005 respectively.

13. On 31 March 2005, Alberta Health and Wellness filed additional reply comments to respond to the United Way of Canada and 211 CSC comments.

Background

14. Within the North American Numbering Plan (NANP), which provides the framework for a continent-wide telephone number system, unique three digit codes, or N-1-1 codes, are assigned as an industry standard to provide access to specific types of services by dialing an abbreviated telephone number. For example, callers can dial 4-1-1 for directory assistance and 9-1-1 for emergency services.

15. In *Allocation of three-digit dialing for public information and referral services*, Decision CRTC 2001-475, 9 August 2001 (Decision 2001-475), in view of the scarcity of N-1-1 codes, the Commission established the following guidelines to be used when

considering the assignment of unused N-1-1 codes:

i) there must be a compelling need for three-digit access that cannot be satisfied by other dialing arrangements or it is demonstrated that existing dialing arrangements are not suitable for accessing the needed services;

ii) the assignment of an unused N-1-1 code should be to a service or services rather than a specific organization;

iii) the provision of N-1-1 dialing is to be based on a need to serve the broad public interest, including providing access to the telephone network to disadvantaged individuals or groups;

iv) the N-1-1 dialing should not confer a competitive advantage on the service provider(s) reached by this number;

v) the services to be provided through N-1-1 dialing are to be widely available geographically and on a full-time or extended-time basis; and

vi) where possible, the N-1-1 allocation to a service does not conflict with the NANP and is in keeping with the Canadian Steering Committee on Numbering (CSCN) guidelines for N-1-1.

Issues

16. The Commission considers that there are six issues on which determinations need to be made with respect to Alberta Health and Wellness' application:

a) the reclamation of the 8-1-1 code;

b) whether the application meets the Commission guidelines for assigning N-1-1 codes;

c) integration of 8-1-1 services with 9-1-1 emergency services;

d) public awareness campaign;

e) implementation time frame; and

f) cost recovery and other issues.

a) Reclamation of the 8-1-1 code

Positions of parties

17. Those Canadian carriers currently using 8-1-1 indicated that they could vacate the resource as follows:

- MTS Allstream within 30 days notice;
- Bell Mobility et al. and TELUS within 6 months from the date of a Commission determination;
- TBayTel in the fourth quarter of 2005;
- Northwestel Inc. (Northwestel) by mid 2006;
- Aliant Telecom by the end of 2006; and
- SaskTel within 18-24 months from the date of the Decision.

18. Aliant Telecom indicated that it was important to communicate the change in the use of 8-1-1 to its customers. Aliant Telecom submitted that its most utilized promotional material are the telephone directories, which will not be updated until April 2006. Aliant Telecom further submitted that it was necessary to have a six-month period to place an intercept on 8-1-1 directing customers to the new number and an additional six-month intercept advising the callers that the number was no longer in service. SaskTel stated that there was no pressing need for it to abandon its current use of the 8-1-1 code since the Saskatchewan Department of Health had advised SaskTel that it had no plans of utilizing an 8-1-1 code for the purposes proposed in the application.

19. Alberta Health and Wellness replied that it would like to see a timely and expeditious process so that those jurisdictions wishing to do so could begin the process of moving to the 8-1-1 number for their teletriage services.

Commission's analysis and determination

20. The Commission notes that the requested time frames to vacate the 8-1-1 resource vary from 30 days to approximately two years, with the average in the range of six to nine months. The Commission considers that waiting for the directories to be updated and placing an intercept on 8-1-1, justify the longer requested time frames. The Commission also notes that in the CO Code Assignment Guidelines, the aging period[1] for CO codes varies from three months to one year. The Commission considers that, for the 8-1-1 code, an aging period of six months should be sufficient for those companies that indicated shorter timeframes.

21. Accordingly, the Commission directs Bell Mobility et al., MTS Allstream, TBayTel and TELUS to vacate the 8-1-1- resource by the end of 2005, Northwestel by 30 June 2006 and Aliant Telecom and SaskTel by the end of 2006.

b) Assigning an N-1-1 code to Alberta Health and Wellness

Alberta Health and Wellness' position

22. Alberta Health and Wellness submitted that its application met the guidelines set out in Decision 2001-475 for assigning unused N-1-1 codes, as follows:

i) Having a universally available three digit number would provide access to services nation-wide, eliminating the need for callers to determine the local number for access.

ii) The N-1-1 code would not be tied to a specific organization, but would be available for use by all provincial and territorial jurisdictions across Canada.

iii) There was no greater broad public need in Canada than easy access to health care. In addition to relieving pressure on 9-1-1 services and on emergency rooms, and becoming a complement to 2-1-1 social/health contact systems, 8-1-1 is an easily remembered number that can be made highly visible, and could significantly assist all Canadians in accessing non-emergency teletriage services.

iv) The 8-1-1 service would be a provincial/territorial service, and not commercial in nature.

v) The implementation model for the 8-1-1 number would be targeted for availability 24 hours a day, seven days a week. Alberta Health and Wellness proposed that 8-1-1 be implemented by provinces and territories according to their readiness to offer a province-wide teletriage service via the 8-1-1 number.

vi) The allocation and adoption of 8-1-1 for teletriage services in Canada would maintain the integrity of the NANP and would be in keeping with the CSCN guidelines for the use of N-1-1 numbers.

Other parties' positions

23. Most parties were satisfied that the applicant had met the guidelines set out in Decision 2001-475. Aliant Telecom and Bell Canada proposed that provincial and territorial Deputy Ministers of Health should be required to officially endorse the entities that would use the N-1-1 code in a defined geographic location.

24. Although SaskTel indicated that it was satisfied that the application met the guidelines, it questioned whether there is a compelling need for three digit access that cannot be satisfied by other dialing arrangements.

25. United Way of Canada and 2-1-1 CSC opposed the application. They indicated their concern that the assignment of 8-1-1 would cause confusion for the public with the 2-1-1 service, a public information and referral service, in terms of access to health and social services. They submitted that it would result in duplication of infrastructure and

would cause competition for scarce resources for the longer-term sustainability of these separate services.

Alberta Health and Wellness' reply comments

26. In reply to SaskTel's comment regarding the merits of Alberta Health and Wellness' application, Alberta Health and Wellness noted that the intent of its application is to make 8-1-1 available in the future to jurisdictions when they are ready to switch and to ensure that when Saskatchewan chooses to, it is able to switch to a single, easily remembered three digit number that is available across Canada.

27. In reply to United Way of Canada and 2-1-1 CSC, Alberta Health and Wellness indicated that the services proposed in its application are different from those available through the 2-1-1 service. Alberta Health and Wellness noted that 2-1-1 service will provide callers with information on community services and programs, while the 8-1-1 service will provide callers with access to specially trained nurses who will be able to provide callers with specific medical information.

Commission's analysis and determination

28. The Commission notes that although SaskTel questioned whether there is a compelling need for three digit access code, no carriers opposed Alberta Health and Wellness' application.

29. The Commission notes that Alberta Health and Wellness, Aliant Telecom and Bell Canada agreed that provincial and territorial Deputy Ministers of Health should be required to officially endorse the entities that will use the N-1-1 code in a defined geographic location. The Commission further notes that Bell Canada stated that the endorsement was necessary in case of conflict between entities who wish to use the N-1-1 code in certain locations. The Commission therefore expects the provincial and territorial ministries of Health to officially endorse the 8-1-1 service providers to ensure an adequate level of medical expertise to deliver this service.

30. The Commission notes that United Way of Canada and 2-1-1 CSC are opposed to the application on the ground that it would cause confusion for the public. The Commission considers that the 2-1-1 service and the proposed 8-1-1 service are sufficiently different to avoid confusion.

31. The Commission considers that given the fact that existing dialing arrangements vary from province to province, an easily remembered three-digit number would greatly assist all Canadians in accessing non-emergency health teletriage services and could reduce inappropriate calls to the 9-1-1 systems.

32. The Commission considers that Alberta Health and Wellness has demonstrated that an N-1-1 code is warranted for non-emergency health teletriage services and that its application meets each of the guidelines established in Decision 2001-475. Accordingly, the Commission approves the assignment of 8-1-1 for access to non-emergency health teletriage services.

c) Integration of 8-1-1 services with 9-1-1 emergency services

Position of parties

33. Alberta Health and Wellness stated that the assignment of 8-1-1 for first-level health teletriage service would complement the well-recognized 9-1-1 emergency number. The knowledgeable 8-1-1 staff would be trained to refer true emergency calls to 9-1-1. It added that calls to 8-1-1 would result in fewer inappropriate calls to 9-1-1, better utilizing limited resources that should be devoted to true emergencies.

34. Aliant Telecom, Bell Canada and TELUS submitted that the 8-1-1 health call centres should be required to advise any callers in emergency situations to hang up and dial 9-1-1 or another emergency number, where applicable. In Aliant Telecom's view, the alternative, which would be to obtain originating caller location information and transfer the calls to 9-1-1 public service answering positions (PSAPs) would be complex and costly to provide and could lead to problems in the provision of reliable 9-1-1 service. Aliant Telecom added that the provision of originating caller identification and location information should not be made part of this service.

35. Alberta Health and Wellness replied that it felt it was essential that 8-1-1 and 9-1-1 services be directly linked for an effective teletriage service to function. It submitted that asking callers to hang up and call 9-1-1 was not a viable option given that these callers may literally be in life or death situations and require immediate assistance. It added that all jurisdictions have developed legislation that addresses issues of privacy in health information, such as the Health Information Act. Alberta Health and Wellness submitted that since some existing teletriage services have implemented links to 9-1-1 services, privacy issues can be addressed, and it would expect each jurisdiction to address them as they switch to 8-1-1 for teletriage services, and link those services to 9-1-1 services.

Commission's analysis and determination

36. The Commission notes that in Decision 2004-71, it considered that there were potential privacy concerns related to integrating the 3-1-1 and 9-1-1 services, and that caller identification and location information should not be made available on 3-1-1 calls. The Commission considered that the complexities, including privacy concerns, related to the integration of the 3-1-1 and 9-1-1 services outweighed the benefits of integration. Accordingly, the Commission determined that 9-1-1 service and 3-1-1 service should not be integrated.

37. The Commission notes, however, that in regard to the 8-1-1 service, while used principally to provide information, the type of information provided is medical in nature. The Commission is of the view that certain 8-1-1 calls may relate to a condition that requires immediate medical attention. The Commission notes the argument that it is possible that during the course of an 8-1-1 call, the caller's medical condition may escalate to a point where the caller becomes unable to hang up and re-dial 9-1-1.

38. The Commission recognizes, however, that there may potentially be some privacy issues that will need to be resolved. In this regard, the Commission notes that it may be possible to resolve these privacy issues in a similar manner as they have been resolved in the telephone companies' tariffs for E-9-1-1 call routing service. The Commission also notes Alberta Health and Wellness' comments that it is fully aware of the privacy issues and what can and cannot be done under various pieces of legislation.

39. The Commission also notes that Alberta Health and Wellness indicated that in some areas teletriage calls are already being transferred or linked to 9-1-1 PSAPs.

40. In light of the above, the Commission considers that there is merit to linking 8-1-1 and 9-1-1 services. Therefore, where an 8-1-1 service provider wants to link the two services, the service providers and the affected telecommunications service providers (TSPs) should negotiate an equitable solution.

d) Public awareness

Position of parties

41. Aliant Telecom and Bell Canada submitted that it was critically important to ensure that 9-1-1 remain as the single and only number to be called in the event of emergencies. Bell Canada submitted that it was critically important that there should be no confusion in the public's mind between the types of services that will be available via the 8-1-1 number versus other N-1-1 numbers, in particular, 9-1-1 emergency services and 2-1-1 community services. Aliant Telecom and Bell Canada submitted that provincial and territorial agencies using the proposed 8-1-1 number, should be required to clearly communicate in their promotional materials the purposes for which the 8-1-1 number is intended (i.e., for access to non-emergency health information).

42. TELUS requested that the Commission specifically direct the applicant to undertake a comprehensive public awareness campaign wherein it should describe to the public in precise terms the types of health teletriage services that will be available through the 8-1-1 service to the public and provide information on how these services differ from the other newly introduced N-1-1 services such as 9-1-1, 3-1-1 and 2-1-1.

43. Alberta Health and Wellness replied that there were three components to the consumer awareness issue: 1) public awareness that 8-1-1 has been reclaimed; 2) public awareness of 8-1-1 as the new access number for teletriage services; and 3) public awareness of appropriate use of 8-1-1 and 9-1-1. Alberta Health and Wellness submitted that these elements will require discussion, negotiation and ongoing work by Ministries of Health in all jurisdictions, providers of teletriage services and TSPs. It recognized that public education and awareness on an ongoing basis is essential to ensure that 8-1-1 and 9-1-1 services are used appropriately and it was committed to working with telecommunications and teletriage service providers to ensure that this education and awareness takes place.

Commission's analysis and determination

44. The Commission notes that all the parties that commented on the issue of public awareness agreed on the need for effective public awareness campaigns associated with the implementation of the 8-1-1 service. The Commission notes that in Decision 2004-71, it considered it necessary and in the public interest for municipalities to promote awareness of their 3-1-1 services, especially for the purpose of minimizing confusion between emergency and non-emergency services and between 3-1-1 and 2-1-1 services. The Commission considers it necessary and in the public interest for teletriage service providers to promote awareness of their 8-1-1 services, especially for the purpose of minimizing confusion between emergency and non-emergency services and between 3-1-1 or 2-1-1 services. The Commission expects all teletriage service providers to undertake comprehensive and effective public awareness campaigns.

45. The Commission also notes that because 8-1-1 was used by TSPs, the TSPs should inform their customers that this resource is no longer available. The Commission therefore directs the TSPs to undertake a public awareness campaign in relation to the reclamation of 8-1-1.

e) Implementation time frame

Position of parties

46. Alberta Health and Wellness suggested that each province should be required to provide at least three months' notice to their local TSPs to program their switches to route 8-1-1 calls to the appropriate service locations.

47. Aliant Telecom, Bell Canada and TBayTel submitted that the three-month notification time frame proposed by the applicant to implement the 8-1-1 service was not reasonable and that the implementation date should be negotiated between the 8-1-1 agency and the TSPs. Aliant Telecom submitted that special provisioning measures, network modifications and system tests may require longer periods than a three-month time frame. Bell Canada added that an official written advance notification of at least six months should also be provided to enable TSPs to make the necessary routing and related arrangements. Bell Mobility et al. claimed it was not in a position to estimate the time necessary to implement the service given its need for sufficient information and time to study, plan and implement the requested service in advance of its being launched. MTS Allstream submitted that TSPs should be given six months while TELUS suggested that a minimum of nine months and, up to 18 months notice should be given.

Commission's analysis and determination

48 In the Commission's view, implementing the 8-1-1 service requires similar steps to

. those required to implement the 3-1-1 service. Accordingly, the Commission considers it necessary that each province or territory that wishes to implement 8-1-1 service provide a minimum of six months notice to the TSPs operating within that province or territory.

f) Cost recovery and other issues

Alberta Health and Wellness' position

49 . Alberta Health and Wellness stated that as the 8-1-1 number becomes well known, people may call 8-1-1 in areas where the service is not yet available. It submitted that provisions must be made for routing calls made to the 8-1-1 service in an area where the teletriage service is not available.

50 . Alberta Health and Wellness proposed that the incremental costs of implementing an 8-1-1 service be borne by telecommunications carriers, in the same manner as was established by the Commission in Decision 2001-475. Alberta Health and Wellness also proposed that the costs for supporting the 8-1-1 teletriage service be charged as a component of carrier bills to all customers at a rate determined by carriers and approved by the Commission.

51 . Alberta Health and Wellness suggested that costs for long distance charges for 8-1-1 service, if necessary, be negotiated between the 8-1-1 service provider and the TSP, and paid for by the 8-1-1 service provider. The applicant also proposed that the costs for 8-1-1 calls for wireless service providers (local and long distance) be recovered from callers as part of the monthly charge for the use of wireless services, or otherwise as part of a service contract with a wireless service carrier.

52 . Alberta Health and Wellness recommended that a CRTC Interconnection Steering Committee (CISC) 8-1-1 sub-committee be formed to address technical issues. As with other CISC committees, membership on this committee would be open to all interested parties.

Other parties' positions

53 . Aliant Telecom and TELUS were of the view that the provincial and territorial governments that choose to implement N-1-1 should be responsible for the associated costs, not the local exchange carriers and wireless service providers. Aliant Telecom submitted, however, that it would not be opposed to covering these costs provided it is able to recover any costs incurred through the deferral account or another appropriate price adjustment. TELUS added that if the Commission decides that carriers should bear the costs of their network modifications, these additional costs would constitute grounds for an exogenous adjustment under the price cap regime. The other carriers submitted that they were prepared to assume the incremental costs of implementing an 8-1-1 service.

54 All carriers suggested that parties requesting special provisioning measures should

. bear the cost of such arrangements.

55. All carriers were opposed to the applicant's proposal that the costs for supporting the 8-1-1 service be charged as a component of all regular monthly carrier bills. SaskTel added that it was opposed to collecting fees from its customers for a service that they may or may not ever utilize.

56. In regard to long distance calls to the 8-1-1 system, Aliant Telecom, Bell Canada and TELUS suggested the use of a toll-free number to which the 8-1-1 dialed numbers would be translated for routing purposes and the 8-1-1 service provider would be billed. They also submitted that calls to 8-1-1 from pay telephones be provided using cash or prepaid calling cards. The offering of additional pay telephone billing options should be subject to a business arrangement between the 8-1-1 service provider and the TSP.

57. MTS Allstream suggested that long distance calls be negotiated between the 8-1-1 service provider and the TSP and that callers should bear the cost of 8-1-1 calls placed from a wireless telephone or a pay telephone.

58. The CWTA supported Alberta Health and Wellness' proposal that costs for 8-1-1 calls for wireless service providers (local and long distance) be recovered from callers. RWI supported the CWTA's comments.

59. TELUS stated that TELUS Mobility might treat 8-1-1 calls as local calls and charge them according to a wireless subscriber's rate plan or, alternatively, charge a monthly access fee for connection to the 8-1-1- system and waive local calling charges that would otherwise apply.

60. Aliant Telecom, Bell Canada, MTS Allstream and SaskTel submitted that the routing of N-1-1 calls should be based on incumbent local exchange carriers exchange boundaries for wireline carriers and on local service boundaries proposed by wireless service providers, unless otherwise negotiated by the 8-1-1 service provider and the carrier operating in that area. Bell Canada and TBayTel suggested that the applicant's expectations regarding the treatment of calls to 8-1-1 in areas where the teletriage service is not available were not clear.

61. TELUS agreed with Alberta Health and Wellness, that technical issues be referred to a CISC sub-committee. Bell Canada did not see the need to create a special sub-committee of CISC to address technical issues related to the implementation of an N-1-1 code. Bell Canada added that existing CISC Working Groups could address any technical issues that may arise that are within their mandates.

62. TELUS recommended that Alberta Health and Wellness retain and publish toll-free or alternate geographic based numbers for their 8-1-1 service providers to respond to the challenge of Voice over Internet Protocol (VoIP).

Alberta Health and Wellness' reply comments

63. Alberta Health and Wellness submitted that the ruling on the implementation costs should be the same as the determination made in Decisions 2001-475 and 2004-71.

It also agreed that in specific instances where complex and special routing arrangements are required, the payment for these special routing arrangements would be negotiated between jurisdictions and their associated TSPs.

64. Alberta Health and Wellness accepted the respondents' comments on its cost recovery proposal recognizing that alternative funding arrangements, such as direct government funding, will have to be developed. Alberta Health and Wellness agreed that 8-1-1 calls should not trigger toll charges to callers and proposed negotiated settlements between the 8-1-1 service provider and the TSPs for cost recovery.

65. Alberta Health and Wellness stated that its sole concern was that the CISC process adopted to deal with outstanding technical issues have the ability to resolve outstanding technical issues in a timely way so that jurisdictions and teletriage service providers are able to proceed with implementing the 8-1-1 service within defined time frames should they choose to do so.

66. With regards to routing calls to the 8-1-1 system, Alberta Health and Wellness replied there would be no need to develop switching and routing processes for areas where teletriage services are not available; adding that if the services were not available jurisdiction-wide, introducing the 8-1-1 service would not be a viable option.

Commission's analysis and determination

67. In regard to the recovery of costs for the 8-1-1 service, the Commission notes that in Decision 2004-71, it directed the TSPs to assume, on an incremental basis, the costs of the basic switch modifications and network changes necessary for the implementation of the 3-1-1 service. In that Decision, the Commission was of the view that if special routing arrangements were made upon a municipality's request, the TSP should not bear the cost of provisioning such arrangements.

68. The Commission notes that in Decisions 2001-475 and 2004-71, it determined that the routing arrangements for N-1-1 calls be based on exchange boundaries unless otherwise negotiated. The Commission considers that the routing arrangements determined in Decisions 2001-475 and 2004-71 would apply to the 8-1-1 service. Accordingly, the Commission determines that call routing arrangements should be based on exchange boundaries, unless otherwise negotiated by the 8-1-1 service provider and the TSPs operating in that area.

69. Consistent with Decision 2004-71, the Commission directs TSPs to assume, on an incremental basis, the costs of the basic switch modifications and network changes necessary for the implementation of 8-1-1 service. The teletriage service providers requesting special routing arrangements should bear the cost of provisioning such arrangements.

70. The Commission notes that all parties agreed that cost recovery for supporting the 8-1-1 service should not be charged as a component on carriers' bills, as is presently done for 9-1-1 cost recovery. The Commission determines that the cost for supporting the 8-1-1 service should not be charged as a component on carriers' bills.

71 With respect to cost recovery for calls placed from wireless networks and from pay

. telephones, the Commission notes that in Decision 2004-71, it determined that callers should bear the costs of 3-1-1 calls. For other types of calls (credit card, collect, toll, etc.), the Commission, determined in Decision 2004-71 that cost recovery arrangements should be negotiated between the municipalities and the TSPs, as each municipality would have its own requirements. Consistent with Decision 2004-71, the Commission determines that callers should bear the costs of 8-1-1 calls placed from wireless networks and from pay telephones. For other types of calls (credit card, collect, toll, etc.) cost recovery arrangements should be negotiated between the jurisdictions and the TSPs.

72. The Commission considers that the routing of 8-1-1 calls in areas where the 8-1-1 service is not available has not been clearly described in this proceeding. The Commission is of the view that, in any event, such routing will have to be negotiated between teletriage service providers and any affected TSPs.

73. The Commission notes TELUS's comments that it may be impossible to correctly route 8-1-1 calls that originate from a VoIP terminal. The Commission is of the view that this may well be the case for calls from nomadic VoIP terminals. The Commission notes however, that in *Emergency service obligations for local VoIP service providers*, Telecom Decision CRTC 2005-21, 4 April 2005, the Commission directed the industry to develop interim 9-1-1 call routing solutions for nomadic VoIP services within three months of the date of that Decision. The Commission also directed the industry to resolve any technical and operational issues within CISC. The Commission is of the view that any industry-developed interim call routing solutions for 9-1-1 calls may also be useful for the routing of 8-1-1 calls.

74. The Commission considers that any purely technical issues arising from the implementation of the 8-1-1 service can be addressed by CISC.

Secretary General

This document is available in alternative format upon request, and may also be examined in PDF format or in HTML at the following Internet site:
http://www.crtc.gc.ca

Footnote:

The period between the time a telephone number is disconnected and the time where the same telephone number can be reassigned.

Date Modified: 2005-07-06

Appendix K: N11 Background Information

Increased use of N11 Numbers in Canada and the United States

Service codes, commonly called N11 codes, use three-digit dialing to access special services. The most common assignment of N11 codes in Canada is:

- 211 – Non-emergency health, social and community services information and referral;
- 311 – Non-emergency municipal government services;
- 411 – Local and long distance telephone number directory assistance;
- 511 – Available (may be used for transportation and weather);
- 611 – Telephone repair service;
- 711 – Message relay services (possible);
- 811 – Non-urgent health care telephone triage and information; and
- 911 – Emergency (police, fire, ambulance and other medical emergencies).

There are two significant variances in how the N11 numbers are assigned in the United States. In the US, 211 provides health and social services access as well as information on other community and government services. In the US, 811 is used for information on the location of underground electrical cables and pipelines.

The move to use N11 (3-digit) numbers for health and social services information and triage gained momentum in 1997 with the launch of United Way 211 by the United Way of Metropolitan Atlanta. This was the first time that a three-digit number had been used for community information and referral purposes. In launching these services, the Georgia 211 service was explained to the public as the "…abbreviated dialing code for free access to health and human services information and referral. 211 makes it possible for people in need to navigate the complex and ever-growing maze of human services, agencies and programs. By making services easier to access, 211 encourages prevention and fosters self sufficiency."

In July 2000, the United States Federal Communications Commission (FCC) permanently assigned 211 nation-wide in the United States, Puerto Rico and Washington, D.C. for free access to health and human services information and referral.

The following year, on August 9, 2001 the Canadian Radio-Television and Telecommunications Commission (CRTC) assigned 211 as "a new toll free service that will supply information and referrals about community, social, health and government services." Two national bodies, United Way-Centraide Canada and the Inform Canada Federation are providing leadership for the 211 initiative in Canada. In the intervening years, 211 has gained momentum in Canada.

Subsequently provincial and territorial departments of health across Canada expressed an interest in having a separate N11 number designated for access to health services information and telephone triage. On August 24, 2004, Alberta Health and Wellness applied

to have an N11 number designated for that purpose and subsequently the number 811 was designated by the CRTC for access to "non-urgent health telephone triage services."

At the same time the 211 initiative continued to expand. By the end of 2005, 211 was operating in the Toronto, Edmonton, Calgary, Niagara Region and South Georgian Bay areas. In 2006, the province of Quebec expects to launch the first French language 211 service in the world. Nova Scotia is moving towards a province-wide 211 system as is British Columbia.

Wherever 211 has been established, it is based on a partnership approach. In Canada the two most common partners to government are the United Way and the local Information and Referral Agency (IRA). Usually one of the two takes the lead role and government joins as a funding partner. At present, the BC Government is contributing approximately $2 for ever $1 from the BC NGOs

By the end of 2005, 211 systems were serving 46% of the US population (in 32 States with 14 States having 100% coverage).

Much as 911 revolutionized access to emergency services, 211 and 811 may do the same for access to vital health information and advice, social service information and community resources.

However, implementing 211 is more complex than simply replacing an information and referral service toll free number with a three-digit telephone number. While 211 may be operated with a municipal, provincial or territorial focus, there is a need to work to national service standards, use a common technology infrastructure, and adopt inter-changeable protocols and language to make 211 services cost-effective and consistent. If 811 comes into use across Canada, many of the same considerations will apply to the design and operation of local 811 systems.

Two major 211 studies were completed in 2005 in British Columbia and a number of 811 studies are currently underway in the Northwest Territories, Alberta, Ontario and Nova Scotia. The 211 studies are predicated on the expectation that national standards will be needed. Some of the issues that these studies raise include:

- The development of an inter-operable technology infrastructure;
- The need for both telephone and Internet focused service delivery;
- The potential for collaboration on the development of national resources such as a web site that can be customized with provincial, territorial and local pages;
- Mixed central/local data analysis function;
- Common "brand" standards and marketing strategies; and
- Larger call centres providing backup to smaller centres.

Key N11 Informant Interviews

Howard Research and Outcrop focused its key N11 informant interviews in British Columbia where plans for both 211, and to a lesser degree 811, are well advanced. In BC as elsewhere, 811 and 211 are ultimately about connecting callers to the resources that are most appropriate to their needs.

Currently British Columbia is a Canadian leader in providing residents with non-emergency health triage and information. These services are accessed through a local number in Vancouver area and by a toll-free number in other areas of the province. The health line service which provides non-emergency triage and health information is branded as the BC NurseLine. Its services are available 24/7. Health information is also provided to BC residents through the BC HealthGuide which is cross-promoted with the NurseLine. NurseLine is not intended as a wayfinding service; however it may suggest telephone numbers that callers could use to get specialized information. BC NurseLine does not deal with social service issues.

To assess options for a province-wide 811 system, the BC Ministry of Health is working closely with the Multi-Jurisdictional Steering Committee (MJSC) and has participated extensively in the development of the *Framework for Implementation of 811 Service* produced by Simon Lucas of Lucas & Associates and released on February 27, 2006.

It appears likely that BC will proceed with both 811 and 211 services and could deliver them in a collaborative and complementary manner. The major operating difference between 211 and 811 in BC would likely be that 811 would be delivered as a service of the Department of Health and 211 would be delivered through a partnership of the United Ways of British Columbia, and BC Information and Referral Agencies with the Government of British Columbia as the major funder.

From a caller perspective, the most significant difference would be that BC211 would be a two-tier service using a call centre that would provide wayfinding for the caller to a second tier which would actually deliver the services. 811 on the other hand may, or may not, have a call centre depending on the range of services to be accessed.

If 811 simply provided the same services that are now available through the NurseLine then a call centre would not be necessary. The 811 calls could go directly to the BC NurseLine which is operated by the Department of Health and is located in Burnaby, BC. Currently, the BC NurseLine is planning to broaden the scope of its health services and consideration is being given to changing the name to “BC HealthLines” or “BC HealthLine Services.” These could provide dietician advice as well as the opportunity to speak directly to a pharmacist. . Any new BC811 service would operate 24/7. At present, it is not intended that social services would be available through BC811, except by referral. BC811 calls would be answered by clinical practitioners.

Eventually BC811 could be expanded to provide follow-up services and palliative care support, allowing home care nurses to more efficiently use their time to meet the needs of difficult cases. Reporting hospital bed availability could also be added.

In addition, BC811 could provide informational assistance to health professionals across the province. This would be particularly valuable to nurses in smaller isolated or rural communities by providing the most up-to-date information on best practices.

BC211, on the other hand, would be primarily a province-wide information and referral service. Trained call takers would triage the most appropriate service for the caller and connect them directly to that service or provide contact information and hours of service (if the recommended agency was not available 24/7).

To maintain a high level of standards for both the call centre and its operators, it is anticipated that BC211 would adopt the Association of Information and Referral Services (AIRS) accreditation and certification protocols.

Both BC811 and BC211 are expected to rely heavily on a database that will grow over time and will need to be updated on a regular basis. To be useful, a province-wide database would need to be customized to reflect local conditions, cultures and languages.

From a BC Government perspective, we were told that the commitment to BC211 is part of a much larger commitment to improve citizen access to all government services – not just those of a health and social services nature. Seven ministries in BC that provide services to public have been part of the development of a "Citizen Services Strategy" that has been endorsed by the BC Cabinet. An inter-departmental Working Group (chaired by the Ministry of Labour and Citizen Services) is identifying the best ways to implement the strategy. BC211 is expected to play a pivotal role. Premier Gordon Campbell has publicly expressed strong and ongoing support for BC211.

In the meantime, detailed BC211 implementation planning is proceeding. Five streams have been identified to focus activity:

- Governance – balance between input from the public, agencies and government departments;
- Database Development – gathering, updating and storage of data;
- Business Model – what kind – how to integrate, how to phase in and how to fund;
- Infrastructure – particularly telephony; and
- Communication – communication within agencies, within the N11 community and with the public.

As BC211 is evolving, it is clear there will be opportunities to build on complementary synergies that are expected to develop among all N11 telephone lines. A common database for 211 and 811 may be the first step, with local data partners at the community and regional level having access to the database to post timely changes and updates.

Because of overlaps in caller expectations, there will need to be an easy "hand-off" from 211 to 811, 311 or 911. In non-emergency situations, the point at which the caller accesses the N11 group of numbers may be less important than the ability of all N11 services to have clear, caller-focused protocols that help to get the caller to the resource they need as quickly as possible. As information focused N11 services point out, the ultimate goal is that "Every door is the right door."

Once BC's 211 and possibly 811 systems are up and running there may be opportunities for areas like the Northwest Territories or Yukon to negotiate access to the BC systems, call centre backup and other resources as a "region" attached to the BC system. BC has expressed a willingness to meet with the NWT to explore these possibilities. It is also possible that Alberta may be willing to consider similar access for the NWT if it proceeds with an 811 system.

Potential Impact of 211 on the Development of an 811 Vision

In order to ensure that 211 databases are compatible across Canada, Inform Canada, is leading a Canadian 211 Taxonomy project. Taxonomy is a classification system that allows indexing and access to community resources in a consistent manner. Detailed and descriptive definitions are being developed for each term in consultation with subject area experts. The Canada Taxonomy has approximately 8300 separate terms which are designed with a unique alpha numeric code. This development of common term definitions is intended to reduce confusion in indexing, searching and accessing services. Edmonton and Calgary have already had experience in adapting the Taxonomy to their use. The Canadian 211 Taxonomy is being developed in both English and French.

Status of Canadian 211 Initiatives

The BC211 initiative is a partnership of the United Ways of British Columbia, Information Services Vancouver, BC Alliance of Information and Referral Services, the BC Crisis Lines Association and the Government of British Columbia (as a funder and resource). The goal of BC211 is "connect people to the services they need in order that they can live fuller, healthier lives. BC211 intends to implement this vision by developing "a province-wide interconnected telephone and web system that will provide telephone access to trained 211 specialists and web access to the 211 database of services 24 hours a day, 365 days a year."

In addition to providing services to the public, BC211 intends to provide critical information for use in community services planning, including data on social needs, trends and duplication or gaps in services. BC is striving to be the first jurisdiction in Canada to offer province-wide 211 access. A final implementation plan for BC211 is expected to be ready for presentation to the Union of BC Municipalities Convention in Victoria, October 23 – 27, 2006. The Ministries Labour and Citizen's Services (project lead), Health, Employment and Income Assistance, Children and Family Development, and Public Safety and Solicitor General are working with Community Services in support of BC211 planning.

In Edmonton, the 211 initiative is spearheaded the Community Information and Referral Centre Support Network in partnership with the United Way and the City of Edmonton Community Services. It is primarily a place to connect with local community services, including health services, social services and community programs. The Edmonton 211 vision includes the following components:

- Provides public access to information the public needs by calling one number;
- Available nationally, implemented regionally and locally;
- Provides portability to other regions;
- Makes effective use of existing infrastructure and expertise;
- Built on an inclusive partnership between the United Way, governments and regional partners; and
- Delivered through the management of an integrated data base that will also be available over the Internet.

In Calgary, 211 is described as based on a collaborative approach between the United Way of Calgary and Area, the Distress Centre of Calgary and Family & Community Support

Services. 211 Calgary is operated by an expanded Calgary Distress Centre staff. The United Way and the City of Calgary are the core funders. The service was publicly launched in January 2005. Discussions continue between Calgary and the Province of Alberta on a province-wide 211 roll-out.

With almost a decade of experience, the US provides examples of the most advanced 211 systems in operation. They have had more time to refine their vision. The South Georgia 211 description includes useful references to both 211 accessible services and the purpose of 211 as “the national abbreviated dialing code for free access to health and human services information and referral. 211 makes it possible for people in need to navigate the complex and ever-growing maze of human services, agencies and programs. By making services easier to access, 211 encourages prevention and fosters self sufficiency.”