

Conference Abstracts

INNOVATIVE PRIMARY CARE DELIVERY IN RURAL ALASKA: A REVIEW OF PATIENT ENCOUNTERS SEEN BY COMMUNITY HEALTH AIDES

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Objectives. This study is a systematic description of the clinical practice of primary care health workers in rural Alaska communities. For more than 50 years, Community Health Aides and Community Health Practitioners (CHA/Ps) have resided in and provided care for the residents of their communities. This is the first program review of the scope of medical conditions seen by Alaska's Community Health Workers in their remote communities. Study Design: Retrospective observational review of administrative records for outpatient visits seen by CHA/Ps in 150 rural Alaska communities (approximate population 47,370).

Methods. Analysis of electronic records for outpatient visits to CHA/Ps in rural clinics from October 2004 through September 2006. Data included all outpatient visits from the Indian Health Service National Patient Information Reporting System. Descriptive analysis included comparisons by region, age, sex, clinical assessment and treatment.

Results. 272,242 visits were reviewed. CHA/Ps provided care for acute, chronic, preventive, and emergency conditions at 176,957 (65%) visits. 95,285 (35%) of records did not include a diagnostic code, most of which were medication-related encounters. The most common diagnostic codes reported were pharyngitis (11%), respiratory infections (10%), otitis media (8%), hypertension (6%), skin infections (4%), and chronic lung disease (4%). Respiratory distress and chest pain accounted for 75% of all emergency visits.

Conclusions. CHA/Ps provide a broad range of primary care in remote Alaskan communities whose residents would otherwise be without consistent medical care. Alaska's CHA/P programs could serve as a health-care delivery model for other remote communities with health care access challenges.

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TRUE VALUE AND VALUES THE USE OF AVAILABLE HUMAN RESOURCES TO MEET HEALTH CARE NEEDS. THE COMMUNITY HEALTH AIDE PROGRAM, DENTAL HEALTH AIDE THERAPISTS AND BEHAVIORAL HEALTH AIDES

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The Health Aide program is a realistic approach to providing health care to remote and underserved communities by MD's, PA's, FNP, Dentists, Psychologists and Psychiatrists. The Community Health Aide program development started in the late 1950's in response to the TB epidemic. Because the Members of the medical community were able to recognize the skills inherent in the native and inability to provide care with existing medical models the above programs evolved. The major difference in the method of delivering health care is that it is a system that does with rather than to or for. Members of the native community are able to provide quality care in their home village. This is also a more immediate and cost effective. The effectiveness of the program was recognized on the floor of the Senate S.Res 526 April 22, 2008. The presentation at the Congress would consist of a short history, training, and scope of practice and supervision of each program. This should be followed by Health Aides speaking about why they became Health Aides and what it is like to practice in their village. Other than providing care, another value is the cooperative effort of a group of professionals as a team. This has led to increased respect for individuals having different values and cultures.

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BUILDING A PROGRAM TO SUPPORT NURSING PRACTICE IN REMOTE NORTHERN SETTINGS IN QUEBEC

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The Distant Teaching and Learning Centre (DTLC) was developed in 2010 by The Northern Health Program of The Montreal Children's Hospital to respond to request from remote regional health boards. The DTLC has developed a learning and training program to improve the quality of practice and retention of nurses. The specific goals are to support 5 aspects of an autonomous advanced nursing practice in remote settings: clinical examination, adapted intervention to the realities, clinical monitoring, communication skills and crisis management. Thus far, the program has focused on four domains: first line care, emergencies, woman and child health, mental health. The program is divided into 6 learning modalities adapted to different learning needs, ranges of professional/ personal experiences and technological capacities: 1) Biweekly 2 hours videoconference/webinar sessions, from September to June; 2) A web platform developed as a central communication tool, where e-learning courses, e-forum, documentation and clinical video vignettes can be found; 3) Access to certification in traumatology and emergency care; 4) Clinical practica organized in the settings of operating room, birthing center and emergency department; 5) Northern Days at the McGill Simulation Centre for hands-on workshops; 6) A mentorship program enhancing knowledge exchange between northern and southern clinicians. Up to now, more than 60% (n = 150) of the nurses in these regions have participated in one or more of the activities delivered by the DTLC. Other health and social services professionals have occasionally joined the group. Seventy eight percent of participants found videoconference program relevant to their practice and 73% believed that the content would improve their nursing practice. This presentation will describe the content of the program, preliminary evaluations and plans for a more rigorous evaluation over the next 2 years.

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CULTURALLY AND LINGUISTIC ADJUSTED HEALTH SERVICES FOR THE INDIGENOUS SAMI POPULATION IN NORWAY

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After a 150-year long history with assimilation policy, the legal and political situation for the Sami people in Norway has gradually improved. The Sami Act was passed on in 1987, and in 1989, the first Sami parliament opened. The Sami people obtained formal status as an indigenous population in 1990, the same year Norway ratified the ILO convention no.169. Chapter 25 in the ILO convention states indigenous peoples right to receive culturally and linguistic adapted health services. This right is incorporated in Norwegian legislations like

Patient and user Rights Act, Health Personnel Act and others. Up to the 1950's the life expectancy was shorter and the infant mortality rates was three times as high in the Sami areas in Northern Norway than the mean rates in the rest of the country. This called for better health services in the northernmost region of the country. Today the state of health for Norwegians and Samis is mainly the same. However, the Samis are more dissatisfied with the health services than Norwegians. One reason for this is lack of Sami speaking health personnel and interpreters. Other reasons are probably lack of cultural competence and lack of cultural adjustment in the clinical encounter. To improve the quality of health services to the Sami, it is necessary to increase the cultural competence among health personnel. Working on ones cultural competence is a process that includes both a personal and professional investigation and development. The presentation is based upon a model of cultural understanding that contains of 1) reflection on ones own cultural background, 2) knowledge about the people, culture and area one is working in, and 3) reflection on ones professional background and biomedical knowledge.

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FREQUENT USE OF PRIMARY HEALTH CARE SERVICE IN GREENLAND: AN OPPORTUNITY FOR CASE-FINDING

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Objectives. To estimate the age and gender consultation rates of primary health care service in Greenland and to analyse contact patterns among patients in Nuuk. Study design: Observational and cross sectional register study using data captured from the medical record.

Methods. Age and gender specific number of patients whom had contacted the primary health care centres within the last year were identified using a statistic module in the electronically medical record system. The population as it was 1st of January 2011 was used as background population. The age and gender specific consultation rates were calculated. Review of most recent contact was performed in a subsample of patients from Nuuk and information of the type of contact and diagnoses was obtained.

Results. Eighty-three of the population in Greenland had been in contact with the primary health care centre within one year. Women were more frequent users than males. A subsample of 400 patients in Nuuk was identified. Personal contact was the most frequent type of consultation, followed by telephone and e-mail consultations. Musculoskeletal symptoms accounted for the most frequent diagnoses.

Conclusion. More than eighty percent of the whole population has been in contact with the primary health care system within one year. This indicates that opportunistic case finding of chronic diseases like diabetes, hypertension etc. is a possible strategy in decreasing the number of undiagnosed cases.

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HEALTH & MEDICAL RESPONSE TO THE 2011 KUSKOKWIM RIVER FLOODING IN CROOKED CREEK, AK

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Seasonal flooding of the Kuskokwim River caused partial evacuation of the Village of Crooked Creek in the early hours of May 9th, 2011 to the nearby mining camp of Donlin Creek. Floodwaters displaced a large percentage of residents and created potential health concerns due to contamination from spilled fuel and raw sewage. Utility systems were disrupted for several days leaving residents without power, clean water or communications. A multi-disciplinary team from the Yukon-Kuskokwim Health Corporation including Administration, Community Health Aides, Environmental Health, Nursing staff, Clinical Facilities, Safety, Behavioral Health; Technology, Infection Control, and Pharmacy responded to the health and medical needs of the affected population. A wide variety of services were delivered including needs assessments, health education, vaccinations, chronic medication delivery, health care and emergency medical service, mental health, environmental assessments, and well and septic monitoring and disinfection were provided. The panel will review the flood response objectives and activities performed by the team, the evaluation to the response, and improvements made to Emergency Operations Plan.

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APPLICATION OF QUALITY MEASURES IMPROVES TRANSFUSION SERVICE DOCUMENTATION IN RURAL ALASKA

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Providing transfusion services in rural Alaska presents significant challenges in assuring quality of care and patient safety. These challenges, primarily related to staff turnover, include training and competency, documentation, consent, and others. In April 2010, Maniilaq Health Center (MHC), a 24-bed acute care facility in Northwest Arctic Alaska, initiated a comprehensive quality improvement project to address these challenges. This project

employed key quality tools including brainstorming, Pareto charting, cause and effect assessment, and task sharing to achieve dramatic improvement over 12 months. From August 2007 to April 2010, MHC Laboratory performed quarterly blood utilization review consisting of assessment of laboratory documents and patient charts for all transfusions. Blood utilization averaged 6 units packed red cells/month during this period. Prior to April 2010, significant errors in documentation, defined as violation of organizational procedures and/or accreditation standards pertaining to transfusion records, involved 86% of all transfusions. In April 2010, MHC initiated a quality improvement project designed to significantly reduce these errors. This project engaged multiple stakeholders (e.g., nurses, laboratorians, and providers) to identify root problems, clarify/simplify forms, develop interdepartmental corrective actions, and monitor actions and forms for effectiveness. Implementation of simplified forms and real-time supervision of documentation proved most effective in reducing errors. This process involved alerting a Nurse Educator prior to each transfusion, thereby allowing real-time oversight and review of documentation and timely remedial training. Quarterly review of blood bank records showed dramatic reduction in the rate of documentation errors, from initial involvement of 86% of all transfusions down to 32% per quarter after 6 months and 20% per quarter after 12 months. In conclusion, the use of simplified forms, real-time oversight of documentation processes, and rapid remedial training proves highly effective in improving accuracy and completeness of transfusion records despite high staff turnover.

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FIRST NATIONS GOVERNANCE AND MANAGEMENT OF A REGIONAL PHYSICIAN SERVICES MODEL

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The Sioux Lookout Regional Physician Services Inc. (SLRPSI) is the organization responsible for meeting the medical human resource needs for 28 remote First Nations communities as well as The Meno-Ya-Win Health Centre and the Town of Sioux Lookout and surrounding area. SLRPSI was formed in response to the development of the Anishinabe Health Plan (AHP) which called for a regional primary health system and an improved Physician Services model under First Nations governance and management. This presentation will outline the process used to bring three different physician practices with three different funding models together in a regional model that is governed and managed by First Nations. It will highlight some of the challenges of

moving forward with the implementation of the model, the strategies used to overcome the challenges and lessons learned along the way. The presentation will also address the capacity of the current system and the process currently underway to evaluate the regional physician services model, the activities of the service delivery process, as well as determine/measure/monitor service delivery outcomes that will help demonstrate the program's viability and help determine impact.

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THE CIRCUMPOLAR HEALTH SYSTEMS REVIEW – NEXT STEP

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The Circumpolar Health Systems Review is an Arctic Council authorized project proposed by the Arctic Human Health Expert Group and conducted by an international team of health systems experts from different circumpolar countries. The review covered profiles of the health systems in the northern regions of Arctic States, with special focus on financing, organization and delivery of primary care, hospital services and public health. The impact of geographic isolation, climatic conditions and the proportion of indigenous people in the population is highlighted. Several cross-cutting issues are identified. The next step is to build on this review to study in depth best practices and assess health system performance.

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THE HEALTH CARE REFORM – THE NECESSARY CHANGE

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The health care system is under pressure. The health care system in Greenland has to serve 56,500 people in a country with a coastline of 44,000 km with many small and scattered settlements. The health care system has difficulty in providing Healthcare personnel to outer areas and it seems difficult to get resources to stretch to all services. Meanwhile, citizens and politicians have a number of expectations for the services that the health care system has to provide - exctations that the health care system cannot always meet. The health care system is required by law strive for equal access to health care regardless of residence. This means that citizens so far as is possible in principle should be treated equally whether they live secluded in one of the 64 villages with a settlement consultation or in one of the 17 towns with

a hospital or health care center. Settlement Patterns, ways of living and the technological options have changed a lot since the health care system structure was founded in 1928 and it has therefore been necessary to reform the health care system and the organization has had to adapt to the development of society. The goal of health care reform is that:

- Ensure that the health care system also in the future can deliver a timely service
- Focusing on local health care service to citizens
- Improve patient access to care, regardless of residence
- Improve the quality of treatment and care
- Improve the recruitment of staff
- Utilizing the financial and personnel resources in the best possible way

This is done through the reorganization of the country from 16 health districts to 5 regions, with fewer leaders and more so called warm hands . . . that have direct patient contact. The focus is on telecommunications technology solutions in relation to communication, referral, diagnosis, treatment and follow-up. Functions moving between different personnel groups, up-qualification of staff competencies and education is an essential element in relation to overcoming recruitment problems and working with common guidelines, and further a service catalog, which establishes the health care systems medical services provided to citizens. The reform was implemented in 2010.

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“SÁMI DEARVAŠVUODASIIDA” – BRINGING TOGETHER SPECIALIST HEALTH SERVICES FOR SAMI PEOPLE UNDER ONE ROOF

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“Sami dearvvašvuodasiida” – bringing together specialist health services for Sami people under one roof. Some countries have chosen to organise health services for indigenous people as a separate service distinct from the ordinary health services. The Sami people are an indigenous group residing in the Arctic part of Scandinavia. Norway has chosen to integrate the treatment services provided for the Sami population with the health services provided for the population at large. The Sami National Centre for Mental Health - SANKS and the Sami Specialist Medical Centre, which has specialists in somatic medicine, have been established to achieve the overall national objective of providing equal health services to the Sami population across geographical, linguistic and cultural boundaries. Both institutions are part of Helse Finnmark health trust, but are organised in

two different clinics. Northern Norway Regional Health Authority has earmarked NOK 40 million to bring together the Sami Specialist Medical Centre and SANKS under one roof to create the “Sami dearvvaŠvuodasiida”. In January 2012, Helse Finnmark health trust held a seminar at which relevant experts and partners had an opportunity to discuss what services the Sami should offer and how it should be organised. There was general agreement that collocating “Sami dearvvaŠvuodasiida” specialist health services in one centre will contribute to the provision of a more comprehensive health service for the Sami population. Highly ambulant interdisciplinary teams were emphasized as a good way of reaching patients regardless of their geographical location. This could also lead to better cooperation with partners in the municipalities covered by the services. Organizing services in this way could prevent hospitalizations and contribute to patients being discharged more quickly after hospital stays. The hope is that the responsible regional health authorities and health trusts will support the establishment.

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AYAANGWAAMIZIWIN: A FIRST STEP TOWARD MAKING FIRST NATIONS COMMUNITIES HEALTHIER

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The purpose of this study was to conduct a Public Health Services inventory and comparison analysis in 10 selected First Nations communities in the Sioux Lookout, Ontario region with the data informing the development of a plan for providing culturally appropriate Public Health services in remote First Nations communities. The research tools for the proposed review and comparison analysis were based on Ontario's Public Health Standards and best practices identified from the literature. This format allowed for the comparison of the collected data against current best practice and the Public Health services mandated by the Ontario Health Protection and Promotion Act (HPPA) and delivered by the local Public Health units. Both qualitative and quantitative data were collected and analyzed. Data analysis as well as the literature review was used to support the identification of service gaps for this population in comparison to mainstream provincial services. Interview data from key community informants provided support for the development of an implementation plan for moving forward. The report highlighted the level of systemic neglect displayed by both federal and provincial governments regarding Public Health services for remote First Nation communities. Communities as well as First

Nation's leadership recognize this issue as having a tremendous impact on their health and well-being and are ready to take action to address these issues. This report has been the catalyst for that action in that it provided best-practice evidence to substantiate long-term claims of service inequities and root causes for deteriorating health status.

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ENHANCING TECHNOLOGY UPTAKE IN HEALTH PRACTITIONERS ON FIRST NATIONS RESERVES IN ALBERTA CANADA

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Through the Virtual Communities of Practice project, First Nations and Inuit Health Branch (FNIHB), Alberta is working with the University of Alberta to increase the uptake of health technology on reserve. FNIHB funds and/or provides health services on 45 First Nations in Alberta. Despite initiatives in areas including Electronic Medical Records and Telehealth, eHealth uptake is lower than expected. This presentation summarizes the outcomes of an engagement process intended to accelerate the uptake of health technologies amongst health providers to First Nations living on reserve in Alberta Canada. An Appreciative Inquiry (AI) process was used to engage specific health provider groups. AI is a whole systems approach to change that involves all stakeholders in an organization to uncover the possibilities for change already inherent in the organization. The 23 interview participants were asked to envision how technology could support their work in First Nations communities and to identify their health technology needs. A follow up group session was held to review the results and inspire collaboration and creativity amongst the program areas. The presentation will summarize participant responses by theme. Overall, participants provided positive feedback about the AI process and wanted to use it in an ongoing manner to guide future strategic directions of FNIHB programming. Participants felt that any particular technological solution should not be imposed. Each of the program areas identified specific opportunities for collaboration and those areas are being actively explored today using available technologies. These opportunities include developing communities of practice for self-learning and professional development, and expanding the FNIHB role in clinical telehealth service provision. AI was an effective engagement tool and provided useful information to guide future health technology initiatives.

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TELEMEDICINE IN NENETS AUTONOMOUS OKRUG: CONTEMPORARY REALITY AND FUTURE

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Practical application of telemedicine in the Nenets autonomous okrug (NAO) began in 2000. From 2003, the telemedicine was singled out as structural unit of the Nenets Area hospital. During 11 years, 1819 consultations have been carried out (1139 adults, 680 children), the biggest number was of consulting has been given to adult patients – in cytology, roentgenology, orthopedictraumatology, neurology, thoracic surgery, and to children – in cardiology, orthopedics-traumatology, urology, roentgenology, functional diagnosis, pulmonology. In 2011, as part of the departmental regional target program, 7 district hospitals and 8 ambulatories were equipped videoconference communication and telemedicine. The main purpose of this program is to create a telemedicine network NAO. Our priorities are: active work with medical staff for giving information about possibilities of teleconsultations, introduction in standards of treatment with use of telemedicine, recognition of telemedical consultations by insurance companies, regulation with orders of sending planned patients to the regional medical institutions with preliminary consulting in telemedicine; carrying out of expertise of medical care quality taking into consideration telemedical resources; material and moral stimulation of all participants of the telemedical process. Further development of telemedicine requires joint efforts of authorities, healthcare organizers, specialists in telemedicine and doctors.

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UPDATES ON THE UTILITY OF TELE-HEALTH IN LABRADOR

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Introduction. Telehealth in Labrador was introduced 20 years ago as a store and forward system using the plain old telephone line. For the past 16 years, we have been using real time video and for the past 3 years, we have been using robotic telemedicine.

Results. The advance in tele-health has:

- improved access to physicians;
- improved management of urgent and emergent care;
- improved mental health assessments;
- improved personal interactions between nurse, patient/family and physician;
- improved collaboration amongst health care team;

- improved job satisfaction and decreased job stress amongst physicians and nurses; and
- decreased costs of medical transportation.

Conclusion. Tele-health is now an essential service in our Circumpolar region. It has improved access to care, reduced cost of transportation and provided professional support for health providers in our remote communities.

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“IT CAN’T BE DONE” ... OVERCOMING BARRIERS TO DELIVER DIGITAL X-RAY TO TB CLIENTS IN NAIN, NUNATSIAVUT

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The rate of TB among Inuit Nunangat is 185 times that of non Aboriginal Canadians (PHAC, 2009). In Nain, Nunatsiavut, TB remains endemic. Applying a Social Determinants lens reveals access to healthcare; x-ray in particular perpetuates the challenge to follow Canadian Tuberculosis Standards. In the jurisdictional quagmire that is Public Health in Labrador, TB control is under the province of Newfoundland and Labrador (NL), Primary Care and Communicable Disease Control is with Labrador Grenfell Health and Public Health at the community level is with Nunatsiavut Department of Health and Social Development (DHSD). The current system of flying to Goose Bay from Nain for x-ray requires the client to be away for a minimum of 3 days (weather). This affects compliance and the success of TB elimination goals. The solution is to bring the x-ray to Nain. When first approached, Labrador Grenfell Health said “it can’t be done” ... not willing to accept that, the lobby group persisted with looking at every aspect of the delivery challenge, monies were secured, a new champion in Diagnostic Imaging was found, and the planning began. Months later, in true collaborative spirit, industry, health authority, provincial and Nunatsiavut governments came together and the first ever digital x-ray clinic was held in Nain, followed by a second, months later. The project was a huge success on many fronts. The presenter takes you through the process with words and pictures and outlines both the direct and indirect success outcomes.

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EVALUATION OF PIPALUK

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The Greenlandic population of 56,700 live along a costal line of 44,000 km in 17 towns and 64 settlements. The framework conditions to ensure equal access for

citizens to health care are difficult. Geography, settlement patterns and nature are a challenge in regards to using scarce resources effectively and meeting citizens' desire to receive competent treatment for disease locally. Pipaluk is a telemedicine tool. There is a computer with a number of tools for diagnostics, which provide decision support to the health service staff in relation to being able to provide rapid diagnostic screening and treatment. The project was conducted from February 2008–July 2010. Pipaluk is now established in all towns and settlements with more than 50 inhabitants. There are in total 68 units in towns and settlements on the coast. The primary purpose of Pipaluk is twofold, firstly to ensure better utilization of resources (e.g. better screening, fewer examinations by health staff, faster diagnosis and treatment, shorter waiting time for patients, fewer patient transports) and secondly to ensure an increase in the quality of services of the health care system - particularly through a more equitable access to health care for all citizens. The project thus aims both to optimization of the health care system's resource utilization, and at the societal level's demand for efficiency in the public sector in terms of increased accessibility to health services and ultimately ensure the citizens most health for money.

Evaluation aims to answer two main questions:

- To what extent has Pipaluk helped to ensure a better use of resources and improving the quality of health services?
- What learning can be extracted from the previous implementation of Pipaluk to make the system better?

The learning perspective is central in the evaluation. The assessment of Pipaluk is based on the following six evaluation criteria: Achievement of objectives, organizational implementation, technical implementation, Process, Efficiency, Quality.

The evaluation includes a number of methods such as literature review, stakeholder analysis, interviews, questionnaires, data-/health economic analysis and expert review. Overall, the evaluation will uncover if the project—the implementation of Pipaluk - have helped to ensure a better use of resources and improving the quality of health care systems' services and also what learning can be extracted in order to make the telemedicine system better.

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