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About NLCAHR & CHRSP

The Newfoundland & Labrador Centre for Applied Health Research (NLCAHR) was established in 1999 to contribute to the effectiveness of the health and community services system of the province and to the physical, social, and psychological well-being of its population. NLCAHR accomplishes this mandate by building capacity in applied health research, by supporting high-quality research, and by fostering more effective use of research evidence by decision makers in the province’s healthcare system.

In 2007, NLCAHR launched the Contextualized Health Research Synthesis Program (CHRSP) to provide research evidence that would help guide decision makers in the provincial health system on issues of pressing interest and concern to them. Topics for study are proposed to CHRSP researchers by health system decision makers and front-line workers from across the provincial healthcare system with the final priorities being voted on by the leaders of the province’s six healthcare organizations: Deputy Ministers of the Department of Health and Community Services, and the Department of Children, Seniors, and Social Development and CEOs of the four Regional Health Authorities. The annual topic selection process yields roughly five research projects per year. To date, CHRSP has published over 25 research reports.

Rather than conducting original research, CHRSP analyzes the findings from high-level research that has already been published in the subject area. The published research is assessed for quality and the findings from different studies are put together, or synthesized, to come up with a list of key findings that will tell decision makers what the research has to say about the topic.

Once CHRSP has answered the question, “What will work?” we then ask “Will it work here?”

Because the original research will typically have been carried out elsewhere, CHRSP asks provincial health system and community partners whether there are any local issues that might have an impact when applying the findings here in Newfoundland and Labrador, recognizing that something that worked well in a large hospital in New York might not be as feasible in Wabush. This process of “contextualization” is the key to CHRSP’s success—it allows decision makers to attune the research findings to their own unique situations.

We then combine the synthesis findings with the contextualization findings to develop a list of implications for decision makers. CHRSP prefers to use the term “implications” rather than “recommendations” because we recognize that evidence is one of several inputs that health system decision makers need to consider when developing health practices, programs, and policies. CHRSP presents a set of issues decision makers should consider, rather than asserting which options they should choose. As a result of our collaborative methods and our ability to attune the research to the local context, the program has been successful—reports produced by CHRSP have actually been used to develop new practices, programs and policies in Newfoundland and Labrador—for researchers, this key goal— bringing research into practice, has been achieved through CHRSP.
About the CHRSP Patient & Caregiver Advisory Council
As noted above, NLCAHR has a well-established partnership with the provincial health system. Working closely with key stakeholders from the four provincial Regional Health Authorities, the Department of Health and Community Services, and the Department of Children, Seniors and Social Development, we have developed an inclusive process to support evidence-informed decision making in health. We have now come to recognize that our research could be even more inclusive. CHRSP can be strengthened further by adding a critical dimension to our collaboration—the perspectives of patients and caregivers. In consultation with our healthcare system, NLCAHR has developed a new Patient and Caregiver Advisory Council (PCAC) in recognition of the value that patients and caregivers will add to the CHRSP research process—as collaborators who can help our researcher and health system partners to develop a better understanding of the unique issues and concerns that face patients and caregivers in Newfoundland and Labrador. Members of PCAC will contribute to the CHRSP research process in a variety of ways that are outlined in this handbook. Please see Appendix “A” of this Report for the PCAC Terms of Reference and Confidentiality Policy.

The Composition of the Council
NLCAHR carried out a public outreach campaign in 2017 to recruit volunteers for the 2018-2019 CHRSP Patient and Caregiver Advisory Council (PCAC). We advertised and sent direct email to our contacts in the community; in response, we received applications from a wide variety of community members from across the province. Applicants for these volunteer positions were interviewed and the first 11-member PCAC was established in Fall 2017. Members were selected on the basis of having lived experience as a patient or caregiver, having an interest in research and in the use of research to support decision making, and having both the willingness and the time to respond in a timely manner to requests to review research materials and to offer feedback. Our 2018-2019 Council includes members who live within all four Regional Health Authorities and who will bring a diverse range of perspectives about health and healthcare from across Newfoundland and Labrador.

The 2018-2019 CHRSP Patient & Caregiver Advisory Council:

**Judi Burgess**  
St. John’s | Eastern Health RHA

**Brenda Critchley**  
Sandringham | Central Health RHA

**Jon Dalton**  
St. John’s & Fogo Island | Eastern Health RHA

**Myra Dean**  
Botwood | Central Health RHA  
Previous experience in Labrador Grenfell RHA

**Edie Newton**  
St. John’s | Eastern Health RHA

**Paula Rolfe**  
Corner Brook | Western Health RHA

**Ian Simpson**  
Corner Brook | Western Health RHA

**Janet Skinner**  
Happy-Valley-Goose Bay | Labrador Grenfell Health RHA

**David Tutton**  
Holyrood | Eastern Health RHA
Roles & Activities of the PCAC
Because both CHRSP and the Council will need time to get to learn from each other as a key part of this process, we will work with the Council to ensure that the process is respectful of your time and that we do not over-burden the membership. **We plan to phase in the responsibilities of the PCAC members incrementally, over a two-year term.**

Year One will involve mutual orientation and training (we will teach you about CHRSP and we will learn more about your interests and perspectives) and a stepped approach to taking on roles in CHRSP studies, including having PCAC members review CHRSP reports as they are released. When the Council is ready to contribute, we will ask some members to consult with us on new projects or to recommend other patient/caregiver partners with whom we might consult. In Year Two, we foresee building more PCAC involvement, including having the PCAC review and vote on topics submitted by the healthcare system. In following years, we foresee having the Council submit topics for possible study.

This collaboration should require no more than 15 hours of your time in any given year. The details of what you can expect in each year of service on the Council are itemized in the sections below. In general terms, you will:

- Commit to a two-year term of service.
- Participate in two training sessions in Year One, including an orientation session on the CHRSP research process and a training session on topic selection.
- Participate in no more than one specific project team per year, either as a project team member or as a consultant on contextual issues.
- Be invited to read completed research reports and tell us what you think, most especially to help us develop more “user-friendly” language and formats for our reports.
- Be invited to meetings at which we present our reports to the public.
- Participate in two meetings in Year Two, including a topic selection meeting and a succession planning meeting.
- Work with CHRSP in Year 2 to identify and select research topics.

To thank you for your service, your will receive a modest stipend of $200.00 at the end of each year of service to the Council.

Timeline for PCAC Activities
Year One: Getting Started: 2018

In the first year, PCAC members will attend two training meetings and will be invited to participate in the research process in a variety of ways, according to your interests and availability.

- **Orientation Meeting | March 9, 2018**
  You will attend an orientation session, in person or by webinar, to learn about the CHRSP research methodology. You will review past CHRSP projects and find out about the program’s current research agenda. You will have an opportunity to tell us more about your interests and experiences.

- **March to December, 2018**
  The PCAC will support CHRSP research projects in the following ways:
  - All members will be sent copies of studies once they are published, so you can keep up-to-date on our work and provide feedback. (Please note that most CHRSP reports are quite brief—10-40 pages.)
  - All members will be invited to CHRSP dissemination events (in person or by webinar) for completed CHRSP studies.
  - Some members will be asked to join a CHRSP project team, based on your interest and availability.
  - Some members will be interviewed about contextual considerations for ongoing studies.

- **Meeting | October 2018 (Date TBA)**
  You will attend a training session on how to choose topics for CHRSP.

Year Two: Continuing Research Support & Topic Selection: 2019

In its second year, the PCAC will support CHRSP through continuing involvement in studies initiated in Year One with the additional role of contributing to the topic selection process for new CHRSP projects.

- **January to March 2019**
  The PCAC will contribute to the 2019 topic selection process for new CHRSP studies by helping to refine the topics put forward by the healthcare system to ensure that issues of value to patients and caregivers are included in the research.

- **Meeting | March 2019 (Date TBA)**
  The PCAC will meet to review and provide feedback and vote on topics proposed for the 2019-2020 round of CHRSP studies.

- **January to December 2019**
  The PCAC will continue to support CHRSP research projects in the following ways:
  - Continue working on teams and consulting on studies that are carried over from Year One, as required.
  - All members will be sent copies of completed studies to keep you up-to-date on our work and offer you the chance to give us feedback.
  - All members will be invited to CHRSP dissemination events (in person or by webinar) for completed CHRSP studies.
Some members will be asked to join a CHRSP project team, based on interest and availability.

Some members will be interviewed about contextual considerations for ongoing studies.

- **Succession Planning Meeting | Fall 2019 (Date TBA)**
  Succession Planning Meeting to review activities, evaluate success, decide on next steps.

**Support for the Council’s Activities**
As a member of the 2018-2019 Patient and Caregiver Advisory Council, you will be provided with an orientation session in March 2018 and with this Handbook and other tools to assist you, as required. The CHRSP PCAC Coordinator is Sarah Mackey. She, and other members of the staff at NLCAHR, are available to support you and to provide information and training, as you may require.

**NLCAHR Contact Information**

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CHRSP Products: Three Report Formats

CHRSP supports informed decision making in healthcare by producing relevant and timely research reports on priority topics that have been identified by our health system partners. CHRSP does not conduct original research, but rather analyzes the findings of high-level research literature that has been published on the issue in question. CHRSP produces three kinds of studies, which are described below.

The PCAC will actively participate in our “gold standard” Evidence in Context projects. Your specific roles are outlined in the following section. Rapid Evidence or Snapshot Reports are not produced collaboratively; the PCAC’s role for these reports would be limited to reading/reviewing completed studies.

Evidence in Context Report (EIC) To produce an EIC report, a research project team, including health system partners, academic researchers, national/international subject experts and now patient/caregiver partners is assembled. The team will publish a 30-60 page, fully contextualized evidence synthesis and release the research results in three formats: a full report, a 4-page summary and a briefing note for decision makers. An EIC Report takes 9-12 months to complete starting with the first team meeting. An EIC Report provides a comprehensive overview and quality assessment of the available scientific evidence on the topic under study. The evidence is gathered, assessed and then synthesized. Then, the team carries out a series of detailed interviews with healthcare and community...
stakeholders from across the province to contextualize the key findings to uncover the implications of the local context on how the evidence may or may not be adapted for use in local settings.

**Rapid Evidence Report (RER)** If decision makers need information more quickly or if they do not require a full evidence synthesis or contextual analysis, or in situations where there is not sufficient literature to conduct an EIC for the topic in question, the *Rapid Evidence Report* provides decision makers with a 10-15 page evidence summary, completed within 45 working days after agreement has been reached on the research question. The RER includes a basic overview of the state of the evidence on a given topic, an assessment of the quality of the available evidence, and a list of some factors that may impact the implementation of the research findings in Newfoundland and Labrador.

**Snapshot Reports** In some cases, decision makers seek information about health practices, programs, models, or policy approaches that have been tried in other jurisdictions and that might be considered for adaptation in the province but that have not yet been the object of extensive scientific study. CHRSP has recently developed a new product to provide decision support in such cases. The *Snapshot Report* provides decision makers with a brief overview of practices and policies that have been implemented in other select jurisdictions so that NL policy makers can consider a set of potential options as they develop new policies and programs for use here. A Snapshot Report does not involve researching the scientific evidence; rather, it is intended to be a catalyst for further study that will be based on models or approaches that have been tried elsewhere and that might be considered for implementation in NL.

**CHRSP Methods & Your Role as a PCAC Member**

Engaging directly with the province’s healthcare system, CHRSP takes a collaborative approach to make sure our research studies address priority concerns for decision makers in Newfoundland and Labrador. The Canadian Institutes of Health Research call this methodology *integrated knowledge translation* because knowledge users and knowledge producers work together throughout the research project. Please see Appendix “C” to learn more key concepts and terms used in health research.
Step 1: Engage Partners/ Select Topics: Every year, CHRSP consults with the top leaders of the six health system organizations in Newfoundland and Labrador (i.e., the Department of Health and Community Services, the Department of Children, Seniors, and Social Development, and the province’s four Regional Health Authorities) to find out what research evidence would be useful to them, seeking those topics for which evidence is needed to help inform a pending healthcare decision. Participating in this topic selection process are senior decision-makers within the six stakeholder organizations, our CHRSP Champions, who link us to fellow decision-makers and facilitate topic identification and selection for our annual roster of CHRSP Projects. Please see Appendix “D” for more information about our partners in the provincial healthcare system.

Where does the PCAC come in? Starting in 2019, we will ask members of the Patient/Caregiver Advisory Council to review the long-list of topics supplied by the health system partner and provide feedback on the topics and suggest modified wording. In years to come, we will have Council members propose topics for CHRSP study.

Step 2: Set Priorities: Once potential research topics have been identified, the initial long list of topics is filtered down to the top five-to-seven topics. CHRSP then meets with all six provincial Health System Leaders (i.e., the Deputy Ministers and the Chief Executive Officers) to clarify and prioritize all proposed research topics. With the Health System Leaders, we determine which topics should be studied as Evidence in Context Reports and which should be examined using the Rapid Evidence Report approach.

Where does the PCAC come in? In 2019, we will ask members of the Patient/Caregiver Advisory Council to vote on topics submitted by our healthcare system; in years following that, the Council will both submit and vote on the topics for study.

Step 3: Build a CHRSP Project Team: For each topic selected, a CHRSP Project Team is assembled. The Project Team Leader is chosen on the basis of national and/or international expertise in the subject area. The CHRSP Project Team typically includes:

- A Team Leader (subject expert)
- A Health System Leader (i.e. The Deputy Minister, a Regional Health Authority CEO, or their delegate)
- A Health Economist (where required)
- The CHRSP Program Coordinator
- A CHRSP Project Coordinator
- A CHRSP Research Assistant
- Local co-investigators from within the province's healthcare system
- Local academic co-investigators
- Local context advisors
- As necessary, experts in research synthesis methodology.

Where does the PCAC come in? Starting in 2018, one member of the Patient/Caregiver Advisory Council will serve on each CHRSP EIC project team; in addition, the Council will be asked to recommend one additional patient or caregiver with specialized knowledge on the issue to join each CHRSP EIC project team.
Step 4: Locate, Assess, and Synthesize Evidence: Once the CHRSP Project Team has been brought together, CHRSP researchers will locate, assess, and synthesize the available research evidence. The Team devises an appropriate search strategy and conducts rigorous electronic and hand searches of periodical indexes and databases to identify relevant evidence. Relevant evidence for a CHRSP project includes high-level research, such as systematic reviews, meta-analyses, and health technology assessments and high-quality primary studies published too recently to have been included in the high-level review literature. Evidence may also include relevant unpublished literature, government documents, etc. known as "grey literature." Once relevant research materials have been collected, the team critically appraises and summarizes the evidence in terms of its quantity (i.e., we assess whether there is ample evidence on which to base a report) and its quality (i.e., we rate its methodological rigour using validated assessment tools).

Where does the PCAC come in? The Council members who are on the EIC project team will receive the summarized evidence for their review.

Step 5: Set the Evidence in Context: While the research evidence is being located and assessed, contextual variables must also be considered. Contextual factors may increase or decrease the positive health impacts or cost-effectiveness of an intervention that was reported in the research literature. These variations in effectiveness result from differences between the research settings and local conditions in Newfoundland and Labrador. For instance, interventions that work well in large urban centres may not translate well into a rural Newfoundland setting. The CHRSP Project Team tailors its synthesis to the local context at every stage of the project. Contextual considerations may include: patient populations, sites of service and/or the service design, health human resources, organization and delivery of services, health economics, and politics. See Appendix “B” for more details about our process of contextualization.

Where does the PCAC come in? In addition to the people serving on the project team, the full Patient/Caregiver Advisory Council will be asked to review the report and offer comments as to how the report can be contextualized to include the perspectives of patients and caregivers in this province.

Step 6: Interpret the Evidence: Once the literature has been located, assessed, and synthesized, the Team Leader will review the report and provide guidance in interpreting the evidence; the CHRSP Project Team will then develop a summary of implications for decision makers to consider. The full report will then be drafted.

Where does the PCAC come in? The Implications for Decision Makers section of the report will be presented to the co-chairs of the Patient/Caregiver Advisory Council for review, interpretation and assistance with knowledge translation.
Step 7: Review, Report, and Disseminate: Finally, the CHRSP study will be reviewed by an external subject expert or experts; the results of the external review will be incorporated into the document, which will then be reviewed and edited by the CHRSP Project Team, finalized, and shared. Evidence in Context Reports include a full report (35-50 pages), an executive summary, a lay summary, other multimedia products, and online companion documents, as applicable. All CHRSP reports are disseminated through face-to-face meetings that are attended in-person or by video conference and that include the Project Team, together with health system stakeholders, decision-makers, relevant community groups, academics and clinicians who share an interest in the topic.

Where does the PCAC come in? The Patient/Caregiver Advisory Council will be invited to attend the dissemination meeting with our health system partners and will help us disseminate a user-friendly summary of the completed CHRSP report to relevant contacts among patient and community groups.

Completed, Current, and Future CHRSP Studies

Completed Evidence in Context Reports
- Exercise Interventions for Long-Term Care (2017)
- Reducing Acute Care Length of Stay (2017)
- Prevention and Screening for Type 2 Diabetes (2016)
- Supporting the Independence of Persons with Dementia (2015)
- Troponin Point-of-Care Testing (2014)
- Agitation and Aggression in Residents with Dementia in LTC (2014)
- Fall Prevention for Seniors in Institutional Healthcare Settings (2014)
- Community-Based Service Models for Seniors (2013)
- Telehealth for Specialist-Patient Consultations (2013)
- Updated Evidence on Rural Dialysis Services (2013)
- Age-Friendly Acute Care (2012)
- Chronic Disease Management (2012)
- Youth Residential Treatment (2010)
- Reuse of Single-Use Medical Devices (2010)
- Childhood Overweight and Obesity (2009)
- PET-CT in Newfoundland and Labrador (2009)
- Options for Dialysis Services in Rural and Remote NL (2008)

Completed Rapid Evidence Reports
- Mental Health Units in Acute-Care Facilities (2017)
- The Effectiveness of Digital Surveys for Collecting Patient Feedback (2016)
- Reducing Wait Times for Outpatient Services (2016)
- Ambulatory Care Services for Patients with Chronic Heart Failure in Newfoundland and Labrador (2013)
- Flu Vaccination for Healthcare Workers in Newfoundland and Labrador (2013)
Mobile Mental Health Crisis Intervention in the Western Health Region of Newfoundland and Labrador (2012)

Safe Patient Handling Programs and Injury Prevention for Eastern Health in Newfoundland and Labrador (2012)

### Completed Snapshot Reports

- Identifying behaviours that place school aged children and youth at risk for poor health outcomes (2017)

### Current Projects

Our researchers are now working on these projects:

**An Evidence in Context study on Barriers and Facilitators to Care Transitions:** “What does the scientific evidence tell us about barriers and facilitators to effective handover/handoff of care between health care providers during transitions of care?” (Project started in October 2017)

**A Rapid Evidence Report on Palliative Care for People with Chronic Disease:** "Is there reliable evidence that can demonstrate how chronic disease management and palliative/end of life care can interact effectively to address client-centred care that can be considered relevant for our Newfoundland and Labrador context (geography, demographics, fiscal constraints, rural nature)?" (Project started in December 2017)

**A Snapshot Report on Rural Psychiatry Services:** “What practices and models for the delivery of psychiatrist services in rural regions have been implemented within other Canadian healthcare settings?” (Project started in February 2018)

### Future Studies:

The NL Healthcare system selected the following topics for CHRSP study in the 2018 topic selection process:

**EIC / RER Reports, in order of priority**

- Preschool Screening: For which growth and development issues should the preschool population of NL be screened, based on scientific evidence?
- Experiences in Palliative Care: Home vs. Healthcare Settings: What are the experiences of patients and families who utilize a palliative/end-of-life program for a death at home compared to the experiences of those who utilize these services within a healthcare facility?
- De-Prescribing Medications: What approaches to de-prescribing medications could be used effectively to improve health outcomes and cost-effectiveness in community, acute care, and long term care settings?
- Centralizing vs. decentralizing high-risk, low-volume obstetrics and pediatric services: What does the evidence tell us about the effectiveness of centralized vs. decentralized provision of low volume, high risk acute care obstetrics and pediatric services in rural sites?
• Advance Care Paramedics (ACPs) in Rural Settings: Does the use of ACPs in rural practice improve quality of care, morbidity, and mortality?

Snapshot Reports, in order of priority

• Remote Patient Monitoring: How have other jurisdictions integrated remote patient monitoring into existing models of care to ensure continuity and improved patient outcomes for those individuals with chronic disease/complex care challenges in patient/client homes and personal care homes?
• Home Dialysis: What home dialysis programs have been implemented in other jurisdictions to improve health outcomes/quality of life and increase healthcare efficiencies for renal patients of all ages in acute and community care settings?

Find out More CHRSP Information Online

Detailed information about our current and pending projects, completed reports, research methods, etc. is available on our website:

About CHRSP: http://www.nlcahr.mun.ca/CHRSP/

Completed studies: http://www.nlcahr.mun.ca/CHRSP/CompletedCHRSP.php

Method for the EIC: http://www.nlcahr.mun.ca/CHRSP/CHRSPMethods.php

Method for the RER: http://www.nlcahr.mun.ca/CHRSP/RER.php
Appendix “A” PCAC Terms of Reference and Confidentiality Policy

CHRSP Patient Caregiver Advisory Council
Terms of Reference

Purpose
The Patient and Caregivers Advisory Council has been created to engage patients and caregivers in the activities of the Contextualized Health Research Synthesis by incorporating their perspectives in its processes and products.

Membership
Members of the council will be:
- 8 to 12 patient and caregiver representatives
- 1 CHRSP staff to act as Patient and Caregiver Advisory Council coordinator
- 1 Director of the Newfoundland and Labrador Centre for Applied Health Research

Members’ Responsibilities
- Commit to a term of two years of service on the Council.
- Participate in an orientation session on the CHRSP process. Participation can be either in person or by webinar.
- Engage with the annual topic selection process by designating one member to represent the Council in the process and advising that representative on preferred topics for study.
- Participate in one project team per year to help interpret research findings and provide input into the resulting recommendations.
- Review several draft reports per year and provide feedback as necessary.
- Participate in meetings at which our reports are presented to the public.
- Your participation in the Council should require no more than 15 hours of your time in any given year of your two-year term

Term
Members will serve for a two-year term, renewable once.

Selection
Council members are selected by the Patient and Caregiver Advisory Council Coordinator in consultation with the Director of NLCAHR and CHRSP staff to include both patients and volunteer caregivers and a broad range of criteria such as age, gender and geographic location. Members are expected to seek to represent the perspectives of patients and caregivers in general rather than of any specific grouping or organization.

General Requirements
- Attend a teleconference to discuss the qualifications and requirements for participating as a council member
- Sign a waiver, sign a confidentiality agreement and read a conflict of interest agreement
- Attend an orientation session
- Read and respond to emails in a timely manner
Reimbursement and Compensation
A stipend of $200 will be paid to each Council member at the end of each year of service.

CHRSP Patient Caregiver Advisory Council
Confidentiality Policy

Oath of Confidentiality and Statement of Understanding
I understand that, except as specifically authorized by NLCAHR staff, the contents of all internal discussions, drafts and reports to which I have access as a member of the Patient and Caregiver Advisory Council are strictly confidential, and must be treated as such until a final project report has been released on the NLCAHR website.
Appendix “B” Setting Research Evidence in Context

While the research evidence is being located and assessed, contextual variables must also be considered. Contextual factors may increase or decrease the positive health impacts or cost-effectiveness of an intervention that was reported in the research literature. These variations in effectiveness result from differences between the research settings and local conditions in Newfoundland and Labrador. For instance, interventions that work well in large urban centres may not translate well into a rural Newfoundland setting. The CHRSP Project Team tailors its synthesis to the local context at every stage of the project. Contextual considerations may include: patient populations, sites of service and/or the service design, health human resources, organization and delivery of services, health economics, and politics.

Contextualization in CHRSP Projects
A CHRSP project will address two fundamental questions: “What works?” and “What will work here?” These questions may refer to any kind of intervention—a treatment, a health service, a program of services or an approach to resolving a problem or a policy. The first question will be familiar to most people working in healthcare; however, the question of context, the matter of whether an intervention will work here, may be new to many.

What works?
A CHRSP project is based on a synthesis of research-based evidence. The evidence included in a CHRSP project is mainly high-level research such as systematic reviews, meta-analyses and health technology assessments—research that combines the findings from individual studies (i.e., "primary research"). On occasion, a CHRSP project may also include evidence from very recently conducted high-quality primary research that will not have been captured by the existing systematic review literature.

What will work here?
The analysis in a CHRSP project includes not only synthesizing the findings of the scientific literature but the 'contextualization' of the synthesis results. Contextualization is the interpretation of the project findings in consideration of characteristics and capacities of Newfoundland & Labrador. Since most research evidence will have been generated in places that are quite different from our province, it is not always the case that the research results can be directly applied here. Local characteristics, capacities and qualities that may have an effect on the research evidence are called 'contextualization factors.'

Contextualization factors
Contextualization factors are typically grouped as follows:

- **Patient-client factors**
  - Do the geography and demographics of Newfoundland & Labrador (where the patient-client populations live) have an impact on the expected cost-effectiveness of the studied intervention/approach?
  - Are there cultural elements that may enhance or detract from the expected clinical effectiveness of the studied intervention?

- **Design or site-of-service factors**
  - Will the location for the site of the proposed intervention make it difficult for the approach to work effectively?
Is the design of the services feasible in the context of the existing infrastructure within some or all of Newfoundland & Labrador’s Regional Health Authorities?

- **Human resources factors**
  - Does the province have the number of appropriately trained and qualified practitioners, at present, needed to provide the service in question?
  - Could the province fill any HR gaps by providing the training required to enable available practitioners to deliver the service in question?

- **Organization of health services factors**
  - Will the organization of existing and related front-line health services accommodate or conflict with the studied intervention/approach?
  - Can the existing management organization incorporate the studied intervention, or will a significant reconfiguration be required?

- **Other department, organization or system factors**
  - Does the intervention in question require information or action from other government departments or provincial organizations, and will that information or action be available?
  - Does the intervention in question require resources that are allocated by other government departments or provincial organizations?

- **Economic factors**
  - Are the existing financial incentives in the province consistent with those of the studied intervention?
  - How will the geographic features of the province and the existing distribution of incomes affect the feasibility of delivering the studied intervention?

- **Political factors**
  - What are the public and media expectations for the intervention? Are they realistic?
  - Is an intervention required as the result of a governmental decision or political pressure?

These contextual factors speak to three aspects of the question "what will work here?"

1. A factor may have an impact on the health equity of an intervention, which is the differential effectiveness of an intervention for different sub-groups in the population.
2. A factor may have an impact on the feasibility of implementing an intervention.
3. A factor may have an impact on the acceptability of an intervention from the perspective of relevant stakeholders.

The equity, feasibility and acceptability of an intervention are critical considerations for decision makers. Significant problems in any of these areas can change the perceived suitability of a treatment, health service or health policy. Conversely, an intervention with particular strengths for key sub-groups of the population, with technical requirements that are already in place or that are easily integrated into existing professional and patient/client patterns of behaviour, could be seen as more attractive.

All of the foregoing factors must be considered in order to place research evidence in context for Newfoundland and Labrador.
Appendix “C” Key Concepts in Applied Health Research

The following is a basic overview of the key concepts and terms you will encounter as you work with us.

Applied health research is different from ‘fundamental’ (bio)medical research because it is not just scientific research— instead it has two missions, both scientific and societal. Applied health research is explicitly concerned not only with scientific knowledge but also with the usefulness and implementation of scientific achievements. So, relevance to society, and more specifically in our case, to healthcare systems, is an important explicit objective of applied health research.

You will encounter many of the following common acronyms, abbreviations, and terminology as you develop your knowledge of applied health research and knowledge translation as a PCAC member.

### Acronyms and Abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHR</td>
<td>Applied Health Research</td>
</tr>
<tr>
<td>AMSTAR</td>
<td>Assessment of Multiple Systematic Reviews (see glossary for definition)</td>
</tr>
<tr>
<td>ARNNL</td>
<td>Association of Registered Nurses of Newfoundland and Labrador</td>
</tr>
<tr>
<td>CNA</td>
<td>Canadian Nurses Association</td>
</tr>
<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>CH</td>
<td>Central Health</td>
</tr>
<tr>
<td>CIHI</td>
<td>Canadian Institute for Health Information</td>
</tr>
<tr>
<td>CHRSP</td>
<td>Contextualized Health Research Synthesis Program</td>
</tr>
<tr>
<td>DHCS</td>
<td>Department of Health and Community Services (Government of Newfoundland and Labrador)</td>
</tr>
<tr>
<td>DCSSD</td>
<td>Department of Children Seniors and Social Development</td>
</tr>
<tr>
<td>DM</td>
<td>Deputy Minister</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>EH</td>
<td>Eastern Health</td>
</tr>
<tr>
<td>EIC</td>
<td>Evidence in Context Report (CHRSP Product)</td>
</tr>
<tr>
<td>EIDM</td>
<td>Evidence-Informed Decision Making</td>
</tr>
<tr>
<td>EIHP</td>
<td>Evidence-Informed Health Policy</td>
</tr>
<tr>
<td>LGH</td>
<td>Labrador Grenfell Health</td>
</tr>
<tr>
<td>HSL</td>
<td>Health System Leader</td>
</tr>
<tr>
<td>HSP</td>
<td>Health System Partner</td>
</tr>
<tr>
<td>IKT</td>
<td>Integrated Knowledge Translation</td>
</tr>
<tr>
<td>KS</td>
<td>Knowledge Synthesis</td>
</tr>
<tr>
<td>KT</td>
<td>Knowledge Translation</td>
</tr>
<tr>
<td>MeSH</td>
<td>Medical Subject Headings</td>
</tr>
<tr>
<td>MUN</td>
<td>Memorial University</td>
</tr>
<tr>
<td>NL</td>
<td>Newfoundland and Labrador</td>
</tr>
<tr>
<td>NLCAHR</td>
<td>Newfoundland and Labrador Center of Applied Health Research</td>
</tr>
<tr>
<td>RCT</td>
<td>Randomized controlled trial</td>
</tr>
<tr>
<td>RER</td>
<td>Rapid Evidence Report</td>
</tr>
<tr>
<td>RHA</td>
<td>Regional Health Authority</td>
</tr>
<tr>
<td>REG</td>
<td>Research Exchange Group</td>
</tr>
<tr>
<td>SE</td>
<td>Subject Expert for a CHRSP study</td>
</tr>
<tr>
<td>SR</td>
<td>Systematic Review</td>
</tr>
<tr>
<td>WH</td>
<td>Western Health</td>
</tr>
</tbody>
</table>
## Glossary of Key Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AMSTAR</strong></td>
<td>Assessment of Multiple Systematic Reviews: an 11-item instrument used to assess the quality and methodological rigor of systematic reviews.</td>
</tr>
<tr>
<td><strong>Downs and Black Assessment Tool</strong></td>
<td>A checklist that was developed to assess the methodological quality of both randomized controlled trials and non-randomized studies.</td>
</tr>
<tr>
<td><strong>Health Technology Assessment</strong></td>
<td>Research that studies the medical, social, ethical and economic implications of the development, diffusion, and use of health technology.</td>
</tr>
<tr>
<td><strong>Heterogeneity</strong></td>
<td>Used to describe the consistency or variation between studies contained within our analysis. The degree of heterogeneity can be quantified on various indices and can be tested with statistical tests.</td>
</tr>
<tr>
<td><strong>IKT (Integrated Knowledge Translation)</strong></td>
<td>IKT is an approach to doing research that applies the principles of knowledge translation (see definition below) to the entire research process. The central premise of IKT is that involving knowledge users as equal partners alongside researchers will lead to research that is more relevant to, and more likely to be useful to, the knowledge users. Each stage in the research process is an opportunity for significant collaboration with knowledge users, including the development or refinement of the research questions, selection of the methodology, data collection and tools development, selection of outcome measures, interpretation of the findings, crafting of the message and dissemination of the results. CHRSP is an IKT program.</td>
</tr>
<tr>
<td><strong>Knowledge Translation</strong></td>
<td>The Canadian Institutes for Health Research (CIHR) defines Knowledge Translation as a dynamic and iterative process that includes synthesis, dissemination, exchange and ethically-sound application of knowledge to improve the health of Canadians, provide more effective health services and products, and strengthen the healthcare system. This is by no means a simple process and involves a range of interactions between researchers and knowledge users that may vary in intensity, complexity and level of engagement depending on the nature of the research and the findings as well as the needs of the particular knowledge user.</td>
</tr>
<tr>
<td><strong>Meta-Analysis</strong></td>
<td>A type of synthesis that uses statistical techniques to quantitatively combine the findings from primary research studies. A meta-analysis may or may not be applied to a systematic review of the literature.</td>
</tr>
<tr>
<td><strong>Primary Research</strong></td>
<td>Research that involves the collection and analysis of data from actual participants, as opposed to the combination of such research (i.e., higher level studies) or secondary analyses of previously collected data.</td>
</tr>
<tr>
<td><strong>Randomized Controlled Trial</strong></td>
<td>A type of primary research in which participants are randomized with regard to treatment, with the objective of eliminating confounding factors that may exist among the participants.</td>
</tr>
<tr>
<td><strong>Systematic Review</strong></td>
<td>A literature review that tries to identify, select, appraise, and synthesize published and unpublished research evidence relevant to some specific research question.</td>
</tr>
</tbody>
</table>
Appendix “D” The Healthcare System in Newfoundland and Labrador
Healthcare in The Newfoundland & Labrador is delivered by four Regional Health Authorities under the legislative mandate of the Department of Health & Community Services. The Department of Children, Seniors, and Social Development has a mandate for some health service delivery/wellness programming.
Key Organizations in Newfoundland & Labrador Healthcare

The Department of Health and Community Services provides a leadership role in health and community services programs and policy development for the province. This involves working in partnership with a number of key stakeholders including regional health authorities, community organizations, professional associations, post-secondary educational institutions, unions, consumers and other government departments.

The Department of Children, Seniors, and Social Development supports individuals, families and communities in Newfoundland and Labrador in achieving improved health and social well-being and reduced poverty; and ensures the protection of children, youth and adults from abuse or neglect. The Department promotes the values of inclusion, diversity, and healthy active living and leads the development of policies, programs and partnerships to improve services and the overall social development of the Province.

Eastern Health is the largest integrated health organization in Newfoundland and Labrador. They provide the full continuum of health services to a regional population of more than 300,000 and are responsible for a number of unique provincial programs. They employ over 13,000 health care and support services professionals who provide healthcare and health service delivery in their region and in the province. Eastern Health extends west from St. John's to Port Blandford and includes all communities on the Avalon, Burin and Bonavista Peninsulas. Eastern Health is governed by a volunteer Board of Trustees appointed by the Minister of Health and Community Services according to the Regional Health Authorities Act.

Central Health provides health and community services to approximately 20 per cent of the province's population. It is the second largest health region serving a population of approximately 94,000. The geographical area served by Central Health includes 177 communities and encompasses more than half the total landmass of the island. The region extends from Charlottetown in the east, Fogo Island in the north, Harbour Breton in the south, to Baie Verte in the west.

Western Health’s geographical boundaries are from Port aux Basques southeast to Francois, northwest to Bartlett’s Harbour, and on the eastern boundary north to Jackson’s Arm. Within this geographical region, Western Health serves a population of approximately 77,980 residents. Western Health provides a broad range of programs and services to the people of Western Newfoundland. It operates from 24 office sites, community based medical services from 26 medical clinic sites and eight health facilities.

Labrador Grenfell Health serves a population of just under 37,000 and covers the communities north of Bartlett’s Harbour on the Northern Peninsula and all of Labrador. Headquarters are located in Happy Valley Goose Bay. It employs 1500 staff and operates 22 facilities, including three hospitals, 3 health centres, 14 community clinics and 2 LTC facilities.
Acute Care Facilities in Newfoundland and Labrador
Acute care facilities in Newfoundland and Labrador

<table>
<thead>
<tr>
<th>FACILITY NAME</th>
<th>NO. OF ACUTE CARE BEDS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eastern Regional Health Authority</strong></td>
<td></td>
</tr>
<tr>
<td>1. Health Sciences Centre (St. John’s)</td>
<td>350</td>
</tr>
<tr>
<td>2. St. Clare’s Mercy Hospital (St. John’s)</td>
<td>206</td>
</tr>
<tr>
<td>3. Waterford Hospital (St. John’s)</td>
<td>89 (65 acute, 17 forensic, &amp; 7 short stay)</td>
</tr>
<tr>
<td>4. Carbonear General Hospital</td>
<td>80</td>
</tr>
<tr>
<td>5. Dr. G.B. Cross Memorial Hospital (Clarenville)</td>
<td>47</td>
</tr>
<tr>
<td>6. Burin Peninsula Health Care Centre (Burin)</td>
<td>41</td>
</tr>
<tr>
<td>7. Dr. Walter Templeman Health Centre (Bell Island)</td>
<td>3</td>
</tr>
<tr>
<td>8. Placentia Health Centre</td>
<td>10</td>
</tr>
<tr>
<td>9. Bonavista Peninsula Health Centre</td>
<td>10</td>
</tr>
<tr>
<td><strong>Eastern Health total:</strong></td>
<td><strong>836</strong></td>
</tr>
<tr>
<td><strong>Central Regional Health Authority</strong></td>
<td></td>
</tr>
<tr>
<td>10. James Paton Memorial Health Centre (Gander)</td>
<td>83</td>
</tr>
<tr>
<td>11. Central Newfoundland Regional Health Centre (Grand Falls-Windsor)</td>
<td>116</td>
</tr>
<tr>
<td>12. A.M. Guy Memorial Health Centre (Buchans)</td>
<td>2</td>
</tr>
<tr>
<td>13. Brookfield Bonnews Health Care Centre</td>
<td>12</td>
</tr>
<tr>
<td>14. Fogo Island Health Centre</td>
<td>5</td>
</tr>
<tr>
<td>15. Notre Dame Bay Memorial Health Centre (Twillingate)</td>
<td>12</td>
</tr>
<tr>
<td>16. Connaigre Peninsula Health Centre (Harbour Breton)</td>
<td>7</td>
</tr>
<tr>
<td>17. Baie Verte Peninsula Health Centre</td>
<td>7</td>
</tr>
<tr>
<td>18. Green Bay Health Centre (Springdale)</td>
<td>9</td>
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<tr>
<td><strong>Central Health total:</strong></td>
<td><strong>253</strong></td>
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<tr>
<td><strong>Western Regional Health Authority</strong></td>
<td></td>
</tr>
<tr>
<td>19. Western Memorial (Corner Brook)</td>
<td>192</td>
</tr>
<tr>
<td>20. Sir Thomas Roddick Hospital (Stephenville)</td>
<td>44</td>
</tr>
<tr>
<td>21. Dr. Charles L. LeGrow Health Centre (Port aux Basques)</td>
<td>14</td>
</tr>
<tr>
<td>22. Calder Health Centre (Burgeo)</td>
<td>3</td>
</tr>
<tr>
<td>23. Bonne Bay Health Centre (Norris Point)</td>
<td>8</td>
</tr>
<tr>
<td>24. Rufus Guinchard Health Centre (Port Saunders)</td>
<td>7</td>
</tr>
<tr>
<td><strong>Western Health total:</strong></td>
<td><strong>268</strong></td>
</tr>
<tr>
<td><strong>Labrador-Grenfell Health Authority</strong></td>
<td></td>
</tr>
<tr>
<td>25. Labrador Health Centre (Happy Valley-Goose Bay)</td>
<td>25</td>
</tr>
<tr>
<td>26. Captain William Jackman Memorial Hospital (Lab City)</td>
<td>14</td>
</tr>
<tr>
<td>27. Charles S. Curtis Memorial Hospital (St. Anthony)</td>
<td>54</td>
</tr>
<tr>
<td>28. White Bay Central Health Centre (Roddickton)</td>
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</tr>
<tr>
<td>29. Strait of Belle Isle Health Centre (Flower’s Cove)</td>
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<tr>
<td>30. Labrador South Health Centre (Forteau)</td>
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</tr>
<tr>
<td><strong>Labrador-Grenfell Health total:</strong></td>
<td><strong>104</strong></td>
</tr>
<tr>
<td><strong>NEWFOUNDLAND AND LABRADOR total:</strong></td>
<td><strong>1461</strong></td>
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