Health Canada Santé Canada

Primary Health Care Transition Fund

Laying the Groundwork for Culture Change

The Legacy of the Primary Health Care Transition Fund

March 2007

Synthesis Series on Sharing Insights

Canada

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This report has been prepared by Sheila Weatherill, CM, BScN, President and Chief Executive Officer, Capital Health (Edmonton).

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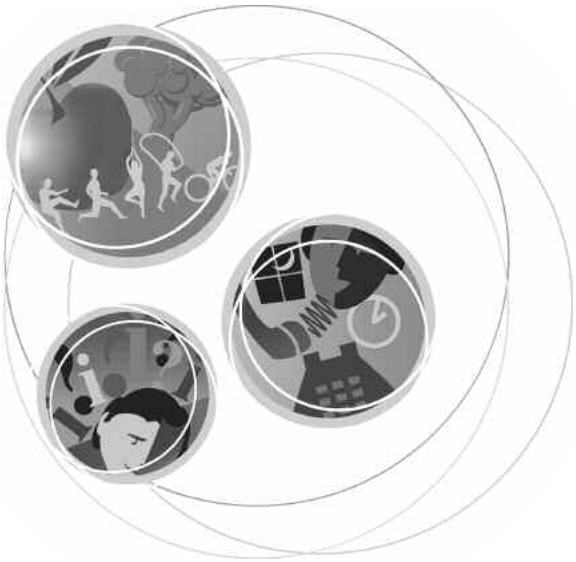
This report is one in a series of five syntheses of PHCTF initiative results addressing the following topics: *Chronic Disease Prevention and Management*, *Collaborative Care*, *Evaluation and Evidence* and *Information Management and Technology*. The fifth report is an overall analysis on the role and impact of the PHCTF in primary health care renewal entitled *Laying the Groundwork for Culture Change: The Legacy of the Primary Health Care Transition Fund*. All are available electronically on the PHCTF website (**www.healthcanada.gc.ca/phctf**), which also contains information on individual PHCTF initiatives.



Preface

When Canadians need health care, most often they turn to primary health care (PHC) services.[1] PHC is the first point of contact with the health care system, and traditionally has focused on the role of family physicians. In the past, Canadians visited their family physicians when in need of health care and their physician either provided services directly or, if more specialized care was required, coordinated patients' needs with specialists, hospitalized-based services, or other parts of the health care system.

This episodic, responsive model has served Canadians well, particularly in the context of a relatively young population and prevalence of acute care needs. However, in recent years, several circumstances have given rise to concerns about the ability of this model to meet the changing needs of Canadians. The population is aging, rates of chronic disease are rising, and the health care system needs to respond to these changing circumstances.

For example, prevention and management of chronic disease to avoid or delay costly complications requires a broad skill set, a proactive approach to care delivery, and a patient-centred approach (including active involvement of the patient in his or her own care). Faced with growing numbers of patients with these complex needs and shortages of family physicians in some areas, many family physicians have expressed concerns regarding their working conditions, including long hours and impacts on their own health and family life. These circumstances point to the advantages of a team-based approach to care, with various health care professionals working together to help the patient maintain and improve his or her health. For example, a nurse practitioner might undertake routine monitoring of a diabetic patient, with advice from a dietitian, and involve the physician when more specialized expertise is required.

There is a growing consensus that PHC professionals working as partners in this team approach will result in better health outcomes, improved access to services, improved use of resources, and greater satisfaction for both patients and providers.[2] Such teams are better positioned to focus on health promotion and improve the management of chronic diseases. A team approach can improve access to after-hours services, reducing the need for emergency room visits. Information technology can support communication among providers, as well as provide support for quality improvement programs (e.g., clinical practice guidelines for chronic disease management). In these ways, all aspects of personal care are brought together in a coordinated way.

Accordingly, in September 2000, Canada's First Ministers agreed that improvements to PHC were crucial to the modernization of the health care system. As part of their 2000 Health Accord, they agreed to work together, and in concert with health professionals, to improve PHC and its linkages with other parts of the health care system.

The Primary Health Care Transition Fund

To support this commitment, the federal government announced the creation of the Primary Health Care Transition Fund (PHCTF). From 2000 to 2006, the PHCTF provided $800 million to provinces, territories and health care system stakeholders, to accelerate the development and implementation of new models of PHC delivery. Specifically, it provided support for the transitional costs of making the shift to new models of PHC delivery (e.g., new curricula for team-based training, or information systems to support team-based care).[3] Although the PHCTF itself was time-limited, the changes it supported were intended to have a lasting impact on the health care system.

[1] Any publication that addresses "primary care" or "primary health care" faces definitional issues. While the two terms are sometimes used interchangeably, some authors draw a distinction between them. However, there is little consensus on this distinction. Generally, the term "primary care" is more limited, and focuses on traditional physician-based medical services, while "primary health care" is broader, including primary care but also extending to other health care providers, and sometimes beyond the health care sector to include other determinants of health such as housing or education. This footnote is intended only to draw attention to the fact of these definitional issues, and not to attempt to resolve them. The issue is addressed within this report to the extent that it was considered relevant by its author.

[2] As PHC services are responsive to the needs of the communities that they serve, the composition of teams will vary; there is no "one-size-fits-all" model.

While the PHCTF was a federally funded program, all provincial/territorial governments agreed to its objectives:

- increase the proportion of the population with access to PHC organizations which are accountable for the planned provision of comprehensive services to a defined population;
- increase the emphasis on health promotion, disease and injury prevention, and chronic disease management;
- expand 24/7 access to essential services;
- establish multidisciplinary teams, so that the most appropriate care is provided by the most appropriate provider; and
- facilitate coordination with other health services (such as specialists and hospitals).

All initiatives funded under the PHCTF were required to address at least one of these objectives.

To create opportunities at various levels and to encourage a collaborative approach, PHCTF funding was available through five funding envelopes. First and foremost, the *Provincial–Territorial Envelope* provided funding directly to provincial/territorial governments to support their efforts to broaden and accelerate PHC renewal. This envelope accounted for approximately 75 per cent of PHCTF funding, and was allocated primarily on a per capita basis. Initiatives reflected the priorities and unique circumstances of each jurisdiction, as well as PHCTF objectives.

The remaining 25 per cent of funds was divided among four pan-Canadian envelopes which were intended to encourage collaborative approaches and to address unique population needs.

- The *Multi-Jurisdictional Envelope* (5 initiatives) enabled two or more provincial/territorial governments to collaborate on common initiatives.
- The *National Envelope* (37 initiatives) was open to provinces, territories and health care system stakeholders, and supported collaborative initiatives that addressed common barriers and sought to create the necessary conditions on a national level to advance PHC renewal.
- The *Aboriginal Envelope* (10 initiatives) responded to the needs of Aboriginal communities for high-quality, integrated PHC services.
- The *Official Languages Minority Communities Envelope* (3 initiatives) responded to the unique PHC needs of francophone minority communities outside Quebec and the anglophone minority community within Quebec.

The Role of Knowledge Transfer

PHC renewal requires fundamental changes to the organization and delivery of health care services. It is a long-term undertaking that began before the PHCTF was created and will continue beyond it. Knowledge development is a key component of this process, for although PHC renewal has yielded some impressive results to date, its evidence base remains relatively modest. Therefore, dissemination of the results of PHCTF initiatives was a key element of the PHCTF. To this end, PHCTF dissemination included: the preparation of summaries and fact sheets for individual PHCTF initiatives consolidated in one report, commissioning of synthesis reports, development of a comprehensive website, and holding a national conference in February 2007. In addition to dissemination activities organized by Health Canada, individual initiatives were responsible for disseminating their initiative-specific results.

The production of a series of "synthesis reports" was a key element of this dissemination strategy. To maximize the usefulness of this material for target audiences (including health care system stakeholders, health care providers and researchers), and to identify common trends or key "lessons learned" arising from the initiatives, experts in health system issues were engaged to prepare a series of synthesis reports. The topics of the reports reflect prominent areas of focus within the PHCTF initiatives:

[3] The PHCTF was preceded by the federal Health Transition Fund (1997–2001), but was distinct from it in several respects. While the Health Transition Fund had four priority areas (including PHC), the PHCTF was exclusively focused on PHC. The Health Transition Fund's mandate was to fund pilot and evaluation projects to generate evidence regarding health care system reform, while the PHCTF was intended to support substantive, sustainable change.

- *Collaborative Care* (Vernon Curran, Director, Academic Research and Development, Memorial University);

- *Chronic Disease Prevention and Management* (Peter Sargious, Medical Leader, Chronic Disease Management, Calgary Health Region);

- *Information Management and Technology* (Denis Protti, Professor, University of Victoria); and

- *Evaluation and Evidence* (June Bergman, Assistant Professor, University of Calgary).

In addition, an "overall" report by Sheila Weatherill, President and Chief Executive Officer, Capital Health (Edmonton) entitled *Laying the Groundwork for Culture Change: The Legacy of the Primary Health Care Transition Fund* examines the legacy of the PHCTF as a whole, and identifies trends across the entire body of PHCTF initiatives.

A Legacy for Change

The PHCTF was never intended to "do it all" and, indeed, the years since its creation have seen a continued emphasis on PHC renewal. Numerous health care system studies at national (Romanow, Kirby) and provincial levels have consistently emphasized the critical role of PHC renewal in health care system reform. Two more First Ministers' Accords (2003 and 2004) have reiterated this emphasis. The Health Council of Canada, which was created following the 2003 Accord to monitor progress in health care renewal, has repeatedly emphasized the critical role of PHC, stating that "Canada's future health system is dependent upon the modernization of primary health care ..."[4]

Although individual PHCTF initiatives ended in 2006, individually and collectively they have helped to build the foundation for further improvements to PHC in Canada. This report reflects, and is intended to provide insight into, this context of ongoing change and reform.

Health Canada

Acknowledgements

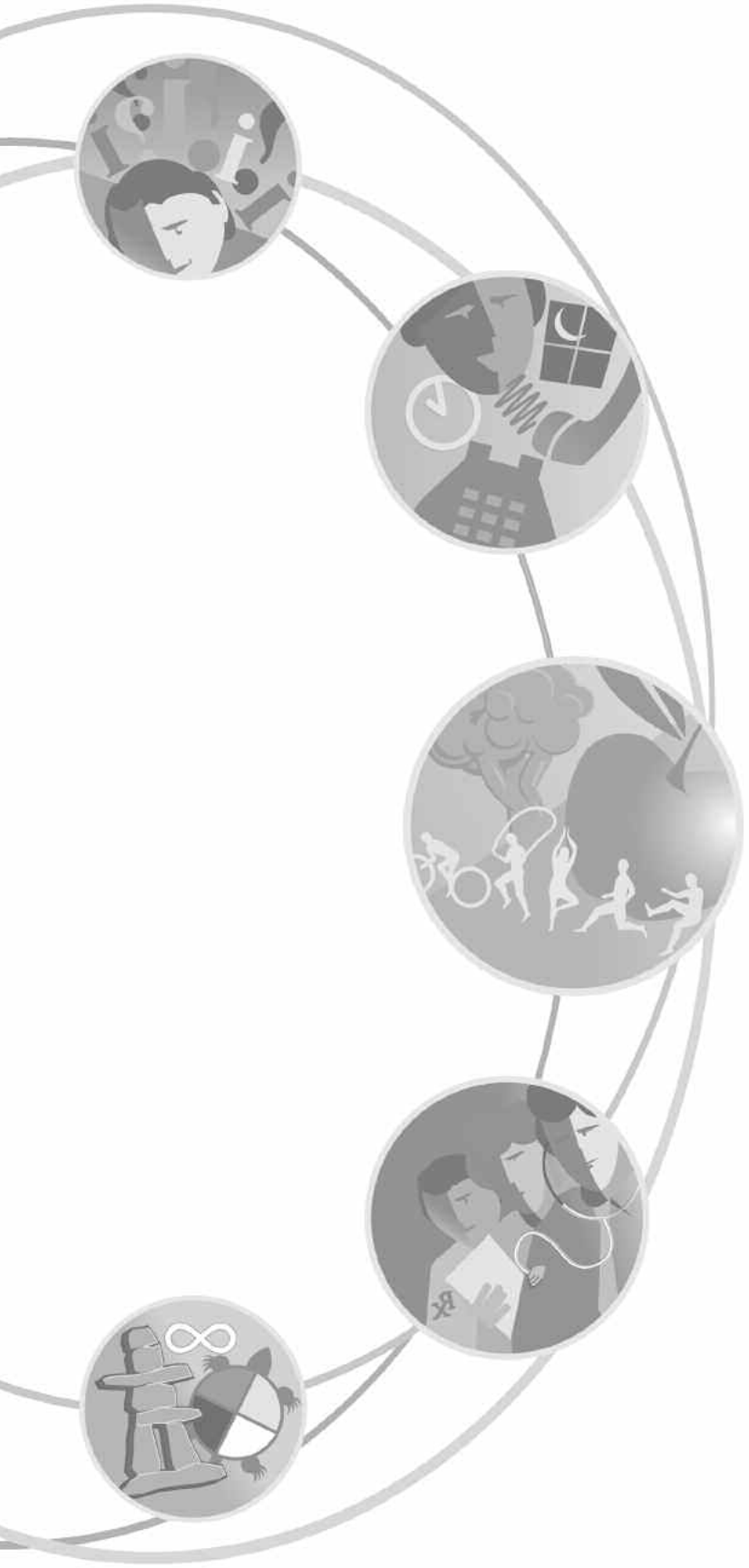
The Primary Health Care Transition Fund *Synthesis Series on Sharing Insights* was commissioned by Health Canada and managed by The Conference Board of Canada.

This paper is the overall synthesis report. It considers the initiative reports themselves and draws on the insights and thoughts provided by fellow synthesizers and their reports: Vernon Curran's insights on collaborative care, those of Peter Sargious on chronic disease prevention and management, Denis Protti's on information management and technology, and June Bergman's on evaluation and evidence. This paper owes much to their provocative work.

I would also like to thank those who contributed their thoughts and time in the development of this paper—Fred Horne, Marianne Stewart and Judith Dyck. I would also like to thank Duncan Sinclair and Paul Darby for their thoughtful review of this paper and comments in their role as challengers, as well as The Conference Board of Canada for its hard work and support. Finally, a thank you to Health Canada for commissioning this and the other synthesis papers. There is much to be done in transforming Canada's primary health care system. The leadership and contributions of Health Canada in partnership with the provinces and territories are an important part of the work that must continue to be done.

Sheila Weatherill, CM, BScN

[4] Health Council of Canada, *Health Care Renewal in Canada: Accelerating Change,* (January 2005), p. 48.



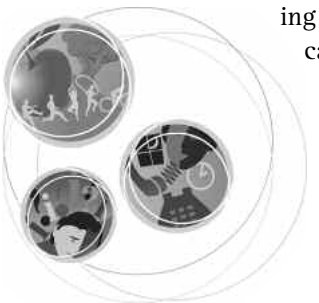
Executive Summary

In Canada, focused national efforts to reform our primary health care system began to emerge more clearly in the early to mid-1990s, as economic downturns forced governments to a greater focus on efficiency and deficit reduction. During that time, many provinces were also engaged in varying degrees of integrating a range of health services—community, long-term care, residential and acute care services—and often public health and mental health, addictions and health promotion within regions. This began a process of amalgamation, reorganization and a fundamental rethinking of how services could better be tied together, including primary care physician practices.

The Primary Health Care Transition Fund (PHCTF) set out to help accelerate this shift in the Canadian health system by supporting primary health care initiatives. Some initiatives worked to increase services for remote communities, official languages minority communities and Aboriginal First Nations. Many reflected the struggle to embed integrated and collaborative primary health care (PHC) within a system built on a solo provider/acute care framework. Some focused on making the fundamental case for reform; some emphasized putting in place the basic building blocks of PHC reform such as collaborative care; while others concentrated on designing cross-cutting strategies such as treatment protocols and registering patients with chronic disease with the aim of managing chronic disease at a population level.

This report is the "overall" synthesis report for the PHCTF. It draws on the syntheses done on collaborative care, chronic disease prevention and management, information management and technology and evaluation and evidence.

Many lessons emerge on how to successfully implement primary health care. One stands out. We must transform the culture of Canadian health care from one that focuses on hospitals and episodes of illness to one that supports people, communities and providers in managing their whole health. Primary health care marks a major shift in thinking about how we, as a country, partner with and provide care to our citizens, whether they live in the North, in urban settings, rural or remote Canada.



This requires a change in how we as individuals look on our responsibility for our own health: Canadians must reclaim ownership of their health and understand their key role in ensuring they are as healthy as they can be, given their personal and community circumstances.

Canadian health care providers must also be supported to do their part and given the tools to move toward:

- patient-centred care;
- community care that reduces the demand for acute care services;
- better management of chronic disease by providers and better management of how providers support people who actively participate in and take responsibility for their own chronic disease management;
- team-based care, away from the well-entrenched tradition of physicians working alone;
- best practices based on evaluation and evidence; and
- vastly improved and transformed information management that supports collaboration and access to information for providers and for Canadians actively managing their own wellness.

These changes, along with an emphasis on personal and community empowerment, are the groundwork for changing the Canadian health care culture.

This will require the Canadian health system—policy-makers, program planners, educators, providers, colleges, associations and others—to think about tackling the foundational and transformational elements necessary for successful primary health care reform.

The *foundational* elements build on a strong body of knowledge and require that sustained and incremental change processes be put in place and then worked on over the next five years and beyond:

- *primary health care teams*, putting aside the notion that, merely as a result of their formation, teams will function well and that optimized collaboration among caregivers and the public will occur without support and a concerted effort nationwide;

- *Canada's information infrastructure*, completing—and in some instances beginning—the work of implementing the information management framework and applications required to support PHC. Information management constitutes the new bricks and mortar of the PHC system with all the attendant costs and care required to maintain traditional infrastructure; and

- *knowledge gathering and diffusion*, taking a strategic, multi-jurisdictional approach to knowledge transfer and dissemination, one that truly creates the momentum to adopt "the best of the best" and understand that this requires a sustained and supported effort.

The *transformational* elements are those things where the end result is not so clearly identifiable, where the outcomes stand to surprise us, but where the risk of not taking on the challenge will leave us mired in our "legacy system":

- *leadership* at all levels of the system that puts aside differences and focuses beyond regulatory barriers, scopes of practice and legislation—and beyond the "health care" system—to promote health outcomes, population health and maximizing the use of scarce resources;

- *putting Canadians at the centre of their care* by arming them with the tools and knowledge they need to manage their own health and care, focusing on the determinants of health and investment in public engagement; and

- *moving to a health outcomes focus in all we do,* expanding our points of reference beyond the health system.

The PHCTF helped bring about a shift in how numerous health care professionals and administrators think about PHC. It has helped challenge Canadians' traditional assumptions about their health system. Leaders across the country—elected, unelected, professional organizations, administrators and others—need to tackle these six critical elements and make primary health care a priority if we are to improve health outcomes and ensure our health system is sustainable.

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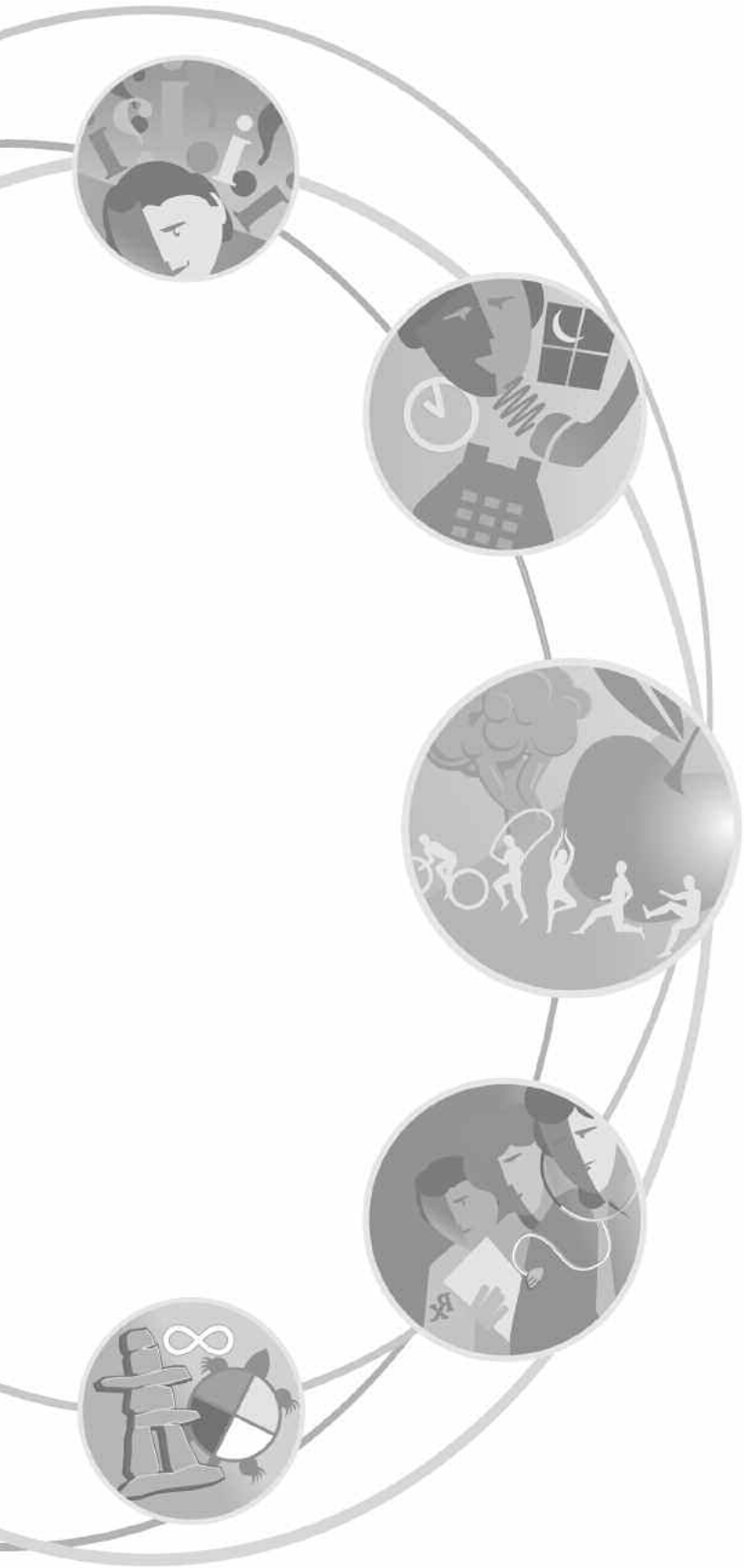


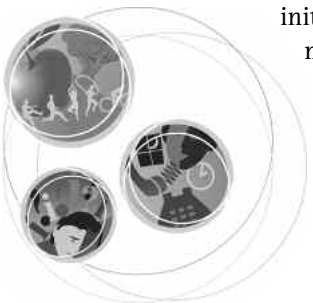
1 Setting the Context

1.1 Introduction

The Primary Health Care Transition Fund (PHCTF) was a large-scale initiative that set out to help shift the Canadian health system's focus away from a model centred on illness and treatment to one focused on self-care, disease prevention and health promotion. It built on the work of the Health Transition Fund that preceded it, as well as the many initiatives being undertaken at the time across Canada.

The PHCTF gave provinces and territories, individual groups and stakeholders across the country the opportunity to make improvements beyond those they had previously been able to consider. It also afforded them the opporutunity to accelerate the pace of change. Although the PHCTF initiatives all related to one or more of the objectives of the Fund, they also reflected jurisdictional differences and the ways in which governments and stakeholders chose to close the gap between available services and the needs of the populations they serve.

Some initiatives worked to increase services for remote communities, official languages minority communities and Aboriginal First Nations. Many initiatives throughout the country also reflected the struggle to embed integrated and collaborative primary health care (PHC) within a system built on a solo provider/acute care framework, one facing critical and mounting challenges. Some of the initiatives focused on making the fundamental case for reform; some emphasized putting in place the basic building blocks of PHC reform such as collaborative care; while others concentrated on designing cross-cutting strategies such as treatment protocols and registering patients with chronic disease with the aim of managing chronic disease at a population level. In short, initiatives funded under the PHCTF encompassed reform across the whole continuum of PHC.



During the same period, other concurrent initiatives funded by the federal government helped advance and support Canada's movement toward PHC. On a national front, Canada Health Infoway continues to work on developing compatible health information systems to support a safer, more efficient health system. The Pan-Canadian Health Human Resource Strategy was launched and is working through provincial/territorial governments, professional associations and other federal departments to secure and maintain an optimal health workforce in Canada and support health care renewal. Increasing concerns about public health issues have resulted in the formation of the Public Health Agency of Canada. These initiatives at the national level are mirrored by steps being taken in each province and territory to tackle growing concerns about health outcomes and sustainability.

1.2 Defining Primary Health Care

There are more than 90 definitions of PHC (Atun, 2004). Health Canada describes PHC as having a dual function in the health system:

- the direct provision of first-contact services (by providers such as family physicians, nurse practitioners, pharmacists and telephone advice lines); and

- a coordination function to ensure continuity and ease of movement across the system, so that care remains integrated when Canadians require more specialized services (with specialists or in hospitals, for example) (Health Canada, n.d.).

The 1978 World Health Organization Alma-Ata definition of PHC (Declaration VI) provides another perspective:

> Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible

> to where people live and work, and constitutes the first element of a continuing health care process (World Health Organization, 1978).

Both these definitions differ from the traditional definition of primary care, which most people take to mean care provided by a physician in solo practice (Marriott & Mable, 2000). However, for all the reasons outlined in the next section and in the preface to this report, this traditional model is increasingly overburdened and the multi-disciplinary strength of the PHC model is increasingly being seen as a more effective way of delivering primary health services.

1.3 The History of Primary Health Care Reform in Canada

Health care reform and in particular primary health care reform is not a new topic. It has been discussed almost since the beginning of Medicare in the 1960s. Even Tommy Douglas, the father of Medicare, had a two-step plan for Medicare. The first phase was the removal of financial barriers and the second was to reorganize the delivery system. According to Duncan Sinclair, past chair of the Health Services Restructuring Commission in Ontario, the second phase is the "big thing that we haven't done yet" (Sinclair, 2004).

Primary health care became a major issue worldwide in the 1970s, culminating in the previously mentioned Alma-Ata Declaration, which stated, "All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national system and in coordination with other sectors" (World Health Organization, 1978).

In Canada, focused national efforts to reform our PHC system began to emerge more clearly in the early to mid-1990s, as economic downturns forced governments to a greater focus on efficiency and deficit reduction. There was a growing recognition among all governments and most stakeholders that Canada's fiscal status was being jeopardized by escalating health care costs; serious attention had to be paid to the causes of those cost escalations, including, among other things, an aging population, rising rates of chronic disease and obesity, growing shortages of health care professionals, the lack of information technology infrastructure that hampered care and efficient delivery, and the time and money required to construct physical facilities. There was also a growing appreciation that the problems of the health system could not be overcome by only adding more money to the system and that other factors would need to be addressed.

During that time, many jurisdictions were also engaged in varying degrees of regionalizing health service delivery. While the models differed from jurisdiction to jurisdiction, fundamental to the process was the integration of a range of health services—community, long-term care, residential and acute care services—and often public health and mental health, addictions and health promotion were consolidated within a geographic area under a single governance structure. Some services were decentralized from provincial governments to the new regional entities, while others were consolidated under the new structures. This began a process of amalgamation, reorganization and a fundamental rethinking of how services could better be tied together. It is important to note that in each province and region, *primary care physician practices* were the one significant piece of the health system not systematically integrated with these new health services entities.

What emerged from all this was national recognition that Canada urgently needed to change the way we plan, fund, deliver and support PHC for Canadians. In the February 1997 budget, the Government of Canada announced the creation of the Health Transition Fund following consultations with provincial/territorial governments. This fund supported pilot and evaluation projects in four priority areas—home care, pharmacare, primary health care and integrated service delivery—and focused on generating evidence around effective service delivery and health system reform.

Between 1997 and 2001, the Health Transition Fund funded 141 pilot initiatives and (or) evaluation studies across Canada for a total cost of $150 million. Primary health care emerged as the biggest single focus within the Health Transition Fund in terms of number of projects and the proportion of dollars allocated to those projects.

In September 2000, the Federal/Provincial/Territorial First Ministers of Health met to negotiate the Action Plan for Health System Renewal, or the 2000 Health Accord as it has become known. The 2000 Health Accord set out public policy priorities, emphasized the need to develop and implement a shared vision, and made the remarkable investment in reform of $23.4 billion over

a six-year period. This very large transfer included $21.2 billion allocated to health care, $18.9 billion of which went to the then-Canadian Health and Social Transfer. The remaining $2.3 billion was earmarked for specific health care initiatives, including primary care reform and health information technology. From this $2.3 billion allocation emerged the $800-million PHCTF.

1.4 Transforming Canada's Health Care Culture

The PHCTF provided funding to provincial and territorial governments to accelerate their PHC efforts. The remaining initiatives were funded under four pan-Canadian envelopes—the Multi-Jurisdictional Envelope, the National Envelope, the Aboriginal Envelope and the Official Languages Minority Communities Envelope. Each of the initiatives provided a final report and analysis of accomplishments and key learnings in 2006.[5] This report is the "overall" synthesis report. It considers the final reports from the individual initiatives and draws on the syntheses on collaborative care, chronic disease prevention and management, information management and technology, and evaluation and evidence. The authors' findings and thoughtful insights, along with reflections on the challenges of fostering new ways of delivering care within established frameworks, provide the basis for this report. (See Appendix A for the executive summaries of each of these four reports.)

Many lessons emerge on how to successfully implement primary health care. One stands out.

We must transform the culture of Canadian health care from one that focuses on hospitals and episodes of illness to one that supports people, communities and providers in managing their whole health. Primary health care marks a major shift in thinking about how we, as a country, partner with and provide care to our citizens, whether they live in the North, in urban settings, rural or remote Canada.

This requires a major shift in how we as individuals look on our responsibility for our own health: Canadians must reclaim ownership of their health, and understand their key role in ensuring they are as healthy as they can be, given their personal and community circumstances.

Canadian health care providers must also be supported to do their part and given the tools to move toward:

- patient-centred care;
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- better management of chronic disease by providers and better management of how providers support people who actively participate in and take responsibility for their own chronic disease management;
- team-based care, away from the well-entrenched tradition of physicians working alone;
- best practices based on evaluation and evidence; and
- vastly improved and transformed information management that supports collaboration and access to information for providers and for Canadians actively managing their own wellness.

These changes, along with an emphasis on personal and community empowerment, are the groundwork for changing the Canadian health care culture.

This will be hard work. It will require a sustained commitment and an even greater share of the health care agenda and dollars. It represents a philosophical rethinking of the role of publicly funded health care. It means getting serious about putting in place the necessary information technology, encouraging the development of collaborative care, and supporting knowledge exchange and transfer.

The Canadian health system—policy-makers, program planners, educators, providers, colleges, associations and others—needs to think about making incremental changes—building on our successes, leveraging proven models and the knowledge we're gaining, and diffusing new models of PHC throughout each province and territory. This, however, will not be enough.

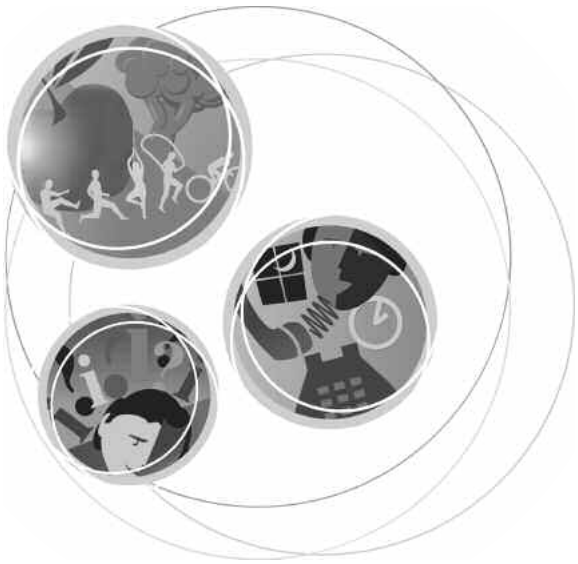
We must also become comfortable—or become comfortable with our discomfort—with the notion of transformational change. This will require all of us to

[5] Further information on the PHCTF is in the preface to this report, as well as at **www.healthcanada.gc.ca/phctf**, which also contains information on individual PHCTF initiatives.

take the risk of informing the public about their responsibilities and giving them the tools to move to the centre of their health management and become more actively involved. Our leaders will have to get beyond the debates on regulation and scopes of practice. However important these issues are, we need to talk instead about leadership that focuses on goals and outcomes.

One of the stories of our time is that of emerging economies with only limited access to phone lines and therefore limited opportunities to use technology to move forward in their goals. The answer wasn't the one that appeared so obvious for decades—string wire. It was to go wireless and leapfrog over the old way of doing things. In fact, infrastructure that was once seen as an advantage is now being called a "legacy system problem" (Kirkpatrick, 2006).

How, in Canada, can we leapfrog over the old health service delivery framework, using what is valuable within it without being held captive by our own legacy system? How do we establish the Canadian health journey as one based on a PHC-driven wellness model, one that leapfrogs over our acute care mindset? This is our challenge.



2 Key Learnings and Implications for Policy and Practice

2.1 Foundational and Transformational Elements Required for Culture Change in Our Primary Health Care System

Moving to a PHC system in Canada requires a shift in the health system culture. How can that be achieved? In his book *Leading Change,* John Kotter describes culture as the norms of behaviour and shared values among a group of people (Kotter, 1996). Understanding the Canadian health system's current culture means understanding how it's organized and how that organization contributes to our behavioural norms and shared values.

Canada does not have one health system; it has 13 different systems—14 if we consider the responsibility of the Government of Canada for health services received by the military, veterans, RCMP, First Nations, correctional services and refugees. These systems are fragmented further by disconnects between different care settings and services, including hospital care, primary care, mental health services, pharmaceutical care, and rehabilitation.

All this is more or less organized around the five common principles of the *Canada Health Act*. The organizing legislative framework behind each of the systems is *The Constitution Act, 1982*, which maintains that the provinces and territories have the exclusive right to administer and deliver health care services, with some exceptions, and the *Canada Health Act* (1984), which ties federal cash transfers to the five principles: universality, accessibility, comprehensiveness, portability and public administration. Cash transfers from the federal to the provincial/territorial governments depend on adherence to these principles within a funding envelope that provides payments for services described as medically necessary. In essence, "medical necessity" is defined as in-hospital and doctor services, although not all of these are necessarily covered under this definition. And therein lies a major rub: If you are a physician providing primary care, you are covered by public funding. If you are a member of any other health profession, you are not necessarily entitled to public reimbursement and traditionally you are not entitled to public funding for delivering PHC services. Provincial governments can, and in fact do, provide payments for some PHC services provided by professionals other than physicians, although this is far from uniform across the country. For example, physiotherapy services or pharmaceuticals are covered if provided in a hospital, but not necessarily within a community care setting. Physiotherapy or dentistry might be covered to some extent in one jurisdiction and not in another. Publicly supported access to prescription drugs outside the acute care setting varies by jurisdiction.

Therefore, the legislative underpinnings and the flow of money support physicians and hospitals, with the vast majority of the money flowing to facility-based care and specialists. Care delivered in the community by other health practitioners is not explicitly acknowledged under this model. It's a simple leap, then, that the culture of health care in Canada has been dominated by hospitals, specialists and physician-focused primary care.

To transform this acute care culture to one that truly supports PHC, our embedded "assumptions" about Canada's publicly funded health care model must be challenged, or at the very least, innovative ways found to work around them.

The four themed PHCTF synthesis reports indicate that this structural and accompanying cultural shift has begun to take root in Canada. Completing this culture shift is a necessary requirement to sustain future change. It will require changes in our infrastructure, including that of information technology, education, training and professional development. It demands new forms of leadership and a new covenant with Canadians, one that moves its focus away from the guarantee of treatment when ill to one in which the system provides people with the information, support and resources they require to manage and improve their own health and, to the maximum extent possible, prevent their becoming ill or injured.

The four synthesis reports have brought together the very large body of learnings from the PHCTF initiatives; they provide very important and critical insights into the areas of collaborative care, chronic disease prevention and management, information management, and

evaluation and evidence. Out of these analyses, six major themes or areas of focus emerge; themes that provide the guideposts for Canada as it moves forward. More than that, they are the critical elements that we must tackle.

First are the *foundational* elements that build on a strong body of knowledge and require sustained and incremental change processes being put in place and then worked on over the next five years and beyond. We must focus on:

- *primary health care teams* and put aside the notion that, merely as a result of their formation, teams will function well and that optimized collaboration among caregivers and the public will occur without support and a concerted effort nationwide;

- *Canada's information infrastructure* and complete—and in some instances begin—the work of implementing the information management framework and applications required to support PHC. Information management constitutes the new bricks and mortar of the PHC system with all the attendant costs and care required to maintain traditional infrastructure; and

- *knowledge gathering and diffusion*, taking a strategic, multi-jurisdictional approach to knowledge transfer and dissemination, one that truly creates the momentum to adopt "the best of the best" and understand that this requires a sustained and supported effort.

Then we must tackle the *transformational* elements—those things where the end result is not so clearly identifiable, where the outcomes stand to surprise us, but where the risk of not taking on the challenge will leave us mired in our "legacy system":

- *leadership* at all levels of the system that puts aside differences and focuses beyond regulatory barriers, scopes of practice and legislation—and beyond the "health care" system—to promote health outcomes, population health and maximizing the use of scarce resources;

- *putting Canadians at the centre of their care* by arming them with the tools and knowledge they need to manage their own health and care, focusing on the determinants of health and investment in engagement of the public; and

- *moving to a health outcomes focus in all we do,* expanding our points of reference beyond the health system.

The answers to accomplishing both the foundational and transformational elements lie in the findings of the PHCTF and beyond.

2.2 Foundational Elements

2.2.1 Foundational Element One: Primary Health Care Teams

Primary health care teams are the fundamental building block for PHC, providing the right care at the right time by the right provider. In the first five years of this decade, strides have been made in establishing PHC teams across the country. And if anything has been learned during that period, it was that establishing functioning teams is not easy. It requires leadership and flexibility, as well as a number of underlying issues that have to be dealt with if a sustainable network of PHC teams is to be created throughout Canada.

The success of PHC reform in Canada depends largely on the ability to grow and sustain collaborative care and teamwork as the new "cultural norm" for Canadians and their PHC providers. Implicit in this is the recognition that teams are not static institutions, but evolving ones. Teams change their composition and their practices in the course of anticipating and responding to the needs of the communities they serve. A "one-size-fits-all" approach will not work.

Given the reality of an aging health care workforce, building effective PHC teams means finding ways to teach old dogs—seasoned professionals with well-established and demanding practices and positions—new tricks. That includes pharmacists, nurses, physicians and others.

Here's the really difficult part—we need health practitioners, particularly physicians in general and family practice, to learn how to deliver care in a team-based model and adapt their practices to the new reality while they continue to provide care to their patients, because we can ill afford a loss in their productivity for

any sustained period of time. And while just focusing on physicians won't result in us getting the collaborative outcomes we need from PHC teams, we need to acknowledge that we can't make these changes successfully without having physicians on the PHC team. Some good local progress was seen in engaging physicians at the program level with PHCTF initiatives. But if we take the findings of the 2006 Commonwealth Fund Physician Primary Health Care Survey (Commonwealth Fund, 2006) as a measure, we see that there hasn't been a broad shift in physician beliefs around our success in building a PHC environment based on the collaboration of physicians with other PHC professionals.

So if physicians are to be more engaged—and they must be if we are to succeed in building collaborative models—what needs to be done? One of the key elements for integrating physicians and others into teams is working out flexible remuneration strategies. The *Family Physician Compensation Models and Primary Health Care Renewal* initiative led by the Nova Scotia Department of Health found that no single solution exists on how to pay family physicians and that diverse and flexible solutions are required. So let's not allow rigidity around funding mechanisms get in the way of reform. The Commonwealth Fund Survey suggests that Canada consider payment initiatives that focus on physicians in primary care through quality-related incentives such as payments for management of chronic disease, rewards for achieving prevention targets, expanded use of nurses, after-hours care and information technology.

As teams evolve, we will need to remain flexible or we risk being caught in the same bind of having legacy systems of remuneration such as fee-for-service that don't lend themselves to evolution. We must also be open to compensating physicians and other team members for their services in ways that are more flexible and that relate more directly to the outcomes of those services having been provided. These other team members include pharmacists, physiotherapists, nurse practitioners, nurses, traditional healers, social workers, those involved in mental health, and dietitians, to name only a few; the list of PHC professionals is a long one and it's important to acknowledge the range of providers who make up a well-functioning PHC team.

We also need to acknowledge the cumulative impact of the number and kind of changes that health care providers are being asked to absorb, a caution that was noted at the National Chronic Disease Management Conference hosted by Ontario as part of its PCHTF initiative in April 2006. It's important to guard against a too rapid pace of change.

One of the key levers for a cultural shift in Canadian health care delivery is a pan-Canadian commitment to interprofessional education and the development of codes of conduct and standards of practice (post-licensure) that reinforce both skills and attitudes toward collaborative care. This includes new models of providing undergraduate training and education so we build a generation of "collaboration-ready" graduates, rethinking professional development and ensuring on-the-job support for PHC teams as they establish themselves and subsequently practice. As Curran points out in his synthesis report, PHC renewal is a departure for most practitioners, and therefore education and professional development are needed to enable them to work in a collaborative environment.

Collaboration-ready graduates will not be produced by colleges and universities without reshaping educational preparation and training of health care professionals. Curran points out that this is key. The work, such as that being done by the Interprofessional Education for Collaborative Patient-Centred Practice Initiative, part of Health Canada's Pan-Canadian Health Human Resource Strategy, and the initiatives discussed below, is fundamental to the future of PHC. We should push our thinking on how health education is provided. If health providers are to work together effectively (interprofessional practice), they must learn together (interprofessional education). We should change the question from "What can health sciences students learn together?" to "What has to be delivered separately for competency reasons?" This should also be a call to action for all leaders in the health system who, in carrying out their day-to-day responsibilities, discuss health human resource requirements and curriculum with academics and others. We should expect them to consider the impact that the decisions they're either making or influencing will have on PHC.

Multi-disciplinary thinking and approaches are becoming better established. For example, the *Integrating Primary Care with the Multi-Disciplinary Team: Collaborative Care for Substance Use and Concurrent Disorders* initiative, led by the Centre for Applied Research in

Mental Health and Addiction, helped establish the National Health Sciences Students' Association to foster multi-disciplinary collaborative care.

But a word of caution is in order if, and as we succeed, at the educational level. We need to ensure that the workplaces these new collaboration-ready graduates enter are open to their new collaborative approaches. Otherwise, the health system risks losing these highly sought-after people to other professions and industries. There is a new generation gap—people born after the baby boom as well as the "echo" generation are entering the health workforce with different expectations around remuneration and working conditions than their baby-boom parents and grandparents. We run the risk of losing these new-generation professionals if we take too long to transition to the team-based environments preferred by younger health professionals, with all the flexibility and interprofessional support they offer.

Change management support for teams is another educational requirement. This process shouldn't be thought of as an event in time but as an ongoing requirement. High-functioning teams will evolve as people come and go, as the team's composition changes, as its patient population changes and as it absorbs and develops new ways of doing things. Support is required at all these stages.

The *Manitoba PHCTF Initiative* suggested a formal team development process be developed to ensure that team members understand their and other members' roles, to help team members integrate and to implement processes and procedures. In Atlantic Canada, *Building a Better Tomorrow—Engaging Current Providers in a Renewed Primary Health Care System for Atlantic Canada* developed a joint continuing professional education "Certificate in Primary Health Care Collaboration."

We also need to establish a comfort zone for practitioners around liability concerns in PHC team environment. *Enhancing Interdisciplinary Collaboration in Primary Health Care: A Change Process to Support Collaborative Practice* found that liability issues are a concern for some PHC providers and that there is uncertainty around legal liability with expanded and cross-functional scopes of practice. Not all health care professionals carry liability insurance, which adds to the uncertainty. Among its recommendations was the development of a policy framework that addresses liability as well as regulation and funding. Curran rightly emphasizes the importance of dealing with this in his synthesis report on collaborative care.

Finally, only a word about information management and technology because it will be dealt with next as a separate foundational element: Teams require a shared understanding of situations and requirements if they are to work. Electronic health records, telehealth, opportunities to use patient simulation to test team functioning, messaging—these are all critical support elements for effective PHC teams.

2.2.2 Foundational Element Two: Information Infrastructure

It can't be overstated: information management is *the* medium that facilitates and drives cultural change in PHC. It is the new infrastructure for the health system. Information management affects the ability of health care professionals to work together, coordinate care, access timely information and provide timely, quality care. Sharing access to the same health-related information allows individuals, families and communities to engage with health care professionals and become both partners in health care and to take charge of their own health.

In the partnership between providers and individuals, families and communities that PHC requires, information management allows for:

- accurate and timely access to clinical information to enable shared decision making by providers and patients or clients;
- ongoing communication and education with and between care partners and patients or clients;
- the ability to collect and manage data to support evidence-based decision making;
- tracking information on the population being served and its specific needs, allowing for more direct and effective responses;
- standardized care practices and access to higher levels of care (specialists) regardless of geographic barriers;

- the development and use of automated protocols and tools (e.g. chronic disease management) to improve efficiency and effectiveness in service delivery;

- ready access to current clinical literature, recognized best practices and performance indicators; and

- the enhanced ability of patients or clients to access information and resources to assist them in the management of their own health, a key tenet of the new culture.

Health information management and technology is not getting the attention and recognition it deserves in Canada. This can be seen in the results of the 2006 Commonwealth Fund Survey, which showed that:

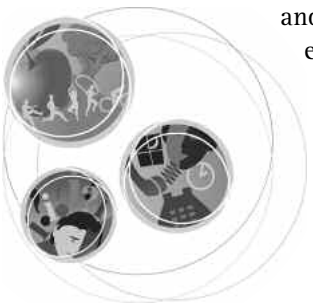
- Canadian physicians' rates of use of electronic medical records (EMRs) are low, well below those of the leading countries.

- Fewer than one in four Canadian and U.S. doctors has computerized systems to provide them with alerts, prompts and patient reminders, all of which help physicians to provide, in particular, quality care for chronically ill patients.

- Canadian physicians, along with U.S. ones, were the most likely to report that generating lists about patients (by diagnosis, prescriptions, etc.) would be difficult or impossible.

- Canadian physicians are the least likely to have medical reports available at the time of the patient's appointment.

The public appears to be far ahead of the health system in its use of information management and technology. The public is using the internet to educate itself about health (and many other) matters. People are using health line services like Health Link Alberta, which became operational province-wide in June 2003. Since the implementation of the health information and symptom-based advice line, an estimated 46 per cent (508,479) of all Albertan households have used the service at least once, and call volumes are rising. Some patients are sending their physicians e-mail and expecting responses (another grey area in terms of liability) and in the future can expect to access their own health information electronically. It's clear that the public's appetite for information and for services will rise, not fall, in the years ahead.



One of the most important warnings Protti makes in his synthesis report—and we should heed it—is that public expectations for technology-based information and communication, for example, booking appointments and asking questions of health providers by e-mail, will be no less in PHC than in any other sector of the economy. If the heart of cultural transformation in PHC is people managing their own care, PHC must be positioned to "step up" and provide people with the information necessary to make it possible.

As a country, we are not stepping up as fast and as well as we should be. While several provinces and territories had a major focus on EMRs and spent many millions on them, and Canada Health Infoway continues its efforts to implement EMRs across the country, only one other initiative focused specifically on EMRs, *Supporting the Implementation of Electronic Medical Records in Multi-disciplinary Primary Health Care Settings*. This reinforces the observation by the Commonwealth Fund Survey that Canada is not placing as much emphasis on this important tool as our peer countries. This apparent lack of emphasis—or results—will impede our ability to effectively manage chronic diseases and complex medical conditions. All parts of the health system must come to a common understanding on the many benefits of information management and technology, particularly for team-based care, chronic disease management, and evaluation and evidence.

As well, information management and technology is an enabler of new processes, not just an "automater" of old ones. Health lines illustrate the point. The lines initially focused on assisting people in managing their episodes of illness without using emergency departments. Their focus has evolved to supporting the health system in general and PHC networks in particular. This evolution was assisted by the *Health Lines* initiative, which brought together Alberta, British Columbia, Manitoba, Northwest Territories, Yukon Territory, Nunavut and Saskatchewan in looking at planning and implementing new health line services such as supporting and delivering chronic disease management initiatives. Another example is the Chronic Disease

Management Toolkit developed through the *British Columbia PHCTF Initiative*, software whose introduction helped lead to widespread adoption of evidence-based care to individuals with chronic disease and a greater focus on prevention and self-management.

Several of the initiatives that used technology to bridge the gap between identifying measures and their implementation were in Aboriginal communities. The *Tuik'n Initiative*, *A Tool to Help People from Far Away—The Ikajuruti Inungnik Ungasiktumi (IIU) Telehealth Network* in Nunavut and the *Initiative to Implement a Digital Radiology and Tele-Radiology System in Nunavik* were undertaken, at least in part, with the aim of providing a more equitable level of PHC services between sparsely populated and geographically separated areas in the case of the Tuik'n Initiative and between the north and south in the latter two initiatives. Other important aims included:

- more prompt and accurate diagnosis and treatment;
- less travel time and therefore lower costs for patients and health providers;
- the ability to treat patients in their own community;
- better health information for self-education aimed at disease prevention and chronic disease management; and
- vital support for health care providers working in remote locations.

These initiatives were markedly successful, and we need to apply these lessons to similar situations in Canada.

Telehealth is another remarkable tool that's being underused in Canada. Telehealth allows care to be delivered closer to home. It facilitates better continuity of care, the development of multi-disciplinary teams even when they're not in the same location and the ability to deliver education at a distance to health workers who otherwise might not be able to access programs. The *Enhancing Access and Integrating Health Services—Keewaytinook Okimakanak (KO) Telehealth/NORTH Network Partnership Expansion Plan* initiative extended telehealth services to 19 Aboriginal communities in Northern Ontario. Not only did this enhance access to health providers, it also helped strengthen the communities by building PHC capacity. Alberta has one of the largest telehealth networks in North America and is finding that in addition to strengthening care, it also opens the door to multi-jurisdictional partnerships that otherwise might not be possible. For example, Alberta Health and Wellness has partnered with Health Canada's First Nations and Inuit Health Branch Alberta Region to make investments to extend both existing and planned telehealth services to First Nations communities.

For all the remarkable achievements, Canada continues to underperform in and underuse information management and technology. One lesson that can be taken from this overall lack of emphasis in this area is that we cannot rely on physician investment to build the necessary capacity. For more and better use of information management and technology to happen, the burden of financing basic infrastructure and particularly the essential "discipline" of an information management system must become owned by the system and be supported centrally. Without a concerted system-level commitment, issues such as insufficient and inflexible funding, administrative pressures and competing demands from acute and higher levels of care (to which it is imperative providers respond) will continue to take precedence and slow progress. This focus on the pressures of the day to the exclusion of building tomorrow's infrastructure is short-term gain for long-term pain.

We are, however, on the right track with Canada Health Infoway, our national plan for the development and diffusion of health information technology. Infoway's goal of having "an interoperable EHR in place across 50 per cent of Canada (by population) by the end of 2009" (Canada Health Infoway, n.d.) sets Canada in the right direction. We have much to do to get there, especially if we are to ensure that the information highway doesn't stop at the major health facilities but reaches to the environments where PHC teams work, whether in offices, clinics or communities. We need to put the technology into people's hands where they can use it on a daily basis. The adoption of information management and technology has been treated as the provider's responsibility. But we have to get beyond that thinking; this is a health system issue that must be dealt with both at a system (central) level and peripherally where the ultimate users of the technology live and work. Linking people through technology and using the technology to share accurate, timely and reliable health information to improve care will drive change.

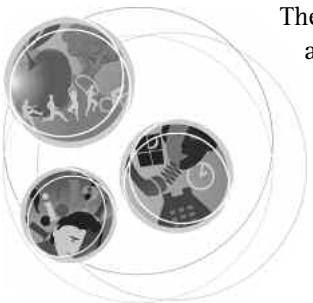
Lack of a structured approach to knowledge management and exchange can delay progress. We may have 13 provincial/territorial jurisdictions, along with the federal health delivery system, but that doesn't mean each has to take a "from the ground up" approach for every application. Information management design needs to incorporate transferability wherever possible. The *Western Health Information Collaborative (WHIC) Chronic Disease Management Infostructure Initiative* is a good example of an intentional effort to do this.

Health human resource planning must take into consideration the supply of skilled information management and technology professionals. In fact, such persons must be carefully considered as a top priority in human resource planning. Only these professionals can provide the necessary infrastructure and tools that will enable providers to deliver more and better PHC with existing resources.

Finally, we should consider opportunities for a shared approach to the evaluation and management of vendors by neighbouring jurisdictions, or even on a pan-Canadian basis. These functions carry a burden of cost and time that could be better devoted to other areas such as the development of teams.

2.2.3 Foundational Element Three: Knowledge Gathering and Diffusion

If we are going to transform our health care culture and meet the health needs of Canadians, we have to take a serious, systematic and sustained approach to knowledge gathering and diffusion throughout the PHC system. Information needs to be shared broadly and deeply—across provincial/territorial boundaries *and* into the hands of those who directly deliver care. If this doesn't happen, we will continue to waste millions of dollars reinventing the wheel and using less than optimal practices. We need to use "the best of the best" and make it as easy as possible for practitioners and the public to do so. This is how capacity will be built across the country, within our institutions and within the lives of Canadians.



The PHCTF initiatives have taken us far along the road to building this capacity. June Bergman notes in her synthesis report on evaluation and evidence, that significant groups of people at national, provincial, regional and local levels have developed interest and expertise in primary care evaluation. As a result, the understanding of primary (health) care as the largest single component of the health system and a prime influence of health care accessibility is very broad.

So what is next?

Clearly, an effective, integrated system of information management supported by the requisite technology is essential. But networking and partnerships are also critical in knowledge gathering as well as its transfer and dissemination. We need to ensure that we have the data and the capacity to figure out what the data are telling us. The capacity and resources both to gather and evaluate information do not exist uniformly across the country. Wherever possible, this challenge needs to be overcome, either through the provision of services by external consultants or, better yet, by networking. The will to work across jurisdictions is there if the connections are made. Many of the PHCTF initiatives are good examples of this. For example, *The Pan-Canadian Primary Health Care Indicator Development Initiative* used extensive consultations across the country to develop agreed-upon pan-Canadian PHC indicators. *Getting a Grip on Arthritis: A National Primary Health Care Community Initiative* brought people together from across the country to develop more patient-centred clinical guidelines.

Bergman calls for the establishment of communities of practice that include concepts like change management in primary care, facilitation and continuous quality improvement. These groups would continue to develop standards, education and resources, and create momentum. At the same time, we need to ensure that we use the pan-Canadian infrastructure already in place. This includes the Canadian Institute for Health Information, Canadian Council on Health Services Accreditation, Canadian Healthcare Association and Canadian College of Health Service Executives, as well as the national and provincial/territorial colleges and associations. They all play important roles in information gathering and dissemination. Curran notes that the professional system had a strong influence on the development of collaborative practice and highlights the work of the *Enhancing Interdisciplinary Collaboration in Primary Health Care: A Change Process to Support Collaborative Practice* spearheaded by one coalition and 10 associations. As well, the *Canadian Collaborative Mental Health Initiative* brought together 12 national organizations

that successfully developed a shared vision of collaborative primary mental health care and a series of practical toolkits.

These communities of practice, formal or informal, are useful to ensure that we can leverage lessons learned in one jurisdiction into other jurisdictions and stop reinventing the wheel. Sargious points to the *Western Health Information Collaborative (WHIC) Chronic Disease Management Infostructure Initiative*, *Health Lines* and the *Health Integration Initiative* as having created economies of scale and avoiding duplication by sharing and co-development. Yukon, Saskatchewan and Manitoba have successfully adapted British Columbia's Toolkit for Chronic Disease Management and *WHIC* created a common framework across the four western provinces.

National institutions can also play an important role in the critical task of connecting knowledge diffusion with accountability and quality assurance. In particular, we need to ensure that the ongoing process of accreditation already embedded in much of Canada's health system spreads to PHC and becomes a tool for disseminating information about best practices in PHC and establishes quality benchmarks that PHC teams can measure themselves against. Accreditation in acute care and long-term care is well established in Canada. Through it, the Canadian health system has worked hard to establish standards in all aspects of acute care, long-term care and more recently, in community care. Work by the Canadian Council on Health Services Accreditation regarding required organizational practices for patient safety in the past few years is another example of how accreditation is being used to further health system goals. We can and should do the same for PHC practices.

Accreditation can also give the public an external measure of the effectiveness of the services they're accessing. As the Health Council of Canada said in its 2006 Annual Report, "Accreditation is a powerful lever to move us towards improved quality of care and better patient safety. Governments should make it a condition of public funding" (Health Council of Canada, 2006, p. 57). Accreditation and its role in establishing standards of practice can also leverage change in the educational sectors—if collaborative care is required by practice standards, it will become reflected in curriculum.

2.3 Transformational Elements

If the above three elements are critical to building a solid foundation for a PHC culture in Canada—and they are—the next three elements are just as critical. These elements are less incremental in that it will be harder to develop a game plan or flow chart for them. That being said, they are even more important than the foundational elements to truly transform Canada's health system.

2.3.1 Transformational Element One: Leadership

Throughout the synthesis reports and within the PHCTF findings, the need for and the importance of leadership arose again and again. Whether it was Sargious talking about the lack of coordinated chronic disease prevention and management strategies at a provincial/territorial level; Curran's call for tort reform and other legislative and regulatory changes to better support interprofessional collaboration; Protti's call for the adoption of national data, coding and messaging standards; or Bergman's identification of the need for a national evaluation body, it all comes down to one thing—leadership. And leadership not just at a national/provincial/territorial level. Leadership within communities, within professions, and within PHC teams is just as vitally necessary.

A lack of leadership costs the health system and Canadians dearly. As the Health Council of Canada said:

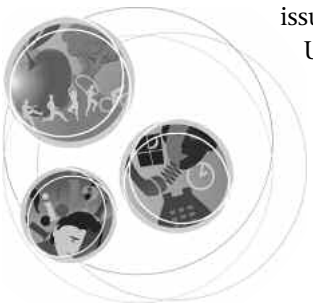
> If we compare ourselves to other places that have transformed their health services in recent years —most notably the National Health Service in the United Kingdom and the Veterans Health Administration in the U.S.—progress in Canada has been slow. The Health Council believes that the biggest roadblock is a general reluctance among governments and health care leaders to set targets and be held accountable for progress. It appears that leaders are waiting for change to be universally endorsed before they vigorously pursue it. Greater leadership is required; without it, renewal efforts will drift. At the current pace of change, critical aspects of renewal—such as the widespread introduction of primary health care teams and the electronic health record—won't be

> fully in place for many years. Can our highly valued health care system afford to wait? What needs to be done to unlock the gridlock? (Health Council of Canada, 2006, p. 6).

How do we do this—unlock the gridlock and accelerate the pace of change? Part of the answer must lie in leaping over processes and looking for results. Rather than looking at what we can't do, let's look at what we can. The *Bigstone–Aspen Shared Initiative Care (BASIC)* addressed the same Government of Canada/FirstNations/provincial and regional cross-jurisdictional barriers that slow progress in Aboriginal health care delivery across the country. BASIC was able to develop a home care delivery model with shared jurisdiction and a new financial reimbursement model for physicians, and build a multipurpose facility used to deliver local health, children's and social services in a remote community accessible only by air. The initiative credits a good deal of its success to strong leadership and support from the administrative leaders of the partner organizations. It can be done.

At times leadership will mean that we set realistic targets for success, rather than waiting to achieve perfection. We should not wait for perfect definitions of scope of practice. Where scopes of practice are defined by provincial/territorial professional associations, governments should give them permission to expand their scope within their professional qualifications and, within a regulated environment, to see how it works. When the limits on scope of practice are set by employer practices, leadership within workplaces needs to examine how its policies and practices are limiting the best use of people's skills.

This necessary measure of realism can be applied to the development of new leadership models that support culture shifts and PHC outcomes. In December 2003, the Alberta Medical Association, Alberta Health and Wellness and the province's nine Regional Health Authorities signed a historic trilateral agreement to guide the system's relationship with Alberta's physicians. The trilateral process uses joint decision-making and is helping the system find new solutions to historic issues, including the provision of PHC. Using $100 million from the province's 2003 Health Accord allocation, the agreement included a plan to create Primary Care Networks to improve and coordinate primary care for Albertans. As part of the additional funding provided to the Primary Care Networks, these organizations were to provide 24/7 access to appropriate primary care providers; an increased focus on health promotion, disease and injury prevention, and chronic disease management; and enhanced coordination between community family physicians and the rest of the continuum of care such as hospitals, home care and palliative care. The outcome? By the end of 2006, almost two-thirds of the province's population was covered by a Primary Care Network either up and running or in the planning stages, a clear outcome from a new leadership model (Alberta Health and Wellness, 2004).



Leadership also means ensuring that enough resources are devoted to system planning, to developing and setting out a vision, putting effective strategic plans in place, and then carrying them out. And not stopping too soon. Anyone who has been around the system has witnessed what can be termed "implementation failure" because the project or initiative has been abandoned as a new issue arose, distracting the system from its initial plans. We need to follow through in PHC reform so that we maximize the benefits from our investments.

Let's agree on the principles, characteristics and components of PHC that Bergman points out as necessary for good comparisons. Let's give regulators the flexibility to adapt regulation and policy to support change. Let's ask our governments to build in the capacity to provide timely rulings and reviews.

Let's find the leaders in the teams, in the communities, in the system and give them permission to lead. If we don't, we will continue to pay more for health care and get poorer health outcomes than if we move more rapidly to a strong PHC culture. Chronic disease prevention and management is an excellent example. The cost of chronic disease is huge and growing; the World Health Organization estimates that two million Canadians will die from a chronic disease in the 10 years leading up to 2015. Chronic disease costs the health system, it costs the economy in terms of productivity, it hurts our ability to care for one another, and diminishes our quality of life as Canadians.

And let's be clear: Developing a robust system of PHC will take considerable resources, and leaders, particularly political leaders, will have to defend and explain those expenditures to the public. Primary health care,

including prevention and wellness, has suffered from a lack of resources. Money has flowed to acute care at a far greater rate. While the PHCTF received a significant allocation of the *targeted* funding available under the 2003 Health Accord (and provinces and territories were able to allocate further funds from the overall 2000 Health Accord funding and other monies provided to them), it was still only a modest portion of the overall funding. Yet we know that PHC is how we will improve health outcomes for the vast majority of Canadians and keep people out of the very expensive acute care system.

Our leaders need to set out a solid course of action on PHC, resource it appropriately in an enveloped budget so that the funding can't shift to acute care, and stay the course—all the while knowing that both the need and demand for acute care will not go away and will have to be managed. They need to explain to the public why meeting the opportunity cost of substantial investment in PHC is in the best interest of the health of all Canadians. Boards and chief executive officers of regional health authorities, hospitals and many other organizations will need to do the same within their spheres of influence.

To everyone in the system goes the clear message that if we want leaders to make these tough choices, we must give them the evidence to support those choices. Good, compelling evidence is essential to support difficult decisions. In the absence of good numbers and strong evaluations of the immediate, intermediate and long-term benefits, it is difficult to explain to the public why more attention must be paid to PHC, especially if it comes at the expense of acute care and our existing model of primary care to which so many people remain attached.

One of the legacies of the cost cutting of the 1990s continues to be the thinness of the leadership and management ranks throughout Canada. Good people left health care in the 1990s, and resources that would have gone to developing the leaders of tomorrow were diverted elsewhere. This, coupled with the same blunt demographic messages everywhere that we're getting older, makes it imperative that we invest in developing new leaders. The Canadian health system has tended to be driven by acute care specialists; even now training programs for physician specialists are far more popular with new trainees than generalist programs like family medicine. When we look for tomorrow's leaders, we should be looking to include more generalists who see a future that stabilizes our acute care needs and balances them with a robust PHC service—the upfront end of any highly functioning health system. And let them know how much their contributions are valued.

Leadership in Canada's health systems is diffused, but this isn't a rationale for inaction. Everyone at every level has to accelerate the pace of change. Collectively, we must all lead.

2.3.2 Transformational Element Two: Canadians at the Centre of Their Care

Patients are at the centre of collaborative care because they are the very reason behind the interdependency of health professionals. They need to be active members of the interprofessional team, together with their caregivers. If we truly believe that patients are at and should be at the centre of the PHC model, we need to help Canadians understand what this means so that they can embrace their part in this new paradigm. More and sustained initiatives such as the *National Primary Health Care Awareness Strategy Initiative* are part of the answer. Health professionals also have an important part to play in helping patients understand their role as full participants in their own care. At the same time, professionals must also be prepared for the required change in how they practise as patients become empowered, more active participants in their own health and wellness.

Information technology is going to play a very large role in this change; indeed, it already has. Across Canada, more and more Canadians have access to health information lines, are looking up information on the internet and demanding access to their care providers by e-mail. This is a significant power shift. However, the use of technology to access health services by Canadians lags that of its use in other parts of their lives. Canadians bank online, book airline tickets and print boarding passes, buy music, communicate with others and access the news. Commensurate access in Canadian health care doesn't exist.

Members of the public will expect to have as ready access to their own and general health information as they do in other areas of interest. We have to be ready for this and think through the liability and privacy issues and how to manage this additional demand on the time of providers.

Self-management of health means that patients, will have access to their own health information, something that we need to build into our understanding of what

electronic health records will be used for. In the United States, for example, Kaiser Permanente has launched a wellness self-management initiative called Choose Health, giving patients the tools they need to track their own baseline information such as blood pressure and cholesterol levels (Kaiser Permanente, 2007). This patient portal gives patients some of the same access to their health information that their primary care team has—they can book appointments, look at lab test results and refill prescriptions—and the uses are expanding. It's a powerful statement about entrusting patients with their own health information and about giving them a role in and responsibility for their health.

On this journey, inevitably there will be points where Canada's publicly funded system will not meet every individual's demand. As a system, we will need to be open to talking about what is and isn't possible, what people should and should not expect from the system. We will need to be just as open to listening to client-generated ideas on how we need to better understand their place at the centre of their care.

This will require investment in public awareness and confidence building. It will require giving PHC teams the resources so they can work with people as they interact with the team. And it will require an understanding that personal change is rarely if ever a conversion experience, but a journey of many small steps.

Perhaps the most important lesson of the PHCTF regarding chronic disease prevention and management is that our cultural assumptions about publicly funded health care must change. Our thinking must no longer be that "the system will take care of me when my health fails" to "the system is here to provide me with information, resources and support to assist me in managing and improving my own health." All of us have to think about our health in terms of risk management, just as we do when we make the decision to use our seatbelts when we drive a car or to change the batteries in our smoke detector.

We have seen evidence of this shift in some PHCTF initiatives, but there is a long way to go before it is "internalized" and distributed throughout Canada.

We need to prepare the new cultural norm of collaborative care by managing expectations and fostering new attitudes like:

- Primary health care is a service I choose to access to help manage my own health, including but not limited to visiting my provider when I'm sick.

- A team of many health professionals—including my physician—shares responsibility with me for managing my care.

Our health initiatives have traditionally used a disease state focus, such as the fight against cancer or heart disease. This "attack and conquer" approach has brought about results. However, we need to consider adopting approaches that focus on how people think, plan and act in relation to management of their "whole" health, giving these approaches the same or greater emphasis we place on our disease state focus. When weighing out the relative merits, let's give more weight to initiatives that will improve long-term sustainability as opposed to which will offer quicker "wins." We need to look at tools such as the Stanford Self Management Approach, where all its programs help people gain self-confidence in their ability to control their symptoms and learn to set plans and manage how their health problems affect their lives (Stanford Patient Education Research Center, n.d.). And again, this goes back to evidence. We need the hard numbers to prove the effectiveness of PHC and bolster the case for devoting the resources to helping people manage their own care.

We cannot help people make this shift unless we address the problem in terms relevant to both their culture and context. Culture can include language and religious beliefs. Context is about meeting people and communities where they *are*—rural/urban, rich/poor, good health/poor health. Sargious uses the term "cultural competence" to describe this.

The *Tui'kn Initiative* is perhaps the best "case study" for Canada in PHC cultural transformation. Tui'kn did not focus on the massive change of a single element; instead, it looked at how five communities could work together to organize collaboration at all levels—between communities, within provider teams, between communities and providers, and between the "system" and patients/clients. Tui'kn aimed high and wide: It sought to show people they are entrenched in a culture of sickness and should shift to a culture of health. It also

showed the effectiveness of PHC in ensuring that disadvantaged populations have access to care that improves their health outcomes. As Barbara Starfield and others have shown, PHC can be a great leveler—systems with a strong primary care focus have better health outcomes across the entire population than systems oriented toward specialty care (i.e. acute care) (Capital Health, 2006).

2.3.3 Transformational Element Three: Health Outcomes

In looking at chronic disease prevention and management, Peter Sargious says that with any answer to the question of what has been achieved in chronic disease prevention and management, some will see the glass as half empty; others as a glass half full. The same is true of any fair assessment of the outcomes of the PHCTF, but we need to ask ourselves: At the end of the day, which glasses should we be examining?

Most initiatives included a focus on developing infrastructure and common definitions of PHC. For example, important work was done by the *Building a Better Tomorrow—Engaging Current Providers in a Renewed Primary Health Care System for Atlantic Canada* initiative, which developed an interprofessional education program and brought together thousands of health care professionals from across the four Atlantic provinces to learn the skills necessary for successful PHC teams. *The Pan-Canadian Primary Health Care Indicator Development Initiative* developed national PHC indicators. These are all important achievements of the PHCTF. However, an overall emphasis on business-level indicators (e.g. funding, administration) will not drive the kind of transformative change—and to some extent the foundational elements as well—that this report is strongly proposing. Going forward, the key questions we need to answer concern the impact of PHC models on health. *What are the health outcomes?*

Lamarche, Beaulieu, Pineault, Contandriopoulos, Denis et al. (2003, p. 2) describe six broad effects that PHC should produce:

1. Effectiveness (the ability to maintain or improve health);
2. Productivity (the cost, quantity, type and nature of health services);
3. Accessibility (promptness and ability to access primary health care professionals);
4. Continuity (the extent to which services are offered as a coherent succession of events);
5. Quality (the total appropriateness of care as perceived by patients or professionals); and
6. Responsiveness (consideration of and respect for the expectations and preferences of service users and providers).

In determining how well we achieve these outcomes, if these are the ones we choose, we need to look beyond our traditional frame of reference in the health system. We will have succeeded when measures of individual and population health and improvements in health status are afforded the same headlines as emergency wait times.

By getting beyond good process as a measure of success and into verifiable outcome measures, we will bolster the case for better and more targeted investment. Our efforts as a system need to move up the management practices' hierarchy from "invest and then measure" to "measure and then invest."

The key cultural shift will be when we have moved from a practitioner focus to a service focus. With a practitioner focus, we say we are successful when one provider provides treatment for one patient to address an episode of ill health. This focus is embedded in the provider's discipline and desire to preserve autonomy. His or her knowledge of the patient, family and community is formed by episodic encounters.

In a service focus, a team of providers makes a range of services available to a given community for the purpose of improving and maintaining individual, family and community health. The team has access to the perspectives of multiple health disciplines, each bringing its own influences. The team's knowledge of the individual, family and community is based on experiential knowledge gleaned over time.

Bergman notes that as people worked through the initiatives, there is a progression in thinking toward the need for outcome evaluation—away from project management, to summative evaluation, to outcome evaluation. This is encouraging because outcome evaluation will be a critical part of transforming our health system.

3 Conclusion

The PHCTF was not intended to solve all the ills of the health system. It was created to encourage the various health systems that co-exist in Canada to move toward team-based care, greater access, and a more efficient way of carrying out and delivering PHC services. Implicit in these objectives was improving the overall quality and efficiency of PHC services, and making better use of health human resources.

The PHCTF recognized from the outset that there was no common starting point, even among the provinces. It was essentially a call for accelerated action. It pointed to what needs to be done to lead and support the transformation that was then beginning to take place among the pioneers in PHC. Although the PHCTF itself was time-limited, the changes that it supported were intended to have a lasting and sustainable impact on the health system.

At the same time, the PHCTF was more than the sum of its initiatives. It represents—and has helped to bring about—a mental shift in how many health care professionals and administrators think about PHC in this country. It has helped to challenge the way Canadians have traditionally thought about their health system. It has turned our view of the health system on its head, giving us a new lens to view the key levers that can influence individual and community health.

In many ways we are thinking—or should be thinking differently and working differently as a result—with our eyes more open to what our priorities should be and the directions in which we need to move.

These are some of the ways in which the Canadian health system is changing:

- Primary health care is shifting, more slowly than is desirable but still shifting, from a practitioner/provider focus to a service focus centred on the needs of people as those needs relate to regaining and maintaining individual health.

- Unique and customized approaches to service delivery are being designed, based on a comprehensive knowledge base and guiding principles.

- Facilitators to lead and support interdisciplinary collaboration in diverse care settings are being trained. Strategic partnerships between health and non-health organizations are addressing determinants of health in addition to care of the sick and injured.

- Patients are beginning to be engaged in making key decisions about their health and health care, and an environment that equips people to self-manage chronic conditions is being built.

In short, we are changing our culture and refocusing it on maintaining and improving health.

To complete this culture shift, the Canadian health system must build a solid PHC foundation by:

- developing, supporting and incenting PHC teams;

- putting Canada's information infrastructure in place and then continuing the work of maintaining it and capitalizing on the opportunities it will create; and

- knowledge gathering and diffusion, giving all Canadians access to the best health opportunities.

These are not sufficient unto themselves. The risks and rewards lie in these elements that will help transform the system and are necessary for success:

- leadership that puts aside differences and focuses on health outcomes, population health and maximizing the use of scarce resources;

- putting Canadians at the centre of their care by arming them with the tools and knowledge they need to manage their own health and their care, focusing on the determinants of health and investing in engagement of the public; and

- moving to a health outcomes focus in all we do, expanding our points of reference beyond the health system.

Perhaps we need to take a lesson from Gene Kranz, who joined the National Aeronautics and Space Administration (NASA) in the 1960s and subsequently wrote the book *Failure Is Not an Option* about the early days when NASA had to create the Mercury mission rules and procedures from the ground up. He says, "Since there were no books written on the actual methodology of space flight, we had to write them as we went along" (Kranz, 2000, p. 8). If they could do it without any books, we should be able to complete the work of creating a viable PHC system with all we know.

We have the knowledge.

We need the collective will to change.

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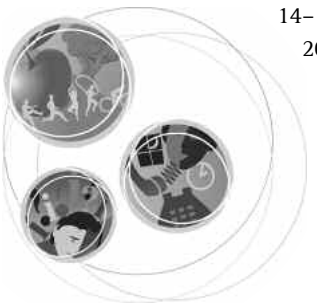
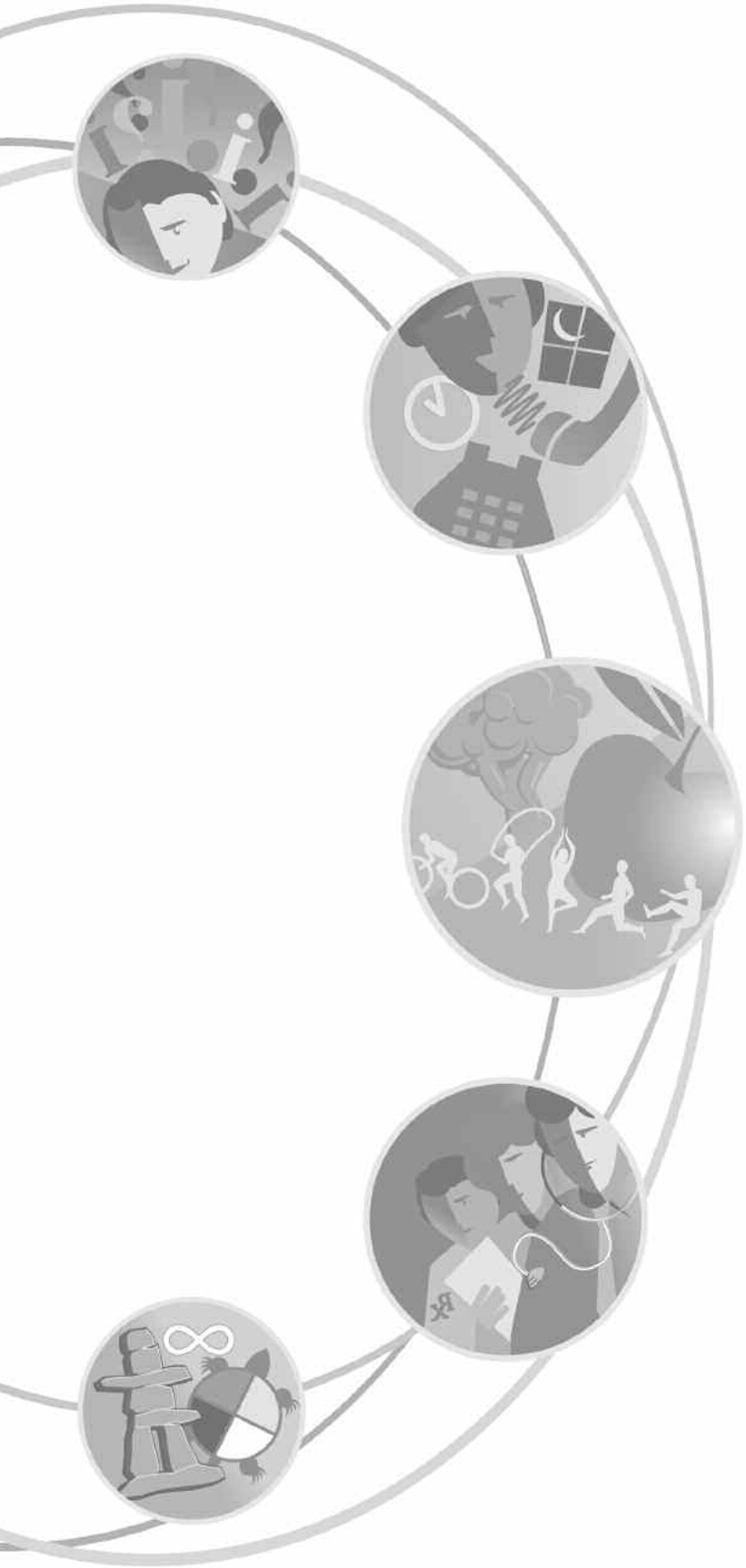




Appendix A

This appendix contains the executive summaries of the four themed synthesis reports.

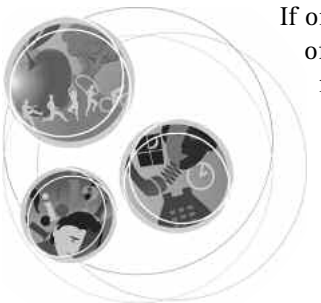
Chronic Disease Prevention and Management

by Peter Sargious

Canada, like other developed and developing countries, is facing an epidemic of chronic disease. As a result, concepts of chronic disease prevention (CDP) and chronic disease management (CDM) are emerging as important challenges to individuals, health systems, communities and society as a whole. Yet in spite of their importance, these concepts, and their interrelationship within health system reform and a broader public health agenda, remain poorly understood by Canadians and, arguably, the governments that serve them.

In reviewing the Primary Health Care Transition Fund (PHCTF) initiatives from the perspective of chronic disease prevention and management (CDPM), the following key learnings were identified:

- CDP and CDM are emphasized to different degrees within provincial/territorial health systems—where the emphasis is strong it appears to provide focus for other elements of primary health care, namely collaborative care, information management and technology, and evaluation.
- Efforts at CDP and CDM do not appear to be co-ordinated.
- Canadian jurisdictions will collaborate to create shared CDPM infrastructure—and benefit from national supports that facilitate and reward this.
- Primary care physician practices were most frequently seen as the focal point around which interdisciplinary CDM should develop.



If one were to regard each of the groups of initiatives (provincial/territorial, national, multi-jurisdictional, official languages minority communities and Aboriginal) as a glass, one could ask, in looking at them, whether in fact the glass is half full or half empty. For each glass, the answer to the question is necessarily both—half empty and half full. All initiatives have contributed in some way to advancing CDPM; all have acknowledged the need to do more.

The experiences related to CDPM in each PHCTF initiative and the findings learned from a collective review have important implications for policy and practice if Canada is to respond strategically to the growing burden of chronic disease. A convergence of thought and strategy between CDM and CDP agendas, and a clearer articulation of their relevance to modern health systems and civil societies, remain ongoing challenges.

Collaborative Care

by Vernon Curran

A fundamental principle of primary health care (PHC) renewal in Canada has been the call for greater collaboration among health care providers. Collaborative care is a patient/client-centred process in which two or more professions/disciplines interact to share knowledge, expertise and decision-making in the interest of improved patient/client care. It is believed that teams that collaborate are more able to address the increasing complexity of the Canadian population's health care needs. It is also believed that greater collaboration between health professionals can result in better health, improved access to services, more efficient use of resources, and better satisfaction for both patients and providers. The purpose of this report is to review initiatives funded through the Primary Health Care Transition Fund (PHCTF), which addressed issues related to collaborative care in different PHC settings.

Across all 13 jurisdictions funded through the *Provincial–Territorial Envelope* there was a range of innovative and varying models of collaborative care involving interdisciplinary/interprofessional teams of health and social care providers. Models of collaboration were characterized by the nature of the collaborative (e.g. geographic region vs. patient type), role expansion of team members, regionalization of collaborative care, and delivery of collaborative PHC services based on population health needs. Interprofessional education

(IPE) at pre- and post-licensure levels, the enhancement of electronic medical/ health record systems, and overall positive outcomes pertaining to patient and provider experiences with enhanced models of collaborative PHC were key trends which emerged across the provincial/territorial initiatives.

The *Multi-Jurisdictional Envelope* supported regional approaches, which complemented the PHC renewal activities of participating provinces and territories. Regional approaches to post-licensure IPE development and delivery, overall coordination of primary health services and the identification of common standards for electronic health information were found to be successful. *National Envelope* initiatives were funded across three sub-envelopes, including National Strategies, Tools for Transition and National Initiatives. Initiatives funded under the National Strategy on Collaborative Care sub-envelope were successful in engaging professional associations and developing resources to foster collaborative care models. A common trend across the Tools for Transition initiatives was stakeholder engagement and consultation at provincial and national levels on issues related to collaborative PHC. National Initiatives were funded at local or regional levels and included a focus on enhancing collaboration in chronic disease care, palliative care and care for targeted populations within Canada.

A common theme across *Aboriginal Envelope* initiatives was the promotion of more effective PHC service delivery to Aboriginal people, while enhancing service delivery coordination among all levels of government as well as Aboriginal communities and health organizations. The *Official Languages Minority Communities Envelope* supported activities that improved access to PHC services for English-speaking minority communities in Quebec and French-speaking minority communities outside Quebec, across Canada.

Key outcomes/results and findings emerging from the review were categorized as either representative of interactional, organizational or systemic determinants influencing collaborative PHC. Interactional determinants represented components of interpersonal relationships among team members that affected collaboration. Understanding the roles of team members and how these roles contribute to client outcomes was reported as vital to building trusting relationships and team development. The location (e.g. co-location) of providers was an important factor that supported team development processes in a number of initiatives. Collaborative care was also found to benefit from the availability of standards, policies and interprofessional protocols. Collegial development of collaborative care guidelines or practice manuals was an important interactional factor across some initiatives as well.

Organizational structure, including administrative supports and leadership, was also reported to be an important organizational determinant that fostered collaborative PHC across a number of initiatives. An organization's philosophy and its inherent values were found to have a direct impact on the degree of collaboration. Several key outcomes emerged from the PHCTF initiatives pertaining to organizational determinants. Key leaders had been successfully engaged in building support and fostering PHC renewal. Some initiatives had advanced knowledge and had adopted best practices to facilitate collaborative PHC. Numerous toolkits, practice manuals, frameworks and other resources related to enhancing and facilitating collaborative PHC resulted from the PHCTF initiatives. Several initiatives also advanced knowledge related to electronic information systems and telehealth to support interprofessional collaboration.

Successful collaborative care was also influenced by systemic determinants. Systemic determinants are elements outside the organization, such as components of social, cultural, educational and professional systems. The professional system has a strong influence on the development of collaborative care approaches, and several PHCTF initiatives were successful in engaging stakeholders from the professional system to advance collaborative PHC. Interprofessional education was a major activity across many PHCTF initiatives, and the outcomes have advanced knowledge of the role and effectiveness of both pre- and post-licensure IPE in fostering and developing collaborative PHC teams. A number of initiatives were also successful in laying the groundwork for advancing collaborative PHC at regulatory and funding/remuneration system levels.

A number of implications for policy and practice form the basis of the following recommendations:

Liability and regulatory enhancements: Further enhancement to liability and regulatory mechanisms at both

national and provincial levels needs to be undertaken to support collaborative care in different PHC settings. The recommendations arising from some of the initiatives funded through the National Strategy initiatives would be helpful in guiding pan-Canadian approaches to such changes.

Compensation and funding: Adequate funding and remuneration models are necessary to support the shift to collaborative care models in PHC settings. Traditional fee-for-service methods of remuneration of health care providers discourage collaboration rather than facilitate it.

Interprofessional education: IPE is important in enhancing collaborative competencies that foster team development. IPE at pre- and post-licensure levels, as well as IPE in practice settings, is critical to fostering patient-centred collaborative care.

Organizational supports: Resources and support at an organizational level are necessary to introduce innovative models of collaborative care, including planning and coordination, information technology (hardware, software, training, ongoing support), common standards, tools and practice guidelines, physical space, and adequate funding and incentives.

Patient-centredness: Patients and caregivers must be included as members of the PHC team. To do this, patients and caregivers need better understanding of the collaborative process and the roles of various providers. Greater efforts to explore the roles of patients and caregivers as members of the team and how to integrate them are critical.

Health human resources plans: The supply, mix and distribution of PHC providers has significant implications for models of collaborative care. Health human resource plans that support collaborative care models are required to sustain PHC renewal.

Integration of traditional providers: Interprofessional teams of both traditional and Western providers are necessary for health care delivery in many Aboriginal communities. Greater effort must be placed on incorporating traditional providers into team-building efforts.

Education of Western providers: Health professional graduates are generally poorly prepared to work with traditional providers in remote areas of the country. Academic institutions need to introduce greater opportunities for students and trainees to learn to be culturally competent.

Greater evidence of collaborative PHC outcomes: There is a clear need for further evidence of the effectiveness of collaborative care models in PHC settings and the characteristics of collaborative efforts that support positive patient and health outcomes, organizational efficiency, and enhanced patient and provider satisfaction.

The PHCTF was successful in fostering and supporting the introduction and further development of a variety of innovative models of collaborative care across Canada. In some initiatives, the PHCTF was effective in establishing collaborative care teams, while in others the PHCTF was helpful in supporting existing strategies to implement new models of PHC collaboration. The PHCTF initiatives brought together key stakeholder groups at both national and provincial levels to advance PHC renewal. The outcomes/results and findings from the initiatives have advanced knowledge of effective strategies for nurturing and sustaining collaborative care in different PHC settings. Patient and provider satisfaction has increased in settings in which innovative models of collaborative care have been integrated. The numerous resources resulting from the various PHCTF initiatives will also continue to support collaborative PHC and help to sustain PHC renewal in Canada well into the future.

Evaluation and Evidence

by June Bergman

The Primary Health Care Transition Fund (PHCTF) supported the development of new and innovative ways to provide primary health care and primary care. Locally developed and implemented care models fulfilled the basic objectives of the PHCTF, but as the initiatives attempted to fulfill their mandate to evaluate their progress, it became obvious that an overarching evaluation framework including indicators and tools was missing.

Fortunately, the federal, provincial and territorial governments had also recognized the absence of an evaluation infrastructure and through the PCHTF commissioned several initiatives grouped under the *National Evaluation Strategy*. This Strategy has now provided a possible framework and indicators to follow for a national comparative evaluation and the subsequent production of evidence.

The initiatives that addressed evaluation and evidence confirmed the need for a strong national evaluation infrastructure, which must also boost local capacity for evaluation. The PHCTF initiatives identified the infrastructure components as being information technology, change management and national communities of practice. Only through partnerships between primary care providers and those with expertise in evaluation can Canadians benefit both from the development of evidence of what works in primary care and from the development of local quality improvement capacity.

As the initiatives attempted their own evaluations, the participants became more interested in the subject and came to appreciate the critical need for factual and defensible outcome evaluation.

We need now to support ongoing evaluation by:

- implementing national support structures for primary health care evaluation;
- maintaining our communities of practice developed through the PHCTF;
- validating and testing the developed primary care evaluation infrastructure;
- building local capacity in quality measurement, and other supportive infrastructure elements; and
- supporting information technology infrastructure that facilitates evaluation capacity.

We now have the opportunity to build on the initiatives to demonstrate and refine the newly developed evaluation infrastructure. By establishing ongoing support for continuing evaluation, we can truly begin to answer some of the critical questions that arise from reformed primary health care:

- What outcomes are we seeking to achieve?
- How will ongoing accurate data retrieval be achieved?
- What is the sustainability of the outcomes being achieved in any innovation?
- What knowledge transfer mechanisms need to be in place to ensure evaluative knowledge (evidence) is reaching the right decision-makers to effect change?

In the area of evaluation and evidence, the PHCTF has been most successful in highlighting areas of need and generating a strong interest and capacity for future comparative evaluation and evidence. It has demonstrated what we need to do next to ensure sustained quality in our primary health care system.

Information Management and Technology

by Denis Protti

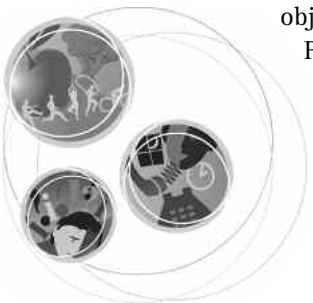
The fundamental objectives of primary health care (PHC) reform are to ensure continuity and coordination of patient care and to facilitate interdisciplinary health care teams. To meet these objectives, the availability of relevant health information to support quality decision-making across multiple health care settings and multiple health care providers is essential. Information management and technology (IM&T) is acknowledged to be a key enabler in reforming primary health care. One facet of IM&T, namely telehealth, has the potential to support more equitable access to primary health care and other services for rural and remote

patients. Having access to technological communication supports, such as e-mail and telehealth perhaps involving satellite technology, means that health professionals and administrators can collaborate more easily and access accurate and up-to-date information when they need it. The result of their collaboration is improved access to care and more effective services for patients and clients and the communities in which they live. Retrospective analysis (secondary uses) of data collected by clinical information systems can support quality improvement, performance management and PHC service planning to meet the needs of populations.

There is increasing evidence in the scientific literature that IM&T has improved PHC in the areas of medical records, communication between physicians and patients, information sharing among health care providers and rapid access to reliable information for both physicians and patients. However, a recent Commonwealth Fund study revealed that 41 per cent of Canadian primary care physicians surveyed reported that a patient's medical record and clinical information was often or sometimes not available at the time of the scheduled visit. The same study reported that only 23 per cent of Canadian primary care physicians had electronic medical record (EMR) systems—in contrast to 98 per cent in the Netherlands, 92 per cent in New Zealand and 89 per cent in the United Kingdom.

EMRs offer a wealth of possibilities. Once a patient's history, diagnosis, allergies, medications and test results are in an electronic format, authorized health practitioners could have immediate access to this potentially lifesaving information should the patient be in their care. On-call or locum physicians could use their home computers to find all needed information about the patient, avoiding a trip to the hospital or clinic for them and possibly the patient. The ease of a referral process using pre-established templates populated by the EMR eliminates chart pulls, searching for the last lab results and reading the chart to create the referral history.

Some of the PHCTF initiatives chose to use IM&T, to greater and lesser degrees, to achieve their objectives. The use of IM&T to support PHC reform can be broken into two broad areas of application:



- **Service delivery and infrastructure support to facilitate team-based care**– particularly as it applies to chronic disease management, team-based communications and satisfying the information needs of clinicians and patients. A number of initiatives demonstrated an impact on this area.

- **Evaluation (secondary use of data)**– particularly as it applies to the collection of data for retrospective data analysis to support program delivery and quality improvement.

Most of the initiatives with an EMR component had one (or more) of the following objectives:

- Facilitate interdisciplinary communication by providing IT systems to support communication and integration among PHC providers;

- Support interdisciplinary health care teams to provide a comprehensive integrated approach for planned care of patients with chronic diseases, with an emphasis on prevention and maintenance to decrease complications and hospitalization;

- Assist in the provision of algorithms/templates for chronic disease management that would enable the use of prompts to provide reminder/call-back features, proactive intervention and self-care support for health promotion and disease prevention, and evidence-based clinical guidelines; and

- Increase the coordination, effectiveness and quality of health care services.

Most of the telehealth initiatives reported that technology:

- Enables client access to specialists from a variety of referral centers;

- Reduces client stress levels and increases their confidence in the care being provided;

- Enables client access to a variety of health promotion and prevention material;

- Provides professionals with various forms of distance continuing education;

- Reassures family member care providers by enabling contact with patients receiving care outside their community;

- Facilitates training sessions and management meetings for staff; and

- Reduces the number of patient transports to larger urban centres, admissions to hospital, and the need for specialists to travel to remote sites.

As with any technology project, all of the initiatives faced the inevitable problems and barriers. They can be grouped under: program and change management, technology, data and standards, funding and human resources. Sometimes these challenges delayed project implementation—initial timelines changed and less was accomplished than anticipated; often, the evaluation component was seriously affected. Many of the initiatives' reports contain first-rate details and insights into the challenges they faced and hence provide valuable learnings for others.

The results of the PHCTF initiatives point to a number of areas which have policy and practice implications, particularly: the importance of *IM&T planning* which is aligned to federal/provincial/territorial health system priorities; the significance of a *change management* philosophy which treats IM&T initiatives not simply as a rollout of new technology but as a project that will transform an organization; the need to adopt data, coding system accreditation and messaging *standards*; the importance of interdisciplinary *leadership* to initiate and support change; the need for *education* programs which help health professionals learn about and adapt to IM&T technologies; leveraging the success that emanated from the First Nations and Inuit communities *telehealth* initiatives; committing to a truly *patient-centred* approach by the adoption of portal technology that provides patients with access to their records, including the ability to schedule appointments online; and the need for policy on health information sharing and the protection of *privacy* including data governance and stewardship.

A number of PHCTF initiatives have added to the knowledge-base of evidence, indicating that the use of IM&T can have important clinical and economic impacts on PHC. In particular, some initiatives reported that in order to maximize the likelihood of success, it is crucial to adopt a proactive implementation strategy, one that takes into consideration not only the technology and economic aspects but, more importantly, the organizational and human factors. In IM&T, the hard stuff is the soft stuff.

Appendix B

The PHCTF Initiatives

Provincial-Territorial Envelope

Yukon Primary Health Care Transition Fund Initiative
Northwest Territories Primary Health Care Transition Fund Initiative
Nunavut Primary Health Care Renewal Initiative
British Columbia Primary Health Care Transition Fund Initiative
Alberta Primary Health Care Transition Fund Initiative
Saskatchewan Primary Health Care Transition Fund Initiative
Manitoba Primary Health Care Transition Fund Initiative
Ontario Primary Health Care Transition Fund Initiative
Quebec Primary Health Care Transition Fund Initiative
Health Care Renewal in New Brunswick
Primary Health Care Renewal in Nova Scotia
Prince Edward Island Primary Health Care Redesign
Newfoundland and Labrador Primary Health Care Initiative

Multi-Jurisdictional Envelope

Building a Better Tomorrow—Engaging Current Providers in a Renewed Primary Health Care System for Atlantic Canada
Health Lines
Integrating Primary Care with the Multi-Disciplinary Team: Collaborative Care for Substance Use and Concurrent Disorders
Selfcare/Telecare
Western Health Information Collaborative (WHIC) Chronic Disease Management Infostructure Initiative

National Envelope

National Strategies

National Strategy on Collaborative Care
Canadian Collaborative Mental Health Initiative
Canadian Nurse Practitioner Initiative
Enhancing Interdisciplinary Collaboration in Primary Health Care: A Change Process to Support Collaborative Practice
e-Therapeutics Drug Therapy Management: Tools and Technology to Enhance Collaboration and Communication to Improve Safety and Outcomes from Drug Therapy
Multidisciplinary Collaborative Primary Maternity Care Project (MCP^2)

National Primary Health Care Awareness Strategy
National Primary Health Care Awareness Strategy Initiative
Moving Primary Health Care Forward—Many Successes … More to Do: A National Primary Health Care Conference

National Evaluation Strategy

Evaluating Primary Health Care in Canada: The Right Questions to Ask

The Pan-Canadian Primary Health Care Indicator Development Initiative

Toolkit of Primary Health Care Evaluation Instruments

Tools for Transition

Federal/Provincial/Territorial Component

Becoming Partners: A Consultation to Build Support for a Canadian Caregiving Strategy Among Primary Care Providers

Building Capacity in Primary Health Care: Disseminating Best Practices in Interdisciplinary Teamwork from Community Health Centres

Enabling Primary Health Care in the North Through Traditional Knowledge

Enhancing Primary Health Care: Learning and Applying Facilitation with a System Model

Family Physician Compensation Models and Primary Health Care Renewal

Increasing Support for Family Physicians in Primary Care

Measuring Cost Effectiveness in Primary Health Care: Developing a Methodological Framework for Future Research

National First Nations and Inuit Telehealth Summit: Collaborative Planning for Community Telehealth Services: 2005–2015

Primary Health Care and Telehealth: Making the Links National Workshop

Supporting the Implementation of Electronic Medical Records in Multi-disciplinary Primary Health Care Settings

Responsive Component

Fetal Alcohol Spectrum Disorder in Newfoundland and Labrador: A Primary Health Care Approach in Labrador

National Conference/Workshop on the Implementation of Primary Care Reform

Sixth National Summit: Cancer Control in Northern and Rural Communities

Shaping the Future of Primary Health Care in Nova Scotia and Building Blocks to a Sustainable Primary Health Care System—Momentum 2005: Moving in the Right Direction

Support Packages for the Uptake of Chronic Disease Management Best Practices

Where's the Patient's Voice in Health Professional Education?

National Initiatives

Continuous Enhancement of Quality Measurement in Primary Mental Health Care—Closing the Implementation Loop

Getting a Grip on Arthritis: A National Primary Health Care Community Initiative

Health Care Interpreter Services: Strengthening Access to Primary Health Care

Issues of Quality and Continuing Professional Development (CPDiQ): Maintenance of Competence

National Home Care and Primary Health Care Partnership Initiative

Pallium Integrated Care Capacity Building Initiative

Physicians and Quality of Care for Canadian Francophone Minority Communities

Rainbow Health—Improving Access to Care

Aboriginal Envelope

Health System Renewal

Bigstone–Aspen Shared Initiative Care (BASIC)
Community and Organizational Transition to Enhance the Health Status of all Northerners
Health Integration Initiative
Northern and Aboriginal Population Health and Wellness Institute
Nursing Strategy Initiative
Tui'kn Initiative

Health System Enhancement

A Tool to Help People from Far Away—The Ikajuruti Inungnik Ungasiktumi (IIU) Telehealth Network
Aboriginal Midwifery Education Program
Enhancing Access and Integrating Health Services—Keewaytinook Okimakanak (KO) Telehealth/NORTH Network Partnership Expansion Plan
Initiative to Implement a Digital Radiology and Tele-Radiology System in Nunavik

Official Languages Minority Communities Envelope

English-Speaking Minority Communities

Improving Access to Primary Health Care Services for English-Speaking Persons in Quebec

French-Speaking Minority Communities

Summary of Initiatives for Francophone Minority Communities
Résautage Santé en français [Francophone Health Networks]