Health Canada   Santé Canada

PRIMARY HEALTH CARE TRANSITION FUND

SUMMATIVE EVALUATION

Final Report

Approved by

Departmental Executive Committee on
Finance, Evaluation and Accountability (DEC-FEA)
Health Canada

April 15, 2008

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Primary Health Care Transition Fund (PHCTF)
MANAGEMENT ACTION PLAN

The PHCTF has sunset since the completion of the Summative Evaluation, but the Action Plan will outline recommendations and lessons learned that suggest how to build on the work completed by the PHCTF initiatives. Of the six major recommendations developed by the consultant, only the first pertains to immediate action. The remaining recommendations (recommendations 2 to 6) are intended to inform future initiatives with features similar to those of the PHCTF. The following Plan highlights the Program's response to the recommendations, associated activities that will address the recommendations, those responsible for the activities, and the time frame for the activities.

Recommendations/Lessons Learned	Response	Key Activities	Responsibility	TimeFrame
Recommendation 1: Build on Momentum and Elements of Program Continuity				
• Provide opportunities for information-sharing and maintaining relationships developed during the PHCTF.	PHCTF managers and staff recognize the benefits of exchanging information post-PHCTF with similar programs within Health Canada, as well as with PHCTF partners. A Best Practices Network (BPN), as agreed to by First Ministers in the *2004 Ten-Year Plan to Strengthen Health Care*, provided such an opportunity. The objectives of the BPN were to identify best practices in primary health care (PHC) renewal, provide opportunities for governments and key stakeholders to share their successful experiences with renewal, and identify areas for potential collaboration. Three workshop events have been held, focussing on topics crucial to the success of primary health care renewal: (1) Provider Participation and Collaboration; (2) Interdisciplinary Approaches to Care; and (3) Responding to Community Needs. Reports from those who participated in these events were mostly positive. However, PHCTF managers and staff recognize that there is currently no one voice or forum to discuss PHC issues and	Efforts to encourage the development of a focal point for knowledge exchange on primary health care are ongoing through our participation in the work of the Canadian Health Services Research Foundation (CHSRF). Opportunities for continuation and potential locations for the Best Practices Network will also be explored. Canada's continued presence at international fora also encourages information-sharing and partnership-building to support PHC enhancements.	Health Care Policy Directorate (HCPD) managers and officers	Fall 2008

Recommendations/Lessons Learned	Response	Key Activities	Responsibility	TimeFrame
	that this a significant gap.			
• Consider developing a mechanism (e.g., website) through which to access the outputs/resources developed by PHCTF initiatives.	Information summaries on the PHCTF and its funded initiatives are hosted on the HC website. Some summaries also include links to the outputs the initiatives produced. Since the resources come in a variety of forms, not all outputs are in a format compatible with this approach.	The process of updating the PHCTF information on the HC website is already underway. Once updated, the website will provide access to most PHCTF outputs/resources. Options will be discussed to identify how best to compile the outputs/resources currently in an incompatible format. The possibility of updating the website on an ongoing basis, as new material become available, will be explored.	HCPD managers and officers	Fall 2008
Recommendation 2: Replicate and Build on Program Strengths				
• Program staff for any similar future initiative should possess the capacity level of the PHCTF management and staff, particularly in the area of provincial/territorial partnering. • Consider continuing the "launch and accelerate" approach. • Continue the use of targeted resources.	Since there are still initiatives underway related to primary health care, it will be important to share the program design and delivery strengths identified by the PHCTF evaluation with other similar programs. However, the PHCTF approach may not always be appropriate, depending on the objectives of a particular program.	A meeting will be organized with other Portfolio members involved in similar initiatives to share our learnings and highlight the successes and things that we would do differently.	HCPD and Departmental Performance Measurement and Evaluation Directorate (DPMED)	Fall 2008
Recommendation 3: Strengthen Program Areas that Presented Issues				
• Consider a longer program funding term. • Strengthen the administrative capacity to avoid delays in funding. • Consider refining the reporting requirements.	Most of the weaknesses of the program presented in this recommendation involve the use and limitations of the contribution agreement as the funding mechanism. This mechanism, however, also had its advantages, such as facilitating direct negotiations with P/Ts and allowing for ongoing contact and creation of F/P/T mechanisms to support monitoring and ongoing reporting. With regards to the funding term of the program, it should be recalled that the PHCTF was established to	A meeting will be organized with other Portfolio members involved in similar initiatives to share our learnings and highlight the successes and things that we would do differently.	HCPD and DPMED	Fall 2008

Recommendations/Lessons Learned	Response	Key Activities	Responsibility	TimeFrame
	assist with the initial, transitional costs of implementing sustainable primary health care initiatives, rather than being a long-term source of funding. As such, the PHCTF supported initiatives that were critical for renewal but beyond the routine operating capacity of governments. The aim of this approach was to ensure long-term, sustainable changes and a lasting impact in primary health care systems across Canada. Initiatives were funded knowing that they would have to leverage money from other sources to continue the momentum that the PHCTF started. Moreover, many provinces and territories are continuing to support renewal efforts within their jurisdictions. Sharing these limitations and trying to mitigate the effects they have on any future funded initiatives is important.			
Recommendation 4: Refine and Reinforce Program Objectives and Coherence of Results				
• Refine the objectives to enhance consistency and coherence. • Health Canada might consider a more assertive stance in the requirements and parameters to reinforce the monitoring and evaluation of the achievement of program objectives.	Even though more precise objectives could have helped produce more consistent activities and results, this was not necessarily the aim of the PHCTF. The PHCTF objectives identified the areas where there was growing consensus that improvements would bring lasting impact on primary health care services and health outcomes (prevention, chronic disease management, multidisciplinary teams, etc.). The broad definitions recognized that various approaches could lead to similar outcomes. As service delivery is under P/T jurisdiction, it was important at the outset to establish the objectives through a collaborative process.	A meeting will be organized with other Portfolio members involved in similar initiatives to share our learnings and highlight the successes and things that we would do differently.	HCPD and DPMED	Fall 2008

Recommendations/Lessons Learned	Response	Key Activities	Responsibility	TimeFrame
	The approach taken gave P/Ts the flexibility to adapt their initiatives to make them consistent with their individual approaches to primary health care renewal and the needs of their respective populations. Due to the variety of ways available to achieve primary health care renewal, and especially in the context of a federal system, the trade-off between specificity and flexibility was actually a strength of the PHCTF as it allowed a greater participation and buy-in from the provinces and territories. However, this approach may not be appropriate to all programs as precise definitions of objectives are generally preferable. While broader objectives were probably an advantage of the PHCTF, more might have been done to facilitate and reinforce the monitoring and evaluation.			
Recommendation 5: Focus more Attention to the Public				
• Consider more direct focus on public capacity building, not just the introduction of providers for this purpose. • Consider a more concise message for any "national" public awareness campaigns about primary health care reform.	There is growing consensus that the patients should be more involved in their own care and efforts are underway in several P/Ts to support patients in managing their care. The national public awareness campaign was developed through a F/P/T process. The "message" therefore had to be broad enough to encompass P/T needs. The downside of this was loss of precision while the advantage was greater P/T buy-in. The lessons learned from PHCTF activities regarding public / patient involvement will be valuable to others.	A meeting will be organized with other Portfolio members involved in similar initiatives to share our learnings and highlight the successes and things that we would do differently.	HCPD and DPMED	Fall 2008

Recommendations/Lessons Learned	Response	Key Activities	Responsibility	TimeFrame
Recommendation 6: Continue Support for a Wider Range of Health Professionals in Primary Health Care				
• More work is needed to be done to broaden the interactions of existing inter-professional activities and to continue the work to incorporate more kinds of health professionals in promising reforms.	While many PHCTF initiatives did add more kinds of health professionals, it is true that a greater emphasis has been placed on physicians and nurse practitioners. This was considered a significant and most important first step. P/Ts continue to explore ways to remove barriers such as remuneration and liability issues in order to facilitate the inclusion of other health professional in teams. This lessons learned could be useful for other initiatives related to inter-professional teams to ensure that these teams go beyond the inclusion of physicians and nurses to include other types of health professionals.	A meeting will be organized with other Portfolio members involved in similar initiatives to share our learnings and highlight the successes and things that we would do differently.	HCPD and DPMED	Fall 2008

Additional Note:

- On page 30, the report states that "*The per capita approach to funding the Provincial/Territorial Envelope was criticized, particularly as it impacted adversely on smaller Canadian jurisdictions. A number of interview respondents pointed to the similarity of the 'base costs' of some changes and went further to suggest that a 'base' amount might be determined for all jurisdictions. The remainder of the designation for their envelope might then be distributed on a per capita basis.*" It should be noted that the territories (Nunavut, Yukon and Northwestern Territory) and Prince Edward Island all received additional funding, above and beyond per capita, to ensure they had the critical mass of funding necessary to produce meaningful and lasting results.

FINAL EVALUATION REPORT
for the PRIMARY HEALTH CARE TRANSITION FUND
SUMMATIVE EVALUATION

Prepared for:
Departmental Performance Measurement and Evaluation Directorate (DPMED)
Health Canada
On March 3, 2008

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The authors wish to extend their greatest appreciation and thanks to the many people who took time to help in various ways — reviewing and testing instruments, responding to surveys and engaging in interviews — to provide further insight and input to enrich the data.

Any assertions expressed in this paper are those of the authors and/or informants, and do not necessarily reflect the views of Health Canada or DPMED.

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EXECUTIVE SUMMARY

The Alder Group is pleased to submit to The Departmental Performance Measurement and Evaluation Directorate (DPMED) at Health Canada the final report for the summative evaluation of the Primary Health Care Transition Fund (PHCTF). The primary audience for the report are staff and decision-makers within the relevant program area in Health Canada and the Treasury Board. Ultimately, the report will be accessible to the public. The summative evaluation builds on previously conducted formative evaluation work on the PHCTF (including a document review, interviews, a literature review and a final evaluation report prepared from 2004 to 2006) and generally aims to assess whether and how the PHCTF served as a significant instrument or catalyst of primary health care and system reform.

The Evaluation Subject and Context

The PHCTF was a product of high-level pan-Canadian commitment and co-action. On September 11, 2000, the First Ministers of Health agreed on a vision, a set of principles and an action plan for health system renewal. The plan articulated the need for a collaborative approach to deliver accessible quality health care programs and services for Canadians and asserted that primary health care improvements were crucial to the renewal of health services.

In response to the First Ministers' agreement, the Government of Canada established the $800 million PHCTF. Over a six-year period (2000–2006), the PHCTF supported provinces and territories to address primary health care reform. Although the program was time-limited, the main goal of the PHCTF was to bring about permanent and sustainable changes within provincial and territorial health systems in the organization, funding and delivery of primary health care services. More specifically, it was geared to support the transition costs of implementing large-scale primary health care initiatives across Canada to improve access, quality of care, accountability and integration of services.

The ensuing PHCTF program funded a total allocation of approximately $735 million flowing to provinces, territories and organizations. The funds were used to launch and accelerate a wide range of primary health care-related activities, resulting in 68 major initiatives being launched within five major sub-allocations, or envelopes (13 provincial/territorial, 5 multi-jurisdictional, 36 national, 10 Aboriginal and 4 official languages minority communities). These, in turn, spawned a significant array of individual projects, participants and activities launched in communities across Canada.

Five common objectives of the PHCTF were agreed upon by the federal, provincial and territorial governments. All initiatives had to address one or more of the objectives. They were to:

- increase the proportion of the population having access to primary health care organizations accountable for the planned provision of a defined set of services to a defined population;
- increase emphasis on health promotion, disease and injury prevention, and management of chronic diseases;

- expand 24-hour, 7-day-a-week (24/7) access to essential services;
- establish interdisciplinary primary health care teams of providers; and
- facilitate coordination and integration with other health services (i.e., in institutions and in communities).

In addition to the PHCTF objectives, the summative evaluation questions examine critical elements important to transitions or *change*, clustered around outcomes, lasting impacts and lessons learned. These provide further insight into the consequences of the PHCTF, in terms of the nature and extent of change, the knowledge gained and the sustainability of initiatives. The questions are listed below:

- To what extent are the current organization, funding and delivery of health care reflective of primary health care renewal?
- What changes have been produced since the inception of the PHCTF in terms of (a) improved infrastructure and systems to deliver primary health care, (b) enhanced knowledge and capacity to deliver primary health care, and (c) a more integrated approach to the delivery of primary health care?
- To what extent did the PHCTF initiatives contribute to the achievement of program objectives?
- To what extent have policies and legislation changed to reflect primary health care renewal since the PHCTF?
- What has been the impact on primary health care providers of PHCTF initiatives?
- Are the outcomes of the PHCTF initiatives sustainable?
- What conditions and factors are necessary for the PHCTF renewal to be adopted? Are these conditions/factors present and to what extent did the PHCTF contribute to the presence of these factors?
- What are the lessons learned and "best practices" as a result of the PHCTF?
- What are the major key success factors that can be applied to similar programs in the future?

Key goals and underlying elements of primary health care, as set out in the PHCTF program objectives and the summative evaluation questions; reflect potential outcomes as anticipated by the Program Logic Model. They underpin the evaluation framework and methodology.

Methodology and Limitations

To assess the outcomes of the PHCTF, primary data were collected using a combination of qualitative and quantitative methodologies encompassing four major lines of evidence. These were developed by The Alder Group for the PHCTF summative evaluation: a document review, a web-based survey, stakeholder interviews and a literature review.The data were analyzed, synthesized and presented in the *Final Evaluation Report for the PHCTF Summative Evaluation*. While the majority of attention was paid to the outcomes related to the *initiatives* as the primary program output, the overall influence of the program was also examined.

Although particular limitations related to each line of inquiry are summarized in Appendix B, the evaluation team faced a number of major overall challenges. They related to delays in the project start-up and highly iterative design interactions with the client throughout, resulting in the overlap of sequential phases. Moreover, the lack of a comprehensive and clear analytical mandate from the outset complicated the process and compounded time requirements in all areas.. As well, the province of Quebec declined any material involvement with the evaluation process, limiting the access to participants and the availability of information on initiatives. This reduced the amount of data that might have been available for analysis and comparison overall and the potential richness of valuable insights.

Conclusions and Recommendations

Overall, the data suggest that the PHCTF achieved a lot of what it set out to do and was widely respected for the results that it made possible. It was recognized as a significant influence on primary health care in many settings across Canada. Respondents were appreciative of the opportunity to try to build on *change*. The PHCTF led to a significant range of activities that were generally consistent with program aims, appropriate to primary health care renewal and in keeping with international trends and practices. Progress was made, and despite challenges during its implementation, the results, outcomes and lessons learned provided rich feedback to inform similar programming in the future.

The results of the PHCTF produced an overall sense of the influence and importance of the contribution made by the PHCTF and the momentum it created, and also produced significant residual need, desire, willingness, expectation and frustration that *more must be done*. The responses to the PHCTF objectives and evaluation questions point directly to both immediate and potential future action. For example, there are indications that the public requires more attention to strengthen its capacity for change. Similarly, primary health care providers beyond physicians and nurses may be insufficiently involved in new approaches to interdisciplinary care, so that all providers' competencies may be optimized. And the breadth with which the PHCTF objectives were articulated, without more directive parameters, resulted in a wide range of possible interpretations and selective responses, as well as in insufficient information being reported to ensure or assess overall progress or achievement.

Across Canada, there are many excellent examples of the presence of organizations, teams, processes and resources that didn't exist before or to the same degree. The results of many PHCTF initiatives remain, however, *formative* in nature, from which change must be *inferred* and, in many cases, deferred to a future not set out within the scope of the PHCTF. For many stakeholders, there was insufficient time to fully achieve the desired primary health care aims. In total, the PHCTF results hold significant promise for Canada, when the full potential of what was developed is fully explored, applied and transferred, *sometime in the future*.

The areas probed by the PHCTF evaluation questions produced results with similar themes identified as those related to the PHCTF objectives. The expectations – the stated objectives of the PHCTF prior to implementation – allowed for a range of possible results but also created some challenges in reporting and assessing them. Exemplary changes were observed, initiatives both launched and accelerated reforms and a significant amount of activity that took place during the PHCTF continues to this day. Also highlighted, even for successful initiatives, was the short

term within which to explore related implications and, in many cases, the fragility of the gains. Sustainability *issues* were a significant finding in the summative evaluation, as was the identification of major barriers. Also recognized was the unfulfilled reality of resources being developed without adequate opportunity to apply or maximize their potential. There was considerable dissatisfaction with an absence of follow-through and support as the projects wound up.

Six major recommendations follow from the integration and analysis of the four underlying lines of evidence. The first recommendation points to steps that might be taken *now* to build on the momentum and resources generated by the PHCTF. The remaining recommendations address future consideration of the development of a program with similar features of the PHCTF. The recommendations are these:

1: Build on Momentum and Program Continuity *Now*

2: Replicate and Build on Program Strengths

3: Strengthen Program Areas That Presented Issues

4: Refine and Reinforce Program Objectives and Coherence of Results

5: Focus More Attention on the Public

6: Continue Focused Support for a Wider Range of Health Professionals in Primary Health Care

The message to take away, perhaps, is that the PHCTF, in a myriad of ways, was a catalyst for change that was flexible and accommodating according to the needs and dynamics of populations and decision-makers at all levels across the country. Its strength is also a weakness, however, as explicit expectations were not provided in regard to how the various projects fit into a grander long-term approach to truly revolutionize health care in Canada.

INTRODUCTION

The Alder Group is pleased to submit to The Departmental Performance Measurement and Evaluation Directorate (DPMED) at Health Canada this final report for the summative evaluation of the Primary Health Care Transition Fund (PHCTF). The general purpose of this final report is to present data analysis and synthesized findings from four lines of evidence developed by the Alder Group and gathered as part of the PHCTF summative evaluation: a document review, a web-based survey, stakeholder interviews and a literature review.

The evaluation was informed by the PHCTF Program Logic Model (Appendix A), which initially framed the anticipated program objectives, activities, outputs and outcomes. The primary audiences for the report are staff and decision-makers within the relevant program area in Health Canada and the Treasury Board. Ultimately, the report will be accessible to the public. The summative evaluation builds on previously conducted evaluation work on the PHCTF and generally aims to assess whether and how the PHCTF served as a significant instrument or catalyst for primary health care and system reform.

METHODOLOGY

To assess the outcomes of the PHCTF, primary data were collected using a combination of qualitative and quantitative methodologies encompassing the four major lines of evidence. Please see Appendix B for a more detailed review of the methodology and challenges. The data were analyzed and synthesized for presentation in this final evaluation report. While the majority of attention was paid to outcomes related to the *initiatives* as the primary program output, the overall influence of the program was also examined.

The document review involved the examination of approximately 100 PHCTF program background documents and initiative reports to identify pertinent data as related to the program objectives and evaluation questions. The web survey gathered data to enrich insights on the PHCTF objectives and the evaluation questions, with specific reference to lasting impacts and sustainability. A total of 50 respondents fully completed the web survey, with an additional 22 respondents completing various sections. Confidential telephone interviews were conducted with 75 predominantly senior level stakeholders. The underlying aims of the stakeholder interviews were to enhance understanding of the PHCTF and the various contexts in which it had evolved and to provide a substantive amount of data to inform the evaluation questions, especially as related to program outcomes. The objectives of the literature review were to examine the broader issues relevant to the Fund, identify comparable large-scale system change initiatives (both within and outside Canada) against which the progress, achievement and/or accomplishments of the PHCTF could be compared and to identify the conditions and factors necessary for successful renewal of primary health care.

Although particular limitations related to each line of inquiry are summarized in Appendix B, the evaluation team faced a number of major overall challenges. They related to delays in project start-up and highly iterative design interactions with the client throughout, resulting in the overlap of sequential phases. Moreover, the lack of a comprehensive and clear analytical

mandate from the outset complicated the process and compounded time requirements in all areas. As well, the province of Quebec declined any material involvement with the evaluation process, limiting the access to participants and the availability of information on initiatives. This reduced the amount of data that might have been available for analysis and comparison overall and the potential richness of valuable insights.

Upcoming sections of the report are organized as follows:

- *The Subject: The Primary Health Care Transition Fund* provides pertinent background regarding the PHCTF, its objectives and the evaluation questions;
- *Key Findings* reviews key findings with respect to PHCTF objectives, evaluation questions and program conduct; and
- *Conclusions and Recommendations* offers recommendations and conclusions that follow from the evaluation.

THE SUBJECT: THE PRIMARY HEALTH CARE TRANSITION FUND

The PHCTF was a product of high-level pan-Canadian commitment and action. On September 11, 2000, the First Ministers of Health agreed on a vision, a set of principles and an action plan for health system renewal. They articulated the need for a collaborative approach to deliver accessible quality health care programs and services for Canadians. As specified in an action plan for health system renewal, the First Ministers agreed to make primary health care reform a priority. They indicated that primary health care improvements were crucial to the renewal of health services.

In response to the First Ministers' agreement, the Government of Canada established the $800 million PHCTF. Over a six-year period (2000–2006), the PHCTF supported provinces and territories to address primary health care reform. Although the program was time-limited, the main goal of the PHCTF was to bring about permanent and sustainable changes within provincial and territorial health systems in the organization, funding and delivery of primary health care services. More specifically, it was geared to support the transition costs of implementing large-scale primary health care initiatives across Canada, to improve access, quality of care, accountability and integration of services.[4] The ensuing program resulted in 68 major initiatives (13 provincial-territorial, 5 multi-jurisdictional, 36 national, 10 Aboriginal and 4 official languages minority communities). These, in turn, spawned a significant array of individual projects, participants and activities launched in communities across Canada.[5]

[4] More background detail about the PHCTF may be accessed on the Health Canada website at: http://www.hc-sc.gc.ca/hcs-sss/prim/phctf-fassp/index_e.html.

[5] More detailed information about the PHCTF initiatives may be found in documentation such as the *PHCTF Summary of Initiatives, Final Edition, March 2007,* which may be accessed at: http://www.hc-sc.gc.ca/hcs-sss/pubs/prim/2007-initiatives/index_e.html.

PHCTF Objectives

Five common objectives of the PHCTF were agreed upon by the federal, provincial and territorial governments. All initiatives had to address one or more of the objectives. They were to:

- increase the proportion of the population having access to primary health care organizations accountable for the planned provision of a defined set of services to a defined population;
- increase emphasis on health promotion, disease and injury prevention, and management of chronic diseases;
- expand 24-hour, 7-day-a-week (24/7) access to essential services;
- establish interdisciplinary primary health care teams of providers; and
- facilitate coordination and integration with other health services (i.e., in institutions and in communities).

To achieve these objectives, the Fund was divided into five envelopes. Each envelope embodied overarching aims:

- **Provincial/Territorial**: to support provinces and territories to accelerate renewal by supporting the transitional costs of introducing systemic primary health care renewal;
- **Multi-Jurisdictional**: to support collaborative initiatives undertaken by two or more provinces and/or territories;
- **National**: to support initiatives of pan-Canadian relevance and significance;
- **Aboriginal**: to support initiatives specific to the renewal of primary health care services for Aboriginal peoples and to address the unique needs of Aboriginal communities more generally; and
- **Official Languages Minority Communities**: to support primary health care renewal initiatives of benefit to Anglophone communities in Quebec and Francophone communities outside Quebec.

As framed by the PHCTF Program Logic Model (Appendix A), the main outputs consisted of the renewal initiatives funded under each of the five envelopes. It was anticipated that they would lead to “immediate outcomes” of increased emphasis on primary health care (i.e., priority, resources) and acceleration of primary health care renewal. The PHCTF funded a total allocation of approximately $735 million, as summarized in the table below.

PHCTF Funding Envelopes	Initiatives Funded		Allocation	
	%	No	%	$M
Provincial/Territorial	20%	13	78%	$576.0
Multi-Jurisdictional	7%	5	4%	$30.2
National: 3 Sub-Envelopes			9%	$64.0
• National Strategies	13%	9		
• Collaborative Care Strategy				
• PHC Awareness Strategy				
• Evaluation Strategy				
• National Initiatives				
• Tools for Transition (T4T)	12%	8		
• Responsive	28%	19		
• Directed				
Aboriginal: 2 Sub-Envelopes			5%	$34.7
• Health System Renewal	9%	6		
• Health System Enhancement	6%	4		
Official Languages Minority Communities: 2 Sub-Envelopes			4%	$30.0
• Francophone	4%	3		
• Anglophone	1%	1		
Total	100%	68	100%	$734.9

The Fund's second major output involved the support and coordination of analysis and information sharing regarding primary health care renewal. As set out in the PHCTF Evaluation Framework, this output is considered essential to the successful outcome of the Fund to ensure that learning and results are shared nationally and to derive maximum benefit from any success.

The PHCTF generated documentation on program outputs in three major ways: reporting on activities related to renewal initiatives and their analysis and dissemination, synthesis reports developed on key themes of interest and the final PHCTF National Conference held in March 2007. These formed the core of pertinent background information underlying the summative evaluation.

The program outputs also encompass the degree of coordinated policy development and management of the Fund by Health Canada, as supported by the activities of the Federal/Provincial/Territorial (F/P/T) Advisory Group. This activity was anticipated by the Program Logic Model as a potential immediate outcome related to increased collaboration in primary health care renewal.

PHCTF Summative Evaluation Questions

In addition to the PHCTF objectives, the summative evaluation questions examine critical elements important to transitions or *change*, clustered around outcomes, lasting impacts and lessons learned. These provide further insight into the consequences of the PHCTF in terms of the nature and extent of change, the knowledge gained and the sustainability of initiatives. The questions are listed below:

1. To what extent are the current organization, funding and delivery of health care reflective of primary health care renewal?
2. What changes have been produced since the inception of the PHCTF in terms of (a) improved infrastructure and systems to deliver primary health care, (b) enhanced knowledge and capacity to deliver primary health care, and (c) a more integrated approach to the delivery of primary health care?
3. To what extent did the PHCTF initiatives contribute to the achievement of program objectives?
4. To what extent have policies and legislation changed to reflect primary health care renewal since the PHCTF?
5. What has been the impact on primary health care providers of PHCTF initiatives?
6. Are the outcomes of the PHCTF initiatives sustainable?
7. What conditions and factors are necessary for the PHCTF renewal to be adopted? Are these conditions/factors present and to what extent did the PHCTF contribute to the presence of these factors?
8. What are the lessons learned and “best practices” as a result of the PHCTF?
9. What are the major key success factors that can be applied to similar programs in the future?

Key goals and underlying elements of primary health care, as set out in the PHCTF program objectives and the summative evaluation questions, reflect potential outcomes as anticipated by the Program Logic Model. They underpin the evaluation framework and methodology, summarized in the next section.

KEY FINDINGS

The findings are organized around three major areas of focus that underpin the summative evaluation:

1. the PHCTF objectives;
2. the PHCTF evaluation questions: outcomes, lasting impacts, lessons learned; and
3. overall program influence: Did the PHCTF make a difference?

The information highlights major achievements and/or challenges in each area, followed by observations that form summary conclusions related to each area.

PHCTF Objectives

This section highlights information related to the PHCTF objectives (set out in section 2.1), which targeted important priorities motivating both primary health care and health system integration reform.

Increased Access to Primary Health Care

The lines of evidence presented a range of responses related to access, and results that must be inferred. All of the provincial/territorial initiatives (representing about 80% of the Fund allocation) reported on some form of approach to enhance access to primary health care services.[1] Similarly, about 80% (n=62) of the interview respondents indicated that they had addressed access. Results about access were qualified in various ways, as summed up by one respondent, "depending on how you define it."[2] The documentation reflected both direct and indirect perspectives on *access.*[3] To illustrate, some responses in this area described expanded *office hours*, while others focused on the expanded capacity of *providers* to serve the public. Half of the web survey respondents (n=34) felt that their project enabled patients/clients to have *more time* with primary health care providers.[4]

Overall, the responses related to access tended to focus more often on changes in services or provider capacities made available to citizens (as compared with changes in getting more citizens *to and through* a range of health services). Such answers covered different topics, such as relating to primary health care *organizations*, *providers* and *services* and/or *other resources*, or the provider *capacity* that was developed or enhanced during the PHCTF. The different kinds of responses reported may have been spurred by the multi-dimensional nature of the PHCTF access objective, as set out. The PHCTF Program Logic Model (which underpinned the PHCTF approach) also appeared to anticipate the multiplicity of potential responses, having made reference to "the optimizing and maximizing use of technology and tools to improve access to primary health care."[5] Accordingly, the PHCTF initiatives were selective about *which* aspects of access they focused on and generally did not respond precisely to what was set out in the access objective, as stated.

The different kinds of responses resulted in insufficient data to assess whether there has been an increase in the *proportion of the population* accessing primary health care organizations or whether any increase was a result of the PHCTF. Sometimes the reporting conveys an impression of an increase, but the proportion hasn't actually changed. For example, Ontario reported that it now has 580 organizations delivering core services and nearly 7 million of its population enrolled with a primary health care organization.[6] This is an impressive result, but many of the new organizations were formed from pre-existing primary health care practices that enrolled existing patients (thus no overall increase in the population having access). This situation is similar to the development or expansion of primary health care organizations in other settings.

Changes in access were also articulated in terms of the perspectives of those who now get services through the new primary health care organizations. A significant number of interview respondents pointed to the presence of new/other providers and services as a result of PHCTF initiatives and the enhancement that this represents *for citizens.*[7] Many of the affirmative responses indicated that access was mainly increased for focused population groups who were the target of particular initiatives, such as for improved chronic disease management.[8] Fifty-five percent (n=39/69) of the web survey respondents stated that their project expanded the use of information technology to *improve access* to primary health care. Of these 39, 89% said that this was still occurring at the time the web survey was being completed (post-PHCTF project completion), while 84% of these 39 respondents felt that this would still be the case two years from now.[9]

Similarly, respondents linked increased access with the availability or use of new or enhanced resources. Fifty-seven percent (n=39/68) of the interview participants indicated that their project expanded the use of tools (e.g., guidelines, templates, how-to manuals) to *improve access* to primary health care. Of the 39 who responded that the outcomes were achieved, 73% stated that this was still the case at the time the web survey was being completed, and 65% felt that this kind of improved access would still continue two years from now.[10] Citizen navigation tools and other process efficiency initiatives were indicated to enhance the flow of people through systems. In addition, several respondents also highlighted the *inclusion of the public* in new ways as enhancing public access, to help define primary health care needs through their input or involvement, such as on community advisory committees.[11]

In addition to describing first-hand experiences with new resources, the data also related the topic of access to the various resources *that were developed but not fully tested or applied during the PHCTF*. Major examples of these were identified in the national and multi-jurisdictional initiatives, which were largely formative in nature (to develop awareness, tools, training and/or capacity to provide services and promote knowledge exchange) and would, *if used*, provide support to primary health care settings. As well, the introduction of telephone help lines was emphasized as *increasing access* to information (another service) and included, in some jurisdictions, assistance to locate a primary health care provider.[12] It may, however, be argued that the presence of new resources and/or enhanced access to information do not replace direct access to a primary health care organization, provider or service.

As reinforced by the literature review, experiences in other countries to enhance access are consistent with the PHCTF approaches taken, including same-day service, transportation assistance, translators, an enhanced "voice" for patients and improved access to information, both "at the office" and (as illustrated in the UK) through telephone support lines. Other jurisdictions are focusing on provision of services to elderly, home-based patients and those with mental illness. Co-location of staff and services, as emphasized in a number of PHCTF initiatives, is also advocated elsewhere as enhancing access.[13]

Summary Conclusions

The breadth of responses to the "access objective" and the nature of information provided do not directly support one definitive conclusion. Access gains attributable to the PHCTF or in terms of proportional changes for the population are not explicitly known. There appear to be access

enhancements for patients associated with the new primary health care organizations due to improved technology and capacity in services better tailored to meet needs and in more or different providers being made available.

Other access improvements *must be inferred* from changes in *what has been made available* to those within range of new initiatives, such as eligibility for targeted services, new links or availability (including technology or after-hours services) and/or changes in process efficiency, among others. The changes made are consistent with steps considered to be improvements in other countries. Thus, from a broad perspective, it may be inferred that the PHCTF has improved access in terms of means and resources at points of contact. It can also be concluded that there is much room for further improvements in access over time as resources are fully applied and primary health care service delivery models mature.

Health Promotion, Disease/Injury Prevention, Chronic Disease Management

In general, the importance of the themes embodied in this three-part PHCTF objective (promotion, prevention and chronic disease management) was promoted strongly by initiatives, as reflected in the data collected in the document review and interviews.[14] PHCTF proposals had to show intent to work in the area of health promotion. Initiatives in all envelope groups reported commitment, emphasis or activity related to this area.[15] The theme was explored in terms of changes in the presence, profile or focus of the related activity.

All the provincial/territorial initiatives reported strong *commitment to* health promotion, with at least two jurisdictions stating that health promotion and sickness prevention were required core services for the primary health care organizations. In support of this, a number of initiatives reported on the inclusion of nurses, dietitians and mental health counsellors in some of the primary health care teams as additional resources to engage patients in education and self-management.[16]

Despite the recognition of the importance of this area and commitment to it overall, most of the evidence related to this PHCTF objective points to a preponderance of activity related to chronic disease management, as compared with prevention or promotion-related initiatives.[17] The enhancement of chronic disease management capacity was a significant focus and emphasis in primary health care organizations.[18] The PHCTF synthesis report *Laying the Groundwork for Cultural Change* indicated that "all initiatives have contributed in some way to advancing chronic disease management; all have acknowledged the need to do more."[19] For the overwhelming majority of interview respondents (85%), most of the reported changes in this area related to improvement in chronic disease management. By comparison, there was less activity reported that was related to promotion or prevention (with a few respondents indicating that injury prevention received the least overall focus).[20]

Changes were identified by interview respondents in the development of numerous chronic disease management-focused activities or mechanisms, including these: shifts in practice patterns, new and different kinds of programming, new tools, opportunities for empowerment, capacity building (new educational/training, new awareness, new ways to engage with communities, providers, issues). Screening tools and programs were created and shared, and facilitators, coordinators and infrastructure spurred and supported these efforts.[21] Most of the

documentation on national and multi-jurisdictional initiatives was geared to the development of training modules, chronic disease management resources for providers and businesses, and self/tele-care for consumers — all pointed to elements that increased the emphasis on, awareness of, knowledge and/or information on health promotion and disease and injury prevention.[22]

Stakeholder interviews reinforced similar elements, pointing to various approaches to building the capacity of the public, communities and providers, and the considerable development of resource educational materials for early diagnosis, intervention and self-management programs. Particular attention was placed on the *providers* involved in this type of care — including them in teams, giving them incentives or specific training or providing them with tools (guidelines, protocols, etc.) — to enhance their capacity to provide certain services or achieve certain results.

The themes overall are consistent with other countries, where primary health care providers are also providing more services in screening and prevention. Chronic disease management is also emphasized, with similar approaches to those in the PHCTF initiatives, including developing chronic disease management models, frameworks and guidelines. Primary health care organizations provide support to those with chronic diseases such as angina, diabetes and rheumatism, including systemic screening, follow-up, the use of nurse supports/clinics and the use of education and other supports to patient self-care and management.[23] Although the precise degree of adoption or use of PHCTF methods across Canada cannot be reported here, the potential *national* impact could be significant if such capacity-building resources were fully used everywhere at the level of service delivery.[24]

Summary Conclusions

Despite the acknowledged priority of this objective and the considerable *commitment* to prevention and promotion, the responses to this PHCTF objective put more focus on chronic disease management, albeit while emphasizing links to the two other areas. Changes were identified that related to the development or application of chronic disease management approaches. A significant effort, however, was formative in nature, such as the development of tools, knowledge and technology, and the capacity-building activities (with more for providers than the public). There is much yet to learn from the *use of* the resources and capacity developed during the PHCTF, and the chronic disease management-related results similarly hold great promise for reinforcing future primary health care.

Overall, while there may have been less focus on direct care or on public-focused self-management in the national and/or multi-jurisdictional initiatives, there was considerable application, particularly of chronic disease management, in the provincial/territorial primary health care initiatives. In many instances, the introduction of nurse practitioners and other providers to *engage* the public provided significant support in this area, with relatively less reporting of results. The PHCTF activities were in line with practices and priorities in other jurisdictions. On the whole, however, the considerable activity may not yet have produced its full potential *results.* Along with gains in chronic disease management, there is much promise and unfulfilled potential, with more work to be done in prevention/promotion in general.

24/7 Coverage

The degree or specificity of "expansion" in this area is difficult to assess for several reasons. Some form of "24/7" access to services existed in many jurisdictions prior to the PHCTF, which was not always emphasized in project documentation. There were insufficient baseline data given to identify prior status or incremental change in this area. In addition, as described in a stakeholder interview, "24/7 still means 9–5, then emergency" in many settings across Canada.[25] A respondent summed up an opinion expressed by many: "In some ways this was a hard question to answer and difficult to evaluate, with no strong evaluation on that." These factors obscure a clear view of PHCTF-related results or impacts.

As with other PHCTF objectives, the 24/7 "coverage" concept tends to be interpreted in many ways, as was reflected in the documentation. While the general idea is about getting people to care when they need it around the clock (e.g., "the doors remain open"), the initiatives mostly chose to address and report on this in other ways. In some cases, there actually were expanded hours at primary health care sites for the public to get direct care (the notion most closely aligned with this objective at a practical level).

The document review stated that eight of the Provincial/Territorial Envelope initiatives reported that primary health care organizations provide 24/7 *coverage*.[26] Other jurisdictions pointed to expanded hours (if not 24/7) at their primary health care sites. In the Aboriginal Envelope, the Tui'kn Initiative has been in the process of extending hours of services with a number and range of providers and also moving to an on-call system as new physicians are added. Other kinds of changes were described as promoting or enhancing 24/7 coverage, including these: provincial funding parameters that incorporated explicit accountability for out-of-hours services, per-person funding within a region tied to a requirement to provide 24/7 access to physicians, and provider agreements with physicians that embedded 24/7 response along with other conditions for remuneration.

According to stakeholder interviews, new providers were introduced to expand the array of services that would be available if needed. In some jurisdictions, teams were formed to share 24/7 coverage, to "move beyond the 'one person' approach" to include nurse practitioners or midwives along with others.[27] The literature review reinforced the validity of such practices as reflected in other countries, including the Netherlands, where approaches were developed to provide services after regular business hours,[28] such as using nurses, pharmacists and general practitioners to provide after-hours access at primary health care sites and, in some cases, in emergency settings.[29]

For the multi-jurisdictional, national, some Aboriginal and other languages minority communities envelopes, the predominant response to this area was formative in nature — it was about making available or making use of technology for providers and the public to access information and/or as a link to services (as described in the document review). *Mechanisms* for approaches to services or *information about* them appeared to receive the most focus, translated in terms of self-help, tele-health or health line technology in the public's 24/7 telephone access to a nurse for health information, links to resources and triage or referral support. Telephone advisory lines were described by a senior level government respondent as "probably the biggest contribution" of the PHCTF.[30] In other uses of technology to enhance services, the Nunavik

Digital Radiology project reported that residents now have 24-hour access to radiology services.[31,32]

Other kinds of formative technological links were developed. For example, core chronic disease management data sets and related information developed in the Western Canada Chronic Disease Management Info-structure have been aligned to help lines and 24-hour access by providers. Indeed, 24/7 access was often described in terms of *providers'* access to chronic disease management information to enhance their capacity or to provide links to other data resources. 24/7 web access for providers to key information was also promoted. As well, the Pan-Canadian Primary Health Care Indicators Initiative developed *indicators* to track primary health care changes (such as access to primary health care in evening and night hours and on weekends), but there was little *activity* in regard to 24/7 coverage of primary health care[33] (*coverage* referring to actual changes in serving citizens' needs).

Changes related to 24/7 coverage were described in terms of the *presence of* new technology (and benefits to be derived from its development). Illustrations included significant use of website visits and tele-health usage, as well as the new levels of stakeholder collaboration that were achieved through technology development processes, within and among jurisdictions. While there was little evaluative information regarding impacts, the formative nature of the use of technology to respond to PHCTF initiatives was highlighted in the PHCTF synthesis report *Information Management and Technology*, which summed up the potential for *future* impacts of technology applications.[34]

Summary Conclusions

PHCTF-related changes in 24/7 access are difficult to determine. The idea of 24/7 *coverage* is interpreted in diverse ways, from more services to more/different providers to the more predominant introduction of telephone links to nurses and information. Some initiatives did respond directly to what was articulated in the PHCTF objective, with examples given of primary health care organizations offering extended hours in conjunction with on-call physicians, nurses and other providers. Other organizational settings (such as clinics or practices) expanded the hours of coverage, followed by having on-call service or access to telephone line information. These approaches are similar to after-hours approaches developed in other countries.

Many PHCTF outputs are formative in nature with 24/7 implications inferred. Technology resources to link to or increase the availability of information or services, *if used*, would expand support to the public as well as for organizations and providers to respond in the future. If such applications were extended throughout Canada, with related reductions in other higher cost service areas, the results for both the public and providers could be substantial in terms of more effective use of resources. Overall, the longer-term impact of the PHCTF on 24/7 coverage remains to be seen.

Interdisciplinary Primary Health Care Teams

The nature of the aim here (to "establish") was straightforward, but responses went beyond the formation and makeup of teams to include focus on collaboration, inter-professional practice and other responses, and related supports for these. Nearly all provincial/territorial jurisdictions

(representing approximately 80% of the Fund investment) reported in one way or another on interdisciplinary or multidisciplinary teams.[35] Eighty-seven percent of those interviewed (n=65) responded affirmatively about this subject area, with indications that this was the objective where the most progress was achieved.[36] Sixty-nine percent of respondents to the web survey (n=48/70) stated that their project had established interdisciplinary teams of providers. Of the 48 who responded as to whether the outcomes were still being achieved, 86% said they were still being achieved at the time the survey was being completed, 78% (n=38) felt they would still be achieved two years from now, while 18% stated they did not know.

For the most part, however, despite progress in some settings, it was noted that "interdisciplinary" still mostly referred to doctors and nurses (a situation considered to be a common and persistent challenge). Several documents reviewed by the evaluation team presented primary health care organization-based interdisciplinary teams, and some were widely diverse. Reports covered the gamut of possible interpretations in this area, often related to *access to* such teams, to supports (tools and training) to develop the capacity to form teams or to mechanisms to accelerate the formation of teams, rather than to evidence of testing or direct results of *operating in* teams.[38]

The PHCTF synthesis report on collaboration also reported that there was a range of innovative and varying models of collaborative care involving interdisciplinary/inter-professional teams of health and social care providers across all 13 provincial/territorial jurisdictions. Models of collaboration were characterized by the nature of the collaborative arrangement (e.g., by geographic regions versus around patient type). Examples involved the role expansion of team members, regionalization of collaborative care and/or delivery of collaborative primary health care services based on population health needs. Key trends that emerged across the provincial/territorial initiatives included inter-professional education at pre- and post-licensure levels and the enhancement of electronic medical/health record systems to support collaborative practice. The results reflected overall positive outcomes pertaining to patient and provider experiences with enhanced models of collaborative primary health care.[39]

A number of providers were added to primary health care teams in addition to physicians and nurse practitioners, including dietitians, pharmacists, midwives, social workers, mental health counsellors, physiotherapists, occupational therapists, health educators and others.[40,41] For many initiatives, however, a nurse may have been the only "addition." In others, a range of providers came together but may have excluded physicians. Tele-health projects serving the north enabled the development of "virtual" primary health care teams through linkage of primary health care providers in different locations.[42] In addition to the building of primary health care organizations, capacity building in chronic disease management also drove the establishment of teams.[43]

The formative national and multi-jurisdictional initiatives created and exchanged knowledge and information; the related dialogue and consultative processes were extensive, and numerous toolkits, decision support modules and templates were developed. Charters, principles and frameworks were developed to enhance the roles, accountabilities and responsibilities of interdisciplinary collaborative primary health care.[44] Numerous toolkits, practice manuals, frameworks and other resources were designed to improve and facilitate the collaborative

primary health care that resulted from the PHCTF initiatives. Several initiatives also advanced the knowledge related to electronic information systems and tele-health to support inter-professional collaboration. For example, 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.*[45]

Significant initiatives repeatedly noted by respondents included the multi-jurisdictional Building a Better Tomorrow Initiative (or BBTI), which developed and provided foundational tools and training for the development of interdisciplinary teams. Its inter-professional education modules were designed to give providers the preparation and tools they need to work in teams. BBTI training was accessed by 8,891 participants and specifically addressed subject matter to prepare them for a collaborative/team environment. The national Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP) Initiative developed principles, frameworks, modules and tools to help develop teams and provider capacity in inter-collaborative primary health care.[46]

Making the transition to collaborative practice and interdisciplinary teams did prove to be challenging. Some respondents observed that there was not enough time to finish the process, and others observed that the work is continuing with the process post-PHCTF.[47] Another issue raised was that, in some of the initiatives and jurisdictions, the primary health care providers beyond the physicians and nurse practitioners were not engaged or treated in the same way.[48] By contrast, however, it was also mentioned that governments are not seeing as much in the way of "turf wars,"[49] inferring positive change. The co-location of providers was also emphasized as important to the success of collaborative teams.[50,51]

Along with enthusiasm for what was accomplished in this area came an underlying concern about sustainability, as illustrated in the stakeholder interviews by the comment that there were "lots of pilot projects that were highly successful in this area, but not sustainable."[52] Progress was highlighted in the PHCTF synthesis report on collaboration, in that "significant gains have been made and, more importantly, critical groundwork has begun to foster and facilitate collaborative primary health care approaches and models across the country."[53] This was reinforced by an interview respondent as follows: "You can't do it [primary health care] without interdisciplinary care — it is the backbone."[54] But the success of given PHCTF initiatives did not guarantee sustainability, with many projects described in stakeholder interviews as facing resistance or challenges, and, in some cases, they were not continued. It has been suggested that some providers (for example, physiotherapists and occupational therapists) faced the greatest challenges related to inclusion.

Similar to the PHCTF priorities and experiences, the Netherlands now sustains a number of former primary health care pilot projects that incorporated teamwork with delegation of tasks.[55] The UK and US trends also reflect a move to the increased use of interdisciplinary teams.[56] Similar to the PHCTF findings, elements identified that provide support for teamwork, as highlighted in other countries, include common working areas or boundaries of responsibility to support cooperation, co-location of staff and services, and training for new staff to ensure the approach is attractive to other providers.[57]

Summary Conclusions

In nearly all jurisdictions, interdisciplinary primary health care teams were established where they didn't exist before or were reinforced where already in place. As such, it may be reported that the aim of the PHCTF was met. Just the same, getting teams *in place* represents a *first* step. There was some indication that efforts are just "scratching the surface," as compared with what is possible, to optimize all providers' competencies in interdisciplinary practice. The primary focus of initiatives was on physicians and nurse practitioners, notwithstanding that many initiatives did add more types of primary health care providers into care settings.

Key drivers of success such as co-location were also emphasized by respondents and may over time call into question the pervasive networking that is keeping entities separated and resources too widely dispersed (except as cannot be avoided in geographically remote settings). More can be done, as in other countries, to support and sustain cooperation, co-location and training to enhance progress. With new teams in place and a foundation of experiences and support resources to draw from, there is more work to be done to maximize the potential of this area.

Coordination/Integration with Other Services

This expansively articulated aim encompassed various related elements, including notions of facilitation, coordination and integration (with neither term further qualified or defined); diverse forms of links and connections (from partnering and networking to use of technology) with other health services (including both institutions and communities); as well as potential changes in terms of roles and their management. The breadth of responses contributed to challenges in assessing the accomplishments to any degree of precision. The implications were aimed at the level of service delivery, but the examples extended to other levels (such as coordination/integration activity between levels of government). Often, the responses in this area were about connections or interactions in the form of *technologies*.[58]

All of the provincial/territorial initiatives reported expressions of enhanced coordination and integration with the rest of the health system and sometimes beyond, to social services.[59] Approximately 85% of interview respondents (n=64) affirmed changes in this area at multiple levels, pointing to links formed among and between primary health care organizations, networks, teams and other sectors.[60] Of the 67 web survey respondents who answered whether their project had contributed to a more integrated approach to the delivery of primary health care, 65% (n=44) stated that it had, while another 15% said it was too soon to tell. Of the 44 who responded that the outcomes were achieved, 82% felt they would still be achieved two years from now, while 13% said they did not know (4% said no). Fifty-three percent of the survey respondents (n=36) stated that their project led to increased collaboration on renewal efforts among primary health providers.

There was much interaction noted at many levels, including beyond the "target" level of primary health care service delivery. For example, there was a significant degree of coordination, interaction and collaboration noted between Aboriginal communities and three levels of government, during and since the PHCTF initiatives. And there are numerous examples at the level of service delivery. They include activity within primary health care organizations and other entities, such as illustrations of co-location or proximity of services, outreach or various

links with mental health clinicians to bring them into the primary health care setting as part of "shared care."

Other examples include a visiting practitioner program and a unique program for cancer patients to link primary health care physicians with oncologists. Pertinent national initiatives included strengthening the links between home care and family physicians through electronic connectivity. Extensive linkages were identified in the Official Languages Minority Communities Envelope initiatives, such as those between community groups and health services organizations, and a primary health care clinic encompassing French language physicians and specialists in occupational therapy, speech therapy, physiotherapy and nursing. All of the Aboriginal projects presented technology linkages, such as those with acute care, including hospitals, as well as with social services, mental health services and home care.[61]

A number of different types of supports for coordination/integration were identified in the findings. The use of technology for information, communication and diagnostic links within primary health care and across sectors was recognized broadly. Interview respondents identified a range of mechanisms for coordination, including informal and formalized primary health care teams, cross-stakeholder partnering and partnerships, "liaisons" with an NGO, changes in referral patterns resulting from jointly determined strategy, group visits, collaborative agreements, cross-sectoral steering committees, representation (including community representatives) on boards, etc. Joint, cross-sectoral strategic or other kinds of planning, training or awareness-building work sessions or conferences took place, involving a range of stakeholders. Considerable mention was made of how focused chronic disease management initiatives linked cross-sectoral individuals, teams and settings.[62,63]

Other major activities were more formative in nature, related predominantly to cross-sectoral capacity-building initiatives concerning education, or tools or technology development. The impact of the multi-jurisdictional initiatives was more indirect, with coordination between stakeholders at different levels (than service delivery) to produce support resources for providers (chronic disease management, health lines) and consumers (tele-health). Reported benefits included the provider linkages and networks gained through inter-professional collaborative education (as in the BBTI and the EICP Initiative). The national initiatives harnessed a wide range of collaborative efforts and conferences, to bring focus to or develop technological or other support resources for collaborative practice. Such efforts were described as "absolutely essential if collaboration is to be a central component of renewed primary health care."[64]

Consistent with PHCTF experiences, other countries reviewed also enhance service coordination and integration as a major focus of reform. It must be noted, however, that in other countries, much of the coordination takes place within a larger scheme of more fully integrated health organizations that include responsibility for both primary health care and other system elements. Similar approaches or mechanisms in this area include these: managing the entrance to and exit from secondary care, discharge planning by nurses, and the use of information technology links, clinical information systems and information management tools, etc.[65]

Summary Conclusions

The broad PHCTF aim to facilitate coordination and integration with other health services was set out without being particularly directive in defining either term, allowing for many possible responses. Accordingly, the aim was met in various ways, with many examples of change, including at levels of activity beyond service delivery. Along with the development of formative resources, there was much recognition of further opportunities to be explored and/or applied in this area. Initiatives related to chronic disease generally as well as to mental health, cancer and other specific diseases provide a foundation for building the linkages and partnerships between primary health care, specialists, hospitals and patients at home.

Although technology cannot supplant direct interpersonal or inter-professional relationships, information and communications technologies played a significant role within practices and in strengthening links, such as in allowing rural/isolated areas to connect with specialists/hospitals. International experiences are consistent with the PHCTF initiatives, but much activity is coordinated within a more cohesive scheme of more fully integrated health organizations that encompass responsibility for primary health care along with other services. While the PHCTF data preclude a precise accounting or assessment of the efficacy of all (or the degree of) accomplishments or changes in this area, the considerable activity generally serves larger aims of building relationships and linking and aligning primary health care and other system resources, with related benefits.

PHCTF Evaluation Questions: Outcomes, Lasting Impacts, Lessons Learned

This section presents information pertaining to the evaluation questions that examine outcomes, lasting impacts and lessons learned, as related to key elements that frame the environment within which primary health care and system reform take place.

Change in Funding Patterns, Structures or Incentives

Changes took place and/or were reinforced within new approaches engaged during the PHCTF, but insufficient information was provided to assess what portion of providers (as compared with all) across the country were affected. References to funding “patterns” and “structures” were similar, as reflected in both the documents and interviews (which sometimes used other terms with similar meanings, such as, “form,” “format,” etc.). By contrast, indications about “incentives” recognized differences in their application. For example, some incentives are associated with (or are within) larger funding or remuneration patterns. Others are used to encourage parties to join an initiative or new direction (e.g., subsidies for office structures, technology, software, education or others).

The literature review showed that funding patterns around the world have generally moved away from fee-for-service funding toward forms that “follow the patient.” The emphasis is on per-person or capitation funding, with incentives to motivate the achievement of particular goals. The PHCTF experiences were consistent with this trend, as reflected in all the lines of evidence. Movement toward alternative funding for primary health care organizations and away from fee-for-service funding of physicians took place, to some extent, in the majority of jurisdictions. Some interview respondents observed that it was difficult to attribute all of this to the PHCTF, as

some of it had already been put in place prior to the PHCTF and was ongoing. However, the PHCTF was seen, even in this context, as providing leverage and acting as an enabler of both the introduction and the expansion of alternative forms of funding.[67]

As revealed in both the document review and stakeholder interviews, alternatives to fee-for-service funding included salary, sessional, contract-based, capitation and blended funding. Twenty percent (14/70) of the web survey respondents indicated that their projects created a shift to alternative funding models for organizations and providers. Of those 14, 79% (n=11) said that this was still being achieved at the time of the web survey.[69] As uncovered in the document review, Nova Scotia reported that 58 physicians moved to alternative funding, and Prince Edward Island reported that 85% are now salaried.[70] Similarly, the stakeholder interviews revealed that in Twillingate, Newfoundland and Labrador, the PHCTF played a role in movement from fee-for-service funding to a blended form of physician funding.[71]

Different approaches and types of funding incentives were reported. These include the following: nursing salaries covered for the first year, bursaries for physicians to join collaborative practices in some parts of Canada, and transitional costs and funding for the purchase of new technology and for relocation. Funding was also provided to support facilitation, for physician champions to promote moves to blended funding. A number of respondents reported that there were still challenges to sustained funding for other kinds of primary health care providers.[72] Refinements of fee codes were also reported, including fee codes to encourage physician/pharmacist interaction and to pay for “group visits” of patients, such as those with diabetes.[73]

Summary Conclusions

Changes in funding did take place in many settings during the PHCTF and were focused mainly on physicians. Some of the movement from fee-for-service to alternative funding was in place to some extent in many parts of Canada prior to the PHCTF. The use of capitation and incentive funding is consistent with changes made in other countries. Where changes had already begun, the PHCTF was recognized as a stimulant for further refinement and expansion. For others, alternative forms of funding were launched or approached as part of primary health care reform during the PHCTF and are still underway post-PHCTF.

Incentive funding motivated the expansion and/or promotion of primary health care-related reform or supports for it. Incentives played an important role to facilitate transitions and to upgrade and/or develop new facilities and resources, depending on the jurisdiction. While changes may be identified, their extent and degree of causation by the PHCTF cannot be determined from the data. The effects of changes underway during the PHCTF are still being felt, and as funding reform was not part of all PHCTF initiatives or jurisdictions, more time and exploration is warranted to fully implement and study the potential of such change.

Change in the Organization of Primary Health Care Service Delivery

Changes in the organization of service delivery generally fell into a few consistent categories, ranging from more to less extensive change. The provincial/territorial and Aboriginal project reports reflected changes that took place in the course of their primary health care organizational development and implementation initiatives. Some provincial/territorial jurisdictions moved to full-scale organizational development, launching new primary health care organizations, or else

used the PHCTF (as did British Columbia, Ontario, Quebec and the Aboriginal Tui'kan initiatives) to *accelerate* the introduction of more of them.[74]

Other provincial/territorial jurisdictions used the PHCTF to move toward the establishment of multidisciplinary teams, with varying levels of achievement in terms of the range of providers incorporated (as discussed earlier). Formative activities in the national and multi-jurisdictional initiatives were seen as critical to support training and facilitation in primary health care models and teams to reorient service delivery. Examples of such focused initiatives included the "Well Women" programs in Manitoba and the rehabilitation clinics in Nunavut.[75]

Just under half of the stakeholders interviewed (30 of 75 respondents) did not offer comment or have the confidence to assess changes in the organization of service delivery. Those who did comment indicated that they had direct knowledge of initiatives and/or what was happening in primary health care reform in their jurisdictions during the time of the PHCTF initiative. Those who indicated that primary health care is organized very differently now illustrated the range of new entities and approaches, such as primary health care networks and various multidisciplinary team models.[76] The PHCTF was cited by one senior respondent as "setting the stage" for family health teams in Ontario.[77]

Fifty-eight percent of the web survey respondents (n=39/68) stated that their project expanded the use of tools to improve the *delivery* of primary health care. Fifty-four percent (37/69) stated that their project expanded the use of information technology to *improve the delivery* of primary health care. The web survey listed a number of kinds of system changes that reinforced shifts identified in the other lines of evidence. Consistent with PHCTF results, other countries examined in the literature review are advancing the use of electronic health/patient records and other decision support systems for clinical and administrative processes.[79]

The PHCTF also provided support for primary health care directors or program leads in some regional health authorities to facilitate reform. As well, interview respondents pointed to various drivers of changes in the organization of primary health care. These include the use of information technology and alignment of existing services and providers, capitation/blended funding linked to rosters of patients assisted in establishing key building blocks, and the emergence of new roles and positions with new primary health care providers in the team (nurse practitioners, mental health providers, pharmacists etc.).[80]

Summary Conclusions

A range of changes took place or were ongoing during the PHCTF. Some transitions were already under way, but the activity was continued or enhanced during the PHCTF. The Fund was recognized in this area as a *facilitator* and *stimulant,* both to enhance the existing organizations and to accelerate the development of additional or new organizational models. Key PHCTF-supported primary health care underpinnings were developed, such as information technology, new funding and provider roles, as well as support for the development of multidisciplinary teams. These were highlighted as important foundations for change in the organization of primary health care service delivery — now and in the future.

Change in Infrastructure, Systems to Deliver Primary Health Care

There was some overlap in response to this area with the prior section; nonetheless, advances in the development of supportive infrastructure were observed in the various lines of evaluation evidence. The range of interpretations and illustrations, however, did not provide sufficient information to assess the overall magnitude or impacts. As revealed in the document review and stakeholder interviews, the data pointed to the establishment of multidisciplinary teams as a change in infrastructure. Electronic patient/health records were introduced with PHCTF financial and other support to primary health care practices. Other technology and software supports applied within primary health care practices included those for scheduling appointments, office management and enrolment of patients.[82] This is consistent with the literature review results, which showed that other countries (the Netherlands prominent among them) have advanced the use of electronic records and other supports for clinical and administrative processes.[83]

A number of PHCTF initiatives implemented information technology to link primary health care organizations, providers and their patients living in isolated areas. As revealed in the document review, related elements included video conferencing to specialists for consultation, for continuing professional education and for enhanced capacity to support diagnostic interpretation through the transmission of digital radiology. Challenges were noted, such as the costs, insufficient understanding of the technology and interjurisdictional "communication" issues that reduced the overall impact of a significant multi-jurisdictional tele-health initiative.[84] Consistent elements were uncovered in the stakeholder interviews and web survey, including toolkits, guidelines, information and other support resources that were produced in National and Multi-Jurisdictional Envelope initiatives. Some were applied within provincial/territorial primary health care organizational initiatives, such as chronic disease management tools and supports for the development of multidisciplinary teams in primary health care organizations.[85,86]

Summary Conclusions

Despite insufficient data to detail the extent or impacts of changes made, the PHCTF provided support for considerable development and implementation of new and renewed support infrastructure and systems to enhance primary health care service delivery. These included various technologies applied within primary health care organizations and links for those in isolated areas to specialists, diagnostics, consultation and education. Technology within organizations included a range of electronic patient/health records and other computers and software associated with enrolment, scheduling and management. Much was formative in nature, with the development of toolkits, guidelines and other supportive documentation for a number of areas, including the formation and implementation of teams and chronic disease management applications. While the full range of impacts and future potential of changes in this area are unknown, support resources applied or developed during the PHCTF strengthen the foundation for continued primary health care progress and reform.

Change in Knowledge, Capacity to Deliver Primary Health Care Services

This type of change was difficult to assess from the data. The PHCTF initiatives tended to emphasize knowledge development and transfer processes and mechanisms as an *indirect means* to support and produce change in capacity to deliver primary health care services. The unspecific nature of the themes (knowledge and capacity), however, as well as the feedback, did not support

any sense of the degree of actual or potential change. Many initiatives were formative and were *designed or produced for* this aim, but they were not always implemented or evaluated in terms of the extent of impact. Progress was generally inferred, and a change in knowledge cannot always assume a change in action or behaviour.

Both the document review and the stakeholder interviews reflected the fairly comprehensive development of formative supports in national and multi-jurisdictional initiatives. To strengthen and enhance provider knowledge of collaborative care and appreciation of different provider roles, various workshops, conferences and educational programs were presented and attended by significant numbers of health providers. A vast array of supportive guidelines and manuals were produced to provide decision supports for those implementing collaborative practices and teams.[87,88]

Similarly, chronic disease management toolkits, guidelines and manuals were developed, coupled with the introduction of mechanisms for ongoing access to inter-professional care through help lines. Focused guides and materials were produced to educate primary health care providers in cultural sensitivity. New resources were used by initiatives developing primary health care organizations and by physicians and others in initiatives to expand capacity in select areas, such as developing chronic disease management approaches.[89,90] A range of changes for providers, in varying degrees, were also noted by web survey respondents.[91] There was generally less focus on the public, however, as compared with *providers*' capacity for service delivery. One investment in a national awareness strategy, albeit a substantial investment, experienced difficulties in getting the message to the public.[92]

The PHCTF focus on various approaches to primary health care knowledge development and capacity building was in keeping with a range of activities in other countries. As highlighted in the literature review, these include opportunities to gain experience with new roles and inter-professional collaboration; and the development and use of new support tools and guidelines, care protocols and indicators along with emphasis on evidence-based care. Advanced training for nurses, with a focus on nursing leadership and the introduction of practice nurses, and the use of electronic information systems to support administrative, clinical and coordination/management decision making are themes shared by many PHCTF initiatives.[93]

Summary Conclusions

The challenge in assessing the nature and extent of success in this area is that the themes of knowledge development, transfer and capacity assume subsequent attitudinal and behavioural change. Although one can be certain that knowledge was transferred, the full impacts are difficult to assess. And while the results and impacts may be difficult to address, and to attribute to the PHCTF, the PHCTF initiatives at the National and Multi-Jurisdictional Envelope levels were particularly notable for the number of educational and other supports developed to enhance the knowledge and capacity of providers. Examples that were particularly noted were geared toward capacity building for collaborative/team practice models and in chronic disease management. The extent of the impact remains to be seen.

Finally, while some resources are available for continued use, the information in some settings was internalized and reinforced locally as part of the development of primary health care organizations and their chronic disease management capacity. It is encouraging but perhaps not surprising that PHCTF-related capacity building is consistent with steps taken elsewhere. At the same time, the positive impacts of considerable PHCTF development activity must be inferred and anticipated, and mechanisms must be applied to enhance their transfer until sufficient time demonstrates that changes in primary health care knowledge and capacity have indeed taken hold.

Change in Policy/Legislation

As aptly summed up by one interview respondent, there is "a lot more policy on primary health care...By the time of the PHCTF introduction, not many jurisdictions had primary health care policies. But by [the end] time of the PHCTF all of them had them. It has a huge profile now." While this is encouraging, it does not convey the explicit degree of changes that took place and/or were attributable to the PHCTF. Some jurisdictions, such as Ontario and British Columbia, already had in place enabling legislation prior to the PHCTF (such as to support nurse practitioners and midwives). Others used the PHCTF to develop or expand policy approaches. The literature review reports that primary health care-specific enabling legislation, as took place during or as associated with the PHCTF, is consistent with other countries' efforts to reform primary health care or introduce new providers.[94]

Prince Edward Island, for example, developed policy to move to collaborative teams. Saskatchewan developed and expanded primary health care teams. Nova Scotia incorporated "cultural inclusion" into its primary health care policy. An Aboriginal midwifery education program was developed and launched, with the first graduates to emerge post-PHCTF. A number of jurisdictions introduced legislation for nurse practitioners and midwives. Both the documentation and stakeholder interviews cited the PHCTF initiative as a major influence in the development of the Aboriginal Health Transition Fund.[95]

Fifty percent of web survey respondents (n=26/52) asserted that their project was influential in policy changes by their organization, and 69% (n=35/51) stated that their project was influential in service delivery and practice changes in their organization. Twenty-nine percent (n=15/52) of web survey respondents felt that their project was influential in policy changes by their provincial/ territorial government.[96] The kinds of changes identified are consistent with international shifts related to primary health care renewal.[97]

Interview respondents with knowledge in this area pointed to policy development and evolution in the following areas: strengthening emphasis on primary health care; stronger support for interdisciplinary work and for the introduction of other primary health care providers into the primary health care organizations; reinforcement of and changes in funding for primary health care physicians and organizations; and, finally, in a number of jurisdictions, refinements and introduction of legislation to introduce nurse practitioners and midwives, and introduction and refinement of legislation related to prescribing by nurse practitioners and pharmacists.[98,99]

Summary Conclusions

Whether or not the magnitude of policy implications may be assessed, changes and/or refinements in legislation and policy indeed took place during or as a result of the PHCTF. They established and/or reinforced primary health care reform as the direction and enabled key primary health care priorities to be explored. They maintained support for key primary health care elements such as collaborative practice, teamwork funding alternatives to fee-for-service, and policy and legislation in support of midwives, nurse practitioners and expanded prescribing. The consistency with steps taken in other countries points to the overall legitimacy. Such changes directly reflect the directions aimed for by the PHCTF program.

Impacts on Primary Health Care Providers

A wide range of "impacts" on primary health care providers were identified, with some overlap between responses to this area and other categories (with some respondents noting enhanced knowledge and capacity, reviewed earlier, as a provider impact). According to a number of interview respondents, the identification and/or assessment of provider impacts or satisfaction was *challenging*. The various reasons given were that it was too early to tell; such information was cursory, non-existent (no chance to test), not the *focus* of the initiative or, in the case of resource development (such as toolkits), there was no knowledge of whether they were being used or not; or simply that there were not enough concise data in this area.

Just the same, reports on initiatives in most jurisdictions that were associated with primary health care organizations (whether existing ones being enhanced or new ones being introduced) referenced a number of impacts on providers. These included evidence of adaptation to collaborative practice as well as the related dynamics of establishing and making primary health care teams *work*. Other illustrations included indications of improved understanding of other primary health care providers' roles and competencies, the introduction of new technology in the practices (computers/electronic health records, tele-health, etc.), and the implementation of guidelines and new approaches to chronic disease management were refined to apply newly acquired skills and education.[100] Similar kinds of impacts were identified by web survey respondents, as related to both system and organizational level and provider-related changes.[101]

Stakeholder interview results pointed out that, while there was a formative nature to the changes for providers, there were indications of increased satisfaction related to PHCTF aims and the new ways of doing things. Some providers "wouldn't go back to the old ways." Although progress was noted in overcoming adversarial roles among different types of providers, this trend needs to be balanced against the testimony of other respondents who noted that something as fundamental as physician-nurse collaboration on primary health care delivery remained a challenge. This was noted as a result of both national and local initiatives, and the explicit efforts made to understand one another and work together. Some respondents noted the particularly facilitating effect of having everyone focusing on the needs of the *patient.*

Within provider groups, most of the focus overall was on physicians, followed by nurse practitioners, with variances in how others were (or were not) engaged. In a larger sense, the building of interdisciplinary capacity and intersectoral working linkages was seen as a major impact of the PHCTF on providers. Others also pointed to impacts associated with the improved access to new or better resources, including focused funding, computers and support

technology.[102] According to the literature review, provider impacts in other countries included access to more information, training, evidence-based data, practice support tools, emphasis on knowledge about quality, freedom to innovate, improved service response to patient needs, reduced workloads, expanded practice and increased provider satisfaction.[103] This is consistent with the experience noted in a number of PHCTF initiatives.

Summary Conclusions

Despite some challenges identifying and assessing "impacts," a number of both direct and indirect examples were identified. Illustrations were indicative of what would be expected of those engaged in primary health care reform and were fitting responses to PHCTF aims, as related to interdisciplinary teams; improved application of technology, including electronic health records; and health promotion, primarily in the area of chronic disease management. The formative nature of training and support resources means that many aims related to primary health care providers are yet to be fulfilled. While "impacts" must be inferred without sufficient data to demonstrate them, the steps taken during the PHCTF provide positive indications about the potential to achieve goals that are important priorities of health professionals in primary health care and about a range of potential benefits, as anticipated in primary health care reform.

Lasting Impacts: Sustainability, Conditions and Factors

This is a challenging area because changes that occurred during the PHCTF were potentially *sustainable* but whether or not they are *sustained* over time relates to factors that go beyond the parameters or timing of the PHCTF initiatives (or indeed, beyond the summative evaluation at this point). As indicated elsewhere, the overall degree of the changes and the PHCTF contribution (other than in broad terms) cannot be quantified or otherwise explicitly confirmed. Inferences about sustainability must be drawn from the kinds of changes that took place and the conditions and factors that might have influenced them.

A wide range of changes took place across the country during the PHCTF program and continued on after it was over. This is particularly illustrated by the way many jurisdictions continued to fund their primary health care organizations. There was evidence of government decisions, policy support and investments made, including in initiatives, in general, as well as for alternative funding models, capital support, equipment and technology (such as information technology, electronic medical records, etc.), and inclusion of new initiatives or practices within provincial/territorial, band, regional or other operational funding. Primary health care organizations and other entities were introduced, expanded, renewed and re-tasked to bring more focus on primary health care. Much took place related to some aspect of each PHCTF objective and area of evaluation inquiry.

More kinds of providers across Canada were delivering primary health care services in new ways, assuming new roles and interacting in more collaborative fashion within and across sectors. Professional attitudes, support, willingness, confidence and credibility were enhanced. Members of the public and community-based organizations were engaged in relation to self-management of services and were involved in primary health care-related activity in various ways. New primary health care-related links were noted within and between teams, organizations, networks and partners inside and outside of health systems across Canada. A range of information and communications technologies, tools, supports and other resources were

studied, developed and/or introduced. Inter-professional stakeholder relationships were established that continue to this day.

Such evidence is promising and may represent permanent shifts from traditional practices over time. Insights about their longevity may be gained from considering the related conditions and factors. For example, any changes exist within many separate publicly funded jurisdictions and are subject to shifts in essential government-level commitment and resourcing decisions made over time. Some stakeholders are already concerned that governments will not continue the emphasis on primary health care, that they have "moved on." Initiatives that were formative in nature (development of awareness, training, tools, technology, conferences, etc.) were not always produced with intrinsic capacity, support or channels for continued use. They depend fully on actions taken afterwards. Assumptions must be made about their continuing value and application (if used), but their full use over time remains to be seen. As widely indicated, there now appears to be significant primary health care-related knowledge and capacity in post-PHCTF settings across the country. It must now be applied and transferred to see the full potential over time.

More specifically, considerable mention was made of the importance of political will, provincial and national consultation, public awareness, leadership, coordinators and champions in the field, and the value of common vision, directions, planning and agreed-upon indicators, frameworks, principles and methods for data collection. The "sustainability" of new primary health care activity was widely articulated, anticipated, planned or hoped for, but too often it was not inherently part of the initiatives or of the larger PHCTF framework in general (beyond final reports and a website with selective information and conferences for some people to discuss findings). Insights about what *wasn't* accomplished or didn't continue are reminders of what else remains to be done. Various elements related to timing created advantages (for those addressed first) or disadvantages (for example, having sufficient time to see an initiative through to fulfillment before the program ended and the funds were cut off, was an issue for many). Access to searchable information on the results of PHCTF initiatives is not straightforward, and there are concerns about whether and how the information will continue to be made widely available.

As indicated by the documents, interviews and web survey, much activity took place but not for everyone or in every area anticipated. Providers or other stakeholders who were not yet included in changes wait in the wings in many settings to be included or for their competencies to be fully realized in service delivery. Not all citizens or communities were involved. Much that was accomplished in one setting was not addressed in others. Some provinces, territories, regions and/or communities have fewer or insufficient resource capacity to continue with even successful initiatives, without further support. Many questions remain about whether and how the PHCTF investment will be fully realized. A widely held view was summed up by one interview respondent this way: "[We learned that] ultimately we can move from illness to promotion…[There are] increased certainties that primary health care reform is possible, but help is needed to see it through."[104,105,106]

The literature review reports that other countries reviewed did not depend on *one* major primary health care-specific, time-limited fund to address reform. Rather, they launched major systemic reform strategies that incorporated elements similar to or the same as what was explored within

many PHCTF initiatives. The major difference was in the ongoing operational funding and the continual refinement of approaches that promote a sustainable and evolving system, including primary health care, over time.[107]

Summary Conclusions

A major response to the evaluation questions, as articulated, would be "yes," that changes are sustainable *if* the conditions identified are able to continue. It would appear that the majority of new and enhanced organizations have been sustained. Have all promising initiatives been continued, or can they assume they'll be in place for the long term? The answer is already "no" for some and is less certain for others where underlying conditions are no longer present. The formative nature of many initiatives means that their continuity into the future has not been determined.

The PHCTF's presence over several years was considered by many to be significant. Its potential to leverage both ongoing and future primary health care renewal was considered substantial by many. Compared with reforms in other countries, time-limited funds applied to certain subsectors may produce gains but may inherently *not* wield the impact of ongoing integrated systemic reform. As was widely indicated in general, the PHCTF contribution has been described as "huge," but the long-term continuity of results is not so easily discernible.

Lessons Learned: Best Practices, Success Factors

It can be said that "lessons learned" are reflected throughout the data gathered for this evaluation. For example, the overarching PHCTF synthesis report noted a number of "lessons learned" with respect to important areas of primary health care focus: collaborative care, chronic disease prevention and management, information management and technology, evaluation and evidence.[108] By comparison, there was relatively little direct feedback provided in the document review, web survey or stakeholder interviews regarding "best practices," and insufficient information provided to know whether an example truly represented a best practice or not (without reference to a process to confirm "best practice" status). A few reasons were given to explain this, such as these: it was not the aim of the initiative to develop best practices; the respondent was not certain whether an example represented a best practice (but knew it was good); or the uncertainty was attributable to the PHCTF (not defined or promoted succinctly). There was also, at times, hesitation to designate what was otherwise considered excellent or "state of the art" as a "best practice."[109,110]

"Best practices" terminology tends to be used throughout health system and primary health care reviews, quite often without confirming whether procedures were in place to establish that a given practice is indeed a *best* practice. Just one PHCTF palliative care initiative, the Prince Edward Island Primary Health Care Redesign, was explicitly noted by the Health Council of Canada as a "best practice" — the only PHCTF initiative or product so designated in the reports. Other initiatives tended to refer to activities considered exceptional in some way or indicated that they aimed for or used best practices drawn from elsewhere to shape or develop their initiatives. The B.C. Toolkit for Chronic Disease Management and Ontario's Financial Management System for Primary Health Care Organizations were singled out for awards of excellence. Some of the Multi-Jurisdictional Envelope initiatives indicated that they developed, applied or aimed for best

practices as related to health lines, research and expertise regarding chronic disease management, and the planning and delivery of collaborative care.

Some initiatives were often mentioned in interviews, due to their perceived high quality and broad potential applicability (the BBTI, the Canadian Collaborative Mental Health Initiative, the Canadian Nurse Practitioner Initiative, the CIHI indicators and others). Others were highlighted as being excellent, implying their potential as best practices, with further illustration of their transferability, such as the multi-jurisdictional health line: "We used much of the material, their framework, to do our evaluation of health lines."[111] As well, documents reviewed for a number of national projects indicated that they used existing best practices as part of their initiative development processes, as related to interdisciplinary care, chronic disease management and quality indicators. The national indicators initiative was referred to as something that *could be considered* a best practice, given its extensive review and development process. Similarly, the Health Care Interpreter Services Project observed that strengthening access to centralized services in primary health care was highlighted as a "best practice."[112]

Responses in this area also provided much comment on success factors or facilitators, identified in the documentation at many levels of the initiatives and as referenced for use in other similar programs. They tended to be articulated in terms of achieving aims or overcoming challenges. There was insufficient baseline or comparative information provided to be able to assess any degree of the capacity of a given example to *produce* the change attributed to it. The PHCTF funding was reported as a major facilitator and contributor to successes. A number of other major kinds of facilitators were also identified. High on the list of examples from all levels were *relationships,* as formed or reflected in teams, networks and partnerships or other forms of collaboration between and among providers and other stakeholders. The strengthened bonds and relationships developed during the PHCTF, and those that have continued since then, were identified as a major foundation for reform and progress in general. Related to this, positive attitudinal orientation, professional respect, trust and better understanding were among the range of general attributes identified in relation to achieving or facilitating success. Other responses highlighted the economies of scale achieved in multi-stakeholder and multi-jurisdictional collaboration and development.

Some initiatives emphasized the benefits of particular process, product or contextual factors that eased implementation and transitional experiences. Examples included interdisciplinary training; common vision across multiple participants; team-building exercises; consultation with and participation of providers (physicians in particular); introduction of nurses into given settings; and the development of a myriad of information, tools and other supports, including practitioner, government, employer and other stakeholder *commitment and endorsement* for primary health care reform and renewal.[113]

A number of success factors similar to those in the PHCTF experiences were noted in other countries, as examined in the literature review, including these: a focus on continuity of care; moving to remuneration that includes capitation and targeted payments for new staff and equipment; and the importance of computers and information systems for patient records, decision support, management and coordination. Organizational evolution toward teamwork and cooperation was also prevalent and was considered the appropriate approach, along with co-

location and training for teams and inter-professional services. All factors are in keeping with what PHCTF initiatives and observers identified as important to success.[114] Success factors identified by interview respondents were similar to those related to sustainability, in terms of the funding and government commitment required to underpin reform. Specific examples included explicit program parameters; joint planning and preparation; mechanisms consistent with desired aims (such as collaborative approaches, funding incentives, consumer input, etc.); leaders, champions, facilitators and coordinators at multiple levels; working groups and stakeholder support; and various forms of engaging providers and other stakeholders.[115]

By contrast, additional insights may be derived from the kinds of barriers identified that limited success (and in many cases, how they were overcome). Barriers were large and small in scale and existed at different levels, from *systemic* (continuing splintered nature of existing system, professional turf protection or insufficient funding) to *service delivery* (language challenges, lack of knowledge and/or understanding of collaborative care or of providers' roles, responsibilities, scope and competencies). Their implications are wide-ranging and considered important to successful primary health care renewal. Their identification demonstrates that, despite the magnitude of PHCTF investment and apparent progress as reported, much more remains to be done.[116]

Summary Conclusions

In response to this area of inquiry, a number of PHCTF "products" and processes were identified as, or associated in some way with, "best practices." While they may have been so designated or related to this area without full confirmation thereof, the value of the initiatives and/or their underlying success factors remains significant. Examples of outstanding practices or products developed during the PHCTF may set standards for others to follow, and they warrant examination to assess the potential for replication in other settings and jurisdictions. Similarly, the success factors are also tangible PHCTF "outputs," which, if well understood and applied, provide building blocks for a stronger primary health care foundation. Conversely, the barriers identified, if not adequately understood, respected and addressed, could serve to impede progress for some time to come. Regardless, all of the responses to this area point to more work that may or must be done. Inattention to this area could slow the pace, efficiency and effectiveness of progress. The examples (both positive and negative) provide valuable outputs, lessons to learn from and foundations to build on, for continued primary health care development and enhancement in the future.

Overall Program Influence: Did the PHCTF Make a Difference?

This section draws together information that puts the focus directly on the PHCTF program (as compared with the results of *initiatives*) and provides comment on overall program implementation. The inputs address whether and how the PHCTF made a difference through its impacts and contributions, and offer suggestions about doing things differently in the future.

Impacts and Contributions

Complementary to the structured responses to the evaluation inquiry, there were many indications of commendation and support for the management and conduct of the PHCTF, regardless of the challenges experienced by initiatives during the program. The interviews

demonstrated that the PHCTF program staff received a wide range of positive affirmations, particularly in terms of their responsiveness, support and assistance to those in the field. There were indications of "kudos to the project managers in Ottawa," noting the "flexibility" with which the program was managed, and interactions with the PHCTF were noted as being "very much a partnership." Respondents often indicated that they were "listened to" and "heard." The respective encouragement to do what was fitting for different settings was particularly appreciated. Flexibility was also acknowledged in terms of the PHCTF allowing the jurisdictions to target initiatives that built on previous renewal efforts. The PHCTF was described as a strong example of F/P/T collaboration.[117]

The PHCTF overall was generally well thought of, with some qualifications. Nearly 80% of interview respondents (n=60) had positive things to say about the Fund, including "liked it," "good for us," "good way to go," "excellent activities," "sensible/excellent" and "intelligent way to distribute the money across the country." There was also some residual desire (and frustration) that *more* might have been done (an indirect compliment). Many respondents supported the legitimacy of the PHCTF and indicated in various ways that what was done "wouldn't have happened without" it. Many illustrations depicted how the Fund's approach made a difference by setting an example in F/P/T partnering and prompting new levels of stakeholder engagement and collaboration. It led many to continued support; the Aboriginal community benefited in particular from the ensuing Aboriginal Health Transition Fund.

For interview respondents, the envelope structure supported a wide range of primary health care-related interactions and opportunities. It enabled different access routes to the funding opportunity, "protecting" it *for* particular groups and *from* being pulled into general revenues, to keep the focus on primary health care. The approach also raised some concerns about impacts on the ground. These included a sense of isolation for some individuals, who felt separated into the different envelope groups without full awareness of activities in other envelopes, thinking they had perhaps missed out on potential linkages with them. Other inputs about the funding approach raised issues with the timing or sequencing of distributions, as well as constraints related to the funding calculation (which produced more for some and less for others), with attendant advantages and disadvantages.[118]

Many web survey respondents reinforced and expanded the input about the degree and sustainability of impacts. Overall, 93% (n=53/57) stated that the PHCTF had a *significant* or *some impact* (with 37% [n=21] noting a *significant impact).* Of the 66 individuals who responded to the question, 48 (73%) strongly agreed or agreed that their project improved the infrastructure and systems used to deliver primary health care. Within this group, 92% (n=44) further indicated that this would be the case two years from now. Web survey respondents consistently noted that various primary health care stakeholders benefited from the PHCTF. Groups identified in particular as receiving "significant" or "some" direct benefit from the PHCTF included the Canadian public, family physicians, nurse practitioners and nurses. Fifty-two percent of respondents stated that there was "significant" or "some direct benefit" of the PHCTF to family caregivers. Other feedback highlighted impacts on *capacity* as a result of the PHCTF. Of the 68 web survey respondents who answered whether their project had enhanced the *knowledge base* to deliver primary health care, 68% (n=46) stated that it had. Forty percent of

web survey respondents (27/68) stated that their project *enhanced the capacity to deliver primary health care*. Moreover, 63% (n=45/72) of web survey respondents felt that the PHCTF had *accelerated primary health care renewal.*[119]

Nearly 90% of interview respondents (n=66) affirmed a range of contributions made by the PHCTF initiatives, as related to primary health care knowledge. While acknowledging different start points, contexts and priorities across the country, comments tended to relate to strengthened and expanded primary health care foundations and to opportunities to better understand reform and to overcome silos. The illustrations confirmed a range of specific information and learnings about what worked and what didn't. The PHCTF was considered to be a "huge" catalyst for research projects and programs, and for building awareness, motivation and momentum. As well, both formal and informal mechanisms for primary health care knowledge development (training, tools, information, conferences, etc.) were considered part of building toward sustainability (as tangible systemic *gains* to be used, refined and developed over time).[120] Interview respondents also identified promising initiatives as representing the potential for pan-Canadian primary health care standards or as foundations for achieving them.[121] And 77% (n=58) of interview respondents offered illustrations at many levels of how the PHCTF support made a difference in achieving primary health care aims or targets.[122]

One interview respondent summed up an apparently widely held perspective by those who had the opportunity to be involved: "The PHCTF was very much appreciated, a credit to Health Canada for what they have done, and we would like that message to be sent forward." To this message was often added concern that, now that it is over, there is "no one" to drive the innovation and reform like the national institutes in other countries. There appears to be considerable residual concern about whether reforms to date will be maintained, the need for continued focus and support resources to ensure fragile new patterns of service delivery are maintained, and how various parts of the country will be able to continue the primary health care focus. A key question often expressed in different ways was, "Where does this lead us to next?"

Doing Things Differently in the Future

Interview and web survey respondents also offered suggestions for how things might be done differently or what else might be done, should a program similar to the PHCTF be employed. For example, there was considerable feedback from interview respondents (91% [n=68], making it the area most widely responded to) about further uses of targeted funding and other primary health care needs. The many ideas offered generally highlight the continuing value of topics addressed by the PHCTF, given the different areas of focus and start points. Gains already in place for some are new ground for others, and so the ideas included more focus on primary health care-related activity engaged during the PHCTF, to try, reinforce, test, study and build on learnings, finish unfinished work and allow others to explore areas they could not address during the program.

Particular themes raised for further exploration included links between primary health care and the rest of the system (including focus on other sectors in particular, such as long-term care); community capacity building; mechanisms for sustainability; more support for research, knowledge and information transfer; and more focus on information technology and other technology applications for the interdisciplinary collaborative environment (and related to this,

preparation of providers' capacity in this area, identified by the synthesis report as a number one priority for the country).[123] The challenge in the aftermath of the PHCTF is how to bring everyone up to the degree of what is possible in primary health care.

When given the opportunity, web survey respondents identified a number of things that they might like to see done differently. Some respondents felt that the time limitations were a problem — too short or constraining. In addition, it was suggested that the program should have run for up to 10 years to allow for fundamental change to happen and then for meaningful and measurable results to be produced.[124] Proposal writing was challenging for some respondents without experience in this area. A stakeholder observed that it was easier for those who wrote proposals frequently but that this might not result in appropriate representation of providers from the "field" engaged in these exercises — suggesting the need for support or assistance for those less experienced in proposal writing.[125]

The per capita approach to funding the Provincial/Territorial Envelope was criticized, particularly as it impacted adversely on smaller Canadian jurisdictions. A number of interview respondents pointed to the similarity of the "base costs" of some changes and went further to suggest that a "base" amount might be determined for all jurisdictions. The remainder of the designation for their envelope might then be distributed on a per capita basis. Concern was also expressed about delays in receiving funds and, at times, in getting answers about extensions. Devolving banking functions outside of Health Canada to one jurisdiction for some initiatives/envelopes created a number of problems associated with legal issues, delays and others. It was suggested that it might have been better if Health Canada had acted as the banker for everything.

At the ground level, plans to hire appropriate staff had to wait for the money, with further delays in finding and hiring people once the funds were there, which impacted on project launch. Reconciling various administrative requirements for the funding was also a concern. Some of the multi-jurisdictional initiatives experienced challenges developing partnerships, and, in one case, jurisdictional partners left the project after it started with negative affects.[126] At the broadest level, there were a number of observations about the public awareness program. Based on interview respondents' own observations and the feedback they received from the public, there was a sense that it did not make any difference, illustrated by the comment that "they didn't think that the average citizen even knew what it was about."[127]

A significant number of resources were produced by the PHCTF initiatives. These included toolkits, guidelines, manuals, handbooks, reports of workshops and conferences, educational curricula, CDs on establishing organizations, cultural sensitivity and other. Some respondents had trouble accessing information. As one respondent asserted, "There must be a thick compendia of what was done." Others cautioned that it would be wise not to lose this enormous resource, suggesting that it should all be consolidated and organized in one spot to make it available for downloading. Interviewees exhibited considerable concern that the wealth of PHCTF-generated information be made available for practitioners, researchers, academics, teachers, students, policy staff and others — to continue to support progress in primary health care.[128]

There was much comment in interviews about the significance of what one person referred to as "the network of networks" formed that "...could never have happened without the PHCTF."[129] Relationships formed at many levels were critical and "gave us an opportunity to work together in this country in a big way and it has been fabulous." Those brought together by the PHCTF indicated that they were able to compare challenges, achievements, answers to questions and more. Information was readily shared and there was considerable openness. Many lamented that, while they now know whom to call, it is not the same, and "it would be great if the federal government could still play a role in keeping this going somehow."[130]

Two suggestions were provided from the provincial/territorial perspective that relate to shaping the program from the outset, with implications for its legacy. First, there is Canada's federal structure and jurisdictional issues in health care. In relation to a shared primary health care vision and the potential for Health Canada to assert certain desired outcomes from a national level, it was suggested that, if Health Canada had played a heavier or more directive role, there would have been an outcry — but quietly there would likely have been some cheering. In addition, it was suggested that it might have been beneficial to have promoted early discussions about sustainability plans and how they were being approached in different jurisdictions — to anticipate strengths and weaknesses in the potential to promote continued progress.

Summary Conclusions

Through all lines of inquiry, it was demonstrated and could be inferred that the PHCTF had laid down foundations for the future (if fully realized). Although the true magnitude of positive changes attributable to the PHCTF cannot be assessed from the data, it is also reasonable to assert that the PHCTF made a difference at many levels of the system. This is reinforced directly by results observed through the lines of inquiry. The program itself set a strong example of F/P/T collaboration, replicated throughout initiatives across the country. The program funding structure maintained focus on primary health care and enabled groups to participate that might not have had access to funding. Important priorities were explored, positive changes were observed in primary health care elements, practices and strategies, and the pace of primary health care reform was accelerated overall.

Positive impacts were identified in the knowledge base and in the experiences of both providers and some citizens and communities. Many initiatives received continued support post-PHCTF. Gains were articulated in terms of strengthened primary health care foundations, now and for the future. Resources and relationships were created that, if maximized and nurtured, hold promise to promote ongoing reform. And respondents widely indicated explicitly that the PHCTF made a difference and that such changes would not have taken place, or to the same degree, without the PHCTF.

Even the critique suggested anticipating a chance to do such a program again *better*, not abandoning the strategy. Indeed, a stronger role for Health Canada was implied in setting directions and ensuring objectives are achieved, and to support the development of centralized resources available for access and update by everyone. There were calls for continuing support in a number of areas, especially to build on the gains made in the relationships and resources developed during the PHCTF, to keep up the momentum of primary health care reform. The

desire for continued action is driven by reasonable concerns that the reforms may not stick or will be overcome by other systemic interests. Indications of both support and concern provide strong indications that people generally *want to do more* and that *more remains to be done*.

CONCLUSIONS AND RECOMMENDATIONS

Overarching Conclusions

Overall, the data suggest that the PHCTF achieved a lot of what it set out to do and was widely respected for the results that it made possible. It was recognized as a significant influence on primary health care in many settings across Canada. Respondents were appreciative of the opportunity to try to build on *change*. The PHCTF led to a significant range of activities that were generally consistent with program aims, appropriate to primary health care renewal and in keeping with international trends and practices. Progress was made, and despite challenges during its implementation, the results, outcomes and lessons learned provided rich feedback to inform similar programming in the future. At the same time, to fully conclude and offer suggestions brings the evaluation team full circle to revisit essential assumptions about the PHCTF objectives, evaluation questions and overall program influence.

The PHCTF was generally aimed to achieve larger system goals, as articulated "at the top" by First Ministers. The PHCTF objectives (for access, prevention/promotion, 24/7 service, interdisciplinary teams and coordination/integration with other services) set out directions, targets and hopes for primary health care and system integration renewal. The PHCTF evaluation questions framed key systemic elements (including funding, organization, infrastructure, knowledge/capacity, policy/legislation and provider impacts) that were anticipated to demonstrate primary health care-related change. Both areas produced and identified important factors related to ongoing sustainability or the capacity for ongoing momentum, and the factors (best practices, success factors and barriers) that promoted gains or blocked progress. Together, all of these features reviewed for the summative evaluation produced an overall sense of program influence, impact and significance.

More focused conclusions drawn from synthesis of the results and findings about the PHCTF objectives and the evaluation questions point directly to both immediate and potential future action. For example, the breadth with which the PHCTF objectives were articulated, without more directive parameters, resulted in a wide range of possible interpretations and selective responses, as well as in insufficient information being reported to ensure or assess overall progress or achievement. There are many excellent examples across Canada of the presence of organizations, teams, processes and resources that didn't exist before, or to the same degree. The results of many PHCTF initiatives, however, remain *formative* in nature, from which change must be *inferred* and, in many cases, deferred to a future not set out within the scope of the PHCTF. For many stakeholders, there was insufficient time to fully achieve the desired primary health care aims. Taken in total, the PHCTF results hold significant promise for Canada, when the full potential of what was developed is fully explored, applied and transferred, *sometime in the future*.

The areas probed by the PHCTF evaluation questions produced results with similar themes identified as those related to the PHCTF objectives. The expectations — the stated objectives of the PHCTF prior to the implementation — allowed for a range of possible results but also created some challenges in reporting and assessing them. Exemplary changes were observed, initiatives both launched and accelerated reforms and a significant amount of activity that took place during the PHCTF continues to this day. But also highlighted, even for successful initiatives, was the short term within which to explore related implications and, in many cases, the fragility of the gains. Sustainability issues were a significant finding in the summative evaluation, as was the identification of major barriers. Also recognized was the unfulfilled reality of resources being developed without adequate opportunity to apply or maximize their potential. There was considerable dissatisfaction with an absence of follow-through and support as the projects wound up.

Recommendations

Six major recommendations follow from the integration and analysis of the four lines of evidence. The first recommendation points to steps that might be taken *now* to build on the momentum and resources generated by the PHCTF. The remaining recommendations address future consideration of the development of a program with similar features of the PHCTF. The recommendations are these:

- 1: Build on Momentum and Program Continuity *Now*
- 2: Replicate and Build on Program Strengths
- 3: Strengthen Program Areas That Presented Issues
- 4: Refine and Reinforce Program Objectives and Coherence of Results
- 5: Focus More Attention on the Public
- 6: Continue Focused Support for a Wider Range of Health Professionals in Primary Health Care

Recommendation 1: Build on Momentum and Elements of Program Continuity *Now*

Notions of time and timing are central to sound implementation and to understanding the nature and extent of success for an initiative on the scale of the PHCTF. The full impact of the program will not be known for another few years, as the momentum of interactions, relationships and resource building that has occurred evolve into more meaningful interchanges associated with front-line reform of service delivery and programmatic integration.

Programs like the PHCTF catalyze such change, but the momentum generated through initiatives is critical here. There is a risk that the results from the considerable PHCTF investment will not be as great as had been hoped for, due to limited or no mechanisms for many new change initiatives to continue. There is a real danger that resources such as websites will simply age and become redundant, and that new relationships will not be sustained, if there are not the resources to keep them active, current and accessible.

Irrespective of whether any similar future program is envisioned, the next two suggestions might be considered now to maximize the greater potential of what has already taken place.

- **Consider supporting the development of a central repository or mechanism through which to access the resources developed during the PHCTF.** The PHCTF initiatives were replete with examples of how many small changes that were put in place have led or may lead to much bigger transformations. This is part of the catalytic effect. The projects produced an enormous wealth of outputs that need securing, consolidating and being made more available and searchable. This rich set of resources needs to be maintained long enough to maximize the investment made to produce the resources. The project and synthesis reports, toolkits, guidelines, manuals, reports on workshops, conferences and meetings, educational materials, CDs and DVDs on primary health care development, chronic disease management, cultural sensitivity and other topics should be readily available to support continued primary health care renewal. Many of the resources are posted on various websites or have been localized or, in the case of CDs/DVDs, simply kept in offices.

  It would be beneficial to everyone if all of the information and lessons learned from these new promising models and practices, as well as the new resources developed, could be effectively disseminated or made fully accessible to all primary health care providers, policy-makers and, indeed, decision-makers at the micro, meso and macro levels of the system. Other stakeholders who are affected by changes or who monitor or study them (the public, researchers and the media) would also benefit from ease of access to pertinent information.

  The very strong suggestion from respondents is that ***all of this information should be tracked down and consolidated in a single repository and on a website*** for information in that form, so that practitioners, government staff, academics, students, researchers and others can access and continue to benefit from these resources. This need not mean that some of the other websites developed by initiatives need to stop, but it would mean that information could be better consolidated, and secured centrally as well, for all to use.

  An associated consideration, given the breadth of resources and the need to maintain support for ongoing primary health care renewal, is to ***support measures to keep it current*** (such as a process to update it, add new materials, etc.), as well as staff support to assist potential users of the information to benefit from the resources and to ensure that the tools remain fully functional and pertinent. Targeted resources could perhaps go a long way to realizing greater outcomes than currently observed. This could multiply the benefits of the PHCTF outcomes by sustaining what gains have been made, while helping others to move forward.

- **Consider supporting the development of some form of primary health care network or post-PHCTF opportunity to build on relationships and other links established during the program.** Interjurisdictional networking supported by the PHCTF program was "a smash hit," with many respondents calling for some way to continue its support. Huge benefits resulted from the informal and formal networking that was supported through PHCTF funding, sponsored meetings and ongoing program support. This is clearly an area of capital generated, to build on in any future programs. Most of the respondents who were engaged in PHCTF initiatives, particularly in provincial/territorial

jurisdictions, are missing the supported networking as they move on with primary health care in their jurisdictions. Many suggested or asked whether there might be some way to develop some form of support for it, at least in some focused follow-up gatherings and opportunities to exchange results, now that time has sharpened their focus.

Considerations for Future Funding Initiatives

The following recommendations pertain to potential considerations for future funding initiatives with elements similar to the PHCTF. In general, a high-level stakeholder panel might be organized to review the major strengths and weaknesses of the PHCTF program and to consider ways to maximize the potential of what has already been done. Examining openly what worked and what didn't can bring focus to what might be replicated in other settings as well as issues to watch out for. The following elements might be explored as part of such an exercise.

Recommendation 2: Replicate and Build on Program Strengths

Within the many areas of strength demonstrated by the PHCTF program that are worthy of repetition, a few particularly deserve repetition and expansion:

- **Program staff for any similar future initiative should possess the capacity level of the PHCTF management and staff, particularly in the area of provincial/territorial partnering.** The highly collaborative program model demonstrated by the PHCTF is one that should be repeated. The PHCTF program management and staff were clearly a major strength in program conduct, as widely expressed by informants. The capacity demonstrated for federal/ provincial/ territorial partnering was a strong suit in particular. Having supportive staff who perceived their role to be a responsive, flexible "partner" with staff in other jurisdictions as well as in initiatives, proved to be a significant contributor to the many levels of program successes identified. Staff for any similar future program should be prepared to operate in ways that repeat the successes of the PHCTF program staff.
- **Consider continuing the "launch and accelerate" approach.** The flexibility to allow for building on prior primary health care renewal work in addition to launching new initiatives was seen as a real bonus for jurisdictions. It contributed to the broader range of successes noted during the PHCTF. Any future funding programs should retain this flexibility. It both recognizes earlier foundational work that could be accelerated or enhanced, and spurs innovation through the development of new resources or approaches products. These characteristics would greatly benefit new program funding parameters.
- **Continue the use of targeted resources.** The focusing, "protective" and enabling aspects of envelope-structured targeted resources were considered another strong suit of the PHCTF, with some caveats (see next recommendation). This approach could be continued and applied to areas such as those suggested in the data, to continue or expand on initiatives as well as explore new related areas. Also, more bridges could be developed between similar or complementary initiatives within different envelopes, to enhance the potential synergies to be gained across projects and from the program overall.

Recommendation 3: Strengthen Program Areas That Presented Issues

A number of suggestions relate to issues of time/timing, funding, proposals and reporting, which emerged among other PHCTF program-related challenges identified that would benefit from refinement in a next round:

- **Consider a longer program funding term**. The limited time frame of the PHCTF resulted in some outcomes not being achieved. Five years may be too short a period of time to allow for fundamental change to mature to the point of producing measurable outcomes. The length of time for the project was considered to be too short by many respondents. There were considerable concerns that there was not enough time to prepare for and launch initiatives and then work toward achieving fundamental changes before the project was over. Some suggested that 10 years would allow for fundamental change to take hold and allow sufficient time to really produce measurable results.
- **Strengthen the administrative capacity to avoid delays in funding.** Consideration of the timing of funding to projects is an area that requires attention. A number of the respondents indicated that delays in this area set their projects back. Future programs should carefully examine ways to ensure that this will not happen.
- **Consider refining the reporting requirements.** There were various kinds of concerns related to reporting. The frequency of reporting might be re-examined, given the requirements overall, the multiple envelopes and the resulting extent of reporting involved. The timing and alignment of reporting requirements might also be reviewed to even the load over the course of initiatives and to reduce redundancy. It was also felt that the final reports required a predominant focus on the specific program requirements and expected outcomes, but did not allow or appear to encourage reporting on other worthwhile achievements or unexpected outcomes of potential value and use to others. Examination of the frequency of reports, content requirements and flexibility to include other "gems" of use to others might strengthen the value and capacity of the reporting process. Future funding programs would benefit from more focus on the evidence to support whether expected as well as unexpected outcomes were achieved. Increased reporting, research and analysis of outcomes would better inform future policies in primary health care and other similar programs. Overall, reporting requirements could be tailored to strengthen the evidence available to support all outcomes and to consider from the outset making project data web-based and cumulative over time, during and after the program.

Recommendation 4: Refine and Reinforce Program Objectives and Coherence of Results

Greater consistency, cohesion and coherence are strongly implied in the findings as being desired for primary health care reform in Canada. The significant degree of collaboration engaged in to interact across jurisdictions and system levels and to develop many resources with strengths that include their primary health care applicability across the country demonstrates the willingness of stakeholders to work toward similar, if not the same, objectives. The next two suggestions point to the value of balancing the options of different jurisdictions to do things differently against the strong impetus in primary health care to work toward common aims.

In any future program, the refinement of program objectives and the central collaborative process, in order to reinforce the capacity for achievement, applicability and coherence of primary health care approaches and results overall, could lead to more effectively delivered results consistent with aims. Accordingly, more distinctly articulated objectives and reporting requirements, backed up by more directive central capacity at the program level to ensure things stay on track, could improve the capacity for more focused return on the significant investment made.

- **Refine the objectives to enhance consistency and coherence**. If flexibility was the aim related to setting out the PHCTF objectives, this feature was certainly achieved in the form of the many diverse initiatives that took place. At the same time, however, the breadth articulated by the objectives, whether intentional or inadvertent, contributed to challenges, as noted in the findings, and much to be inferred. There are many trade-offs that counter the good intentions of having flexibility, including differences in interpretations of goals; selectivity in responding to some (but not all) of them; diversity and breadth in the range of activities to be monitored, reported on and evaluated; and the risk of overall insufficient information generated to understand results and/or confirm progress. A future funding program might benefit from more succinct objectives and parameters, not only to improve the capacity to ensure achievement and transferability of results but also to contribute to more coherent foundations from which consistent and uniform primary health care progress may be made to benefit all Canadian health professionals and the citizens they serve.
- **Health Canada might consider a more assertive stance in the requirements and parameters to reinforce the monitoring and evaluation of the achievement of program objectives.** With appropriate respect due to the realities of a federal system, a number of respondents inside and outside of government indicated that there could be considerable benefit from Health Canada taking a stronger stance in certain areas. Such a stance might promote and produce more defined objectives and requirements for meeting them, and more consistent results that are more easily transferable. Among other benefits, this could contribute to achieving a more unified vision for primary health care across Canada and ensure that all recipients of funding participate fully in important contributions (such as information and involvement in evaluation) to benefit all Canadians.

Recommendation 5: Focus More Attention on the Public

The findings reflect that overall there was more PHCTF program focus on providers than on the public, which is not unreasonable given the health system focus and the implied benefits of changes *for the public*. At the same time, if the full range of anticipated benefits of primary health care is to be achieved (with significant focus on illness prevention and health promotion), the public will need more preparation than what was allowed during the PHCTF.

- **Consider more direct focus on public capacity building, not just the introduction of providers for this purpose.** The health system would benefit from more direct public capacity building to accelerate the shift toward the goals of primary health care. The public would benefit from more focused attention to build the capacity for self-care, self-management and better use of health system resources. Greater knowledge of what to do

would enhance public and provider satisfaction and strengthen their potential for partnering to improve overall health and care, in general, and to move the system to become more public-centred. Many steps were taken and resources were developed during the PHCTF that could be expanded and built upon in future funding programs.

- **Consider a more concise message for any "national" public awareness campaigns about primary health care reform.** Any public awareness campaign should be approached and developed with care to ensure that it is consistent with program and primary health care aims, supports other areas of program activity and involves measures to ensure that it is clearly understood by its audience (and if not, why not). There were concerns that the public awareness campaign was not understood by the public and did not send any message about what was happening in terms of initiatives. For those jurisdictions that were already engaged in primary health care-related activity, it also failed to clarify that such activity was already consistent with what was being done during the PHCTF. (Instead of those activities being applauded and links drawn with the PHCTF goals, the campaign added to the confusion about primary health care activity already under way, as compared with what was being articulated during the PHCTF.)

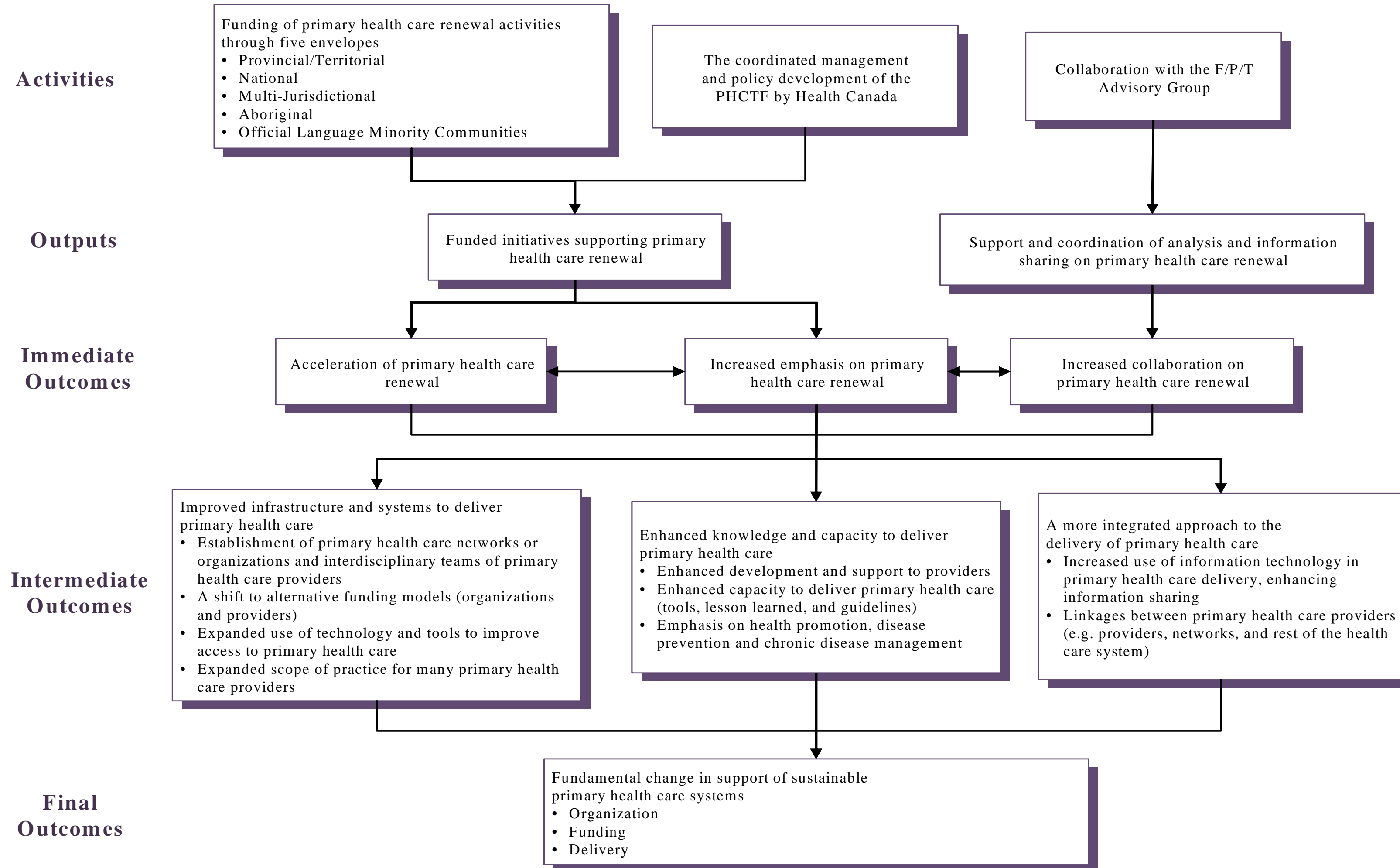
Recommendation 6: Continue Focused Support for a Wider Range of Health Professionals in Primary Health Care

There was a notably predominant focus on physicians and nurse practitioners as the subject of many PHCTF initiatives. Although such focus was not inappropriate, the overall aim was to engage a wider range of primary health care health professionals. While some initiatives did this, it was clear from the findings that more needed to be done to broaden the interactions of existing inter-professional activities and to continue the work to incorporate more kinds of health professionals in promising reforms. Much was learned about this during the PHCTF, including both facilitators and barriers to this process. Such work could be picked up and carried on, and targeted support provided (as was done for selected providers during the PHCTF), to ensure the breadth of possibilities for all primary health care providers, to optimize their competencies through more effective use of new approaches and to remove barriers to their doing so.

In summary, the results of the PHCTF produced an overall sense of the influence and importance of the contribution made by the PHCTF and the momentum it created, and also produced significant residual desire, willingness, need, expectation and frustration that *more must be done*. The message to take away, perhaps, is that the PHCTF, in a myriad of ways, was a significant catalyst for change that was flexible and accommodating according to the needs and dynamics of populations and decision-makers at all levels across the country. Its strength is also a weakness, however, as explicit expectations were not provided in regard to how the various projects fit into a grander long-term approach to truly revolutionize health care in Canada.

APPENDIX A

THE PRIMARY HEALTH CARE TRANSITION FUND - LOGIC MODEL



APPENDIX B

METHODOLOGY AND CHALLENGES

The summative evaluation of the Primary Health Care Transition Fund was planned to occur in the last year of the program (2006-2007) before the Fund expired. The Alder Group commenced work in the first quarter of 2007. The overall approach focused on providing evidence on the impact and success of the program. The methodology was based on an evaluation framework that addressed the PHCTF objectives and key evaluation questions that probed into outcomes, lasting impacts and lessons learned. While the majority of attention was paid to outcomes related to the *initiatives*, the overall influence of the program was also examined.

Importantly in the context of this summative evaluation, the *Primary Health Care Transition Fund Evaluation Framework* (June 2004) anticipated that there were a number of particular challenges with respect to PHCTF program evaluation. These include the complexity of the PHCTF, the unique needs and different stages of primary health care renewal represented in each province and territory, and the resulting variety of initiatives engaged in each of the five funding envelopes. Each individual initiative was required to include evaluation and dissemination activities.

Another notable distinction is that the PHCTF provided funding to the provinces and territories, which, in turn, used the funding to support primary health care reform. The PHCTF was designed to be a *non-uniform full coverage program,* which means that, although the program shares common objectives, the implementation can, and indeed did, vary significantly. As a result, the PHCTF funding flowed to provinces, territories and organizations, which used the funds to launch and accelerate a wide range of primary health care-related activities. The research design for the summative evaluation needed to consider this diversity of allocative approaches in order to assess the nature and extent of success in achieving program objectives and outcomes, which were further scrutinized through the evaluation questions.

B.1 Multiple Lines of Evidence

To assess the outcomes of the PHCTF, primary data were collected using a combination of qualitative and quantitative methodologies encompassing four major lines of evidence. These were developed by The Alder Group for the PHCTF summative evaluation:

- document review
- web survey
- stakeholder interviews
- literature review

Each line of inquiry is briefly summarized below.

Document Review

The review involved the collection and examination of available information about the PHCTF program and initiatives, as provided mainly by DPMED. The review examined approximately 100 background program documents and initiative reports (many being summary in nature and covering multiple initiatives) to identify pertinent data as related to the program objectives and evaluation questions.

Data were gathered and systematically integrated into templates, or knowledge matrices, adapted through interactions with DPMED. Importantly, beginning with this phase of the work, The Alder Group was specifically directed to *compile rather than analyze* the data. Accordingly, the review included a summary of considerations related to each objective and evaluation question, but it did not have as its intended purpose (until much later in the year) the goal of analyzing the rich and vast array of information.

Web Survey

Beginning in the spring of 2007, the web-based survey went through a series of reviews and drafts through discussions with DPMED. The focus of the web survey was on the PHCTF objectives and the evaluation questions, with specific reference to lasting impacts and sustainability. The target population to be surveyed was all the projects funded by the PHCTF and thus included all the envelopes. The draft web survey was piloted with project recipients. A process was identified with DPMED through which potential contacts would be notified and invited to participate. To access potential survey respondents (i.e., the projects) required communication and coordination between DPMED and the provincial and territorial health ministries and departments.

The Alder team originally sent a total of 405 notifications requesting participation. Unfortunately, only 50 respondents fully completed the web survey, with an additional 22 respondents completing various sections. Limited analysis was possible, and the data were compiled with caveats highlighting process-related challenges. The web survey data received did, however, corroborate and enrich evidence gathered through the other lines of inquiry. The web survey was conducted during the summer of 2007 and analysis was completed in the fall.

Stakeholder Interviews

The underlying aims of the stakeholder interviews were to enhance understanding of the PHCTF and the various contexts in which it had evolved and to provide a substantive amount of data to inform the evaluation questions, especially as related to program outcomes. The interview methodology comprised the development of a sample strategy and the design of an interview protocol with approximately 14 major questions. All elements were developed through an iterative process with DPMED during the spring and summer of 2007.

The interview questions focused on the program objectives, evaluation questions and inquiry related to overall program impacts and influence. Confidential telephone interviews were conducted with 75 predominantly senior level stakeholders in late summer and early fall. For consistency across lines of inquiry, the summary responses were systematically organized in data matrices similar to those used for the document review, and key findings were summarized.

Literature Review

The primary purpose of the literature review was to update information that had been gathered during a 2004–2005 literature review for the PHCTF formative evaluation. The current review focused mainly on the years 2005–2007, so as not to overlap with the prior review. The objectives as set out were to "look at the broader issues relevant to the entire Fund; identify comparable large-scale system change initiatives against which the progress, achievement and/or accomplishments of the PHCTF can be compared; and to identify the conditions and factors necessary for successful renewal of primary health care."

To compensate for the absence of primary health care-focused program structures like the PHCTF in other countries (which had challenged the earlier review), the methodology was refined to include review over a broader time frame of *relevant national and international reform initiatives associated with primary health care*. Some early reference data were pulled into the review to build a contextual picture of where other countries stood with respect to primary health care reform prior to the early 2000s. The general approach comprised the development of search criteria, document search and procurement, document review, and synthesis and analysis of the information, the results of which formed the basis for the report. Thirty-six pertinent documents were identified for review. These, along with 13 contextual references, provided the background and comparative elements for the review. Relevant data were gathered into matrices (as directed by DPMED), and selected major themes were summarized in the body of the report.

B.2 Reporting of Results

Much of the data was qualitative in nature. As fitting and possible, quantitative counts and/or percentage responses were reported. With respect to the more qualitative information, the following guidelines adapted from those applied to an earlier stage of PHCTF evaluation were used to interpret results:

- some, a number, a few = 25% of respondents or less (i.e., 10 respondents or fewer);
- many, several = 25% to 75% of respondents; and
- almost all, most, a majority = 75% or more.

For illustration purposes, the perspectives and/or comments of individual respondents are included in the report. They are used to highlight particular points expressed by a substantial number of respondents; to reinforce important points of contrast; or to illustrate the variety in the views or information reported.

B.3 Methodological Challenges

In addition to the particular challenges of complexity, variety and scale embodied in evaluation of the PHCTF, as noted at the beginning of this section, the evaluation team faced a number of methodological challenges in conducting the summative evaluation. There were particular limitations related to each line of inquiry.

Limitations on the document review included that initiative reports provided much general information, and did not always articulate progress in terms of the PHCTF objectives, or provide baseline information from which to assess change, or "best practices," or corroborate assertions made. In addition, levels of detail and quality varied significantly, limiting the fit of information to evaluation categories. During the web survey phase, a highly iterative design phase with DPMED significantly delayed implementation and produced a prohibitively large web survey, noted as a constraint by prospective respondents. This plus inconsistency in processes to contact participants (involving various provincial/territorial representatives) produced further delays and a significantly reduced response rate, which complicated analysis of that information.

The stakeholder interviews similarly experienced delays due to protracted approvals of interview instruments, the necessity to update and validate a significant number of additional prospective interviewees, and delayed responses from participants due to the ensuing conduct of interviews during late summer/early fall. The qualitative nature of responses reduced precision in the assessment of change, and some gaps emerged, such as hesitation by some interviewees to comment based on the view that insufficient time had elapsed for initiatives to mature and demonstrate results; while others asserted a bias in conflict with PHCTF definitions, or with how their province or territory had conducted the process or initiatives. The conduct of the literature review was impacted on by delays in other phases, and influenced by parameters such as no review of any financial information (precluding a sense of scale of investment), and the absence of any explicit PHCTF-like initiatives in other countries. This required refinement of the approach with more extensive time necessary for selective search and mining of relevant focused information on primary health care reform strategies and results, for comparison with the orientation and elements of the PHCTF.

In addition to challenges in particular phases, there were several overarching methodological challenges and assumptions, which are highlighted here with respect to the evaluation process:

- The work underlying the evaluation began months later than originally scheduled. This, in addition to highly iterative design processes with DPMED, contributed to later start and completion dates than anticipated for all phases. This resulted in the overlap of much design and implementation activity, which compromised the appropriate sequencing of phases and significantly impacted on the time that ought to have been available for implementation and thoughtful analysis of data and formulation of findings and recommendations.
- The arrangements through which The Alder Group was asked to develop the literature review and to prepare the analysis and final evaluation report were not confirmed until late summer 2007. This was well after other underlying phases of work were either finished or materially under way. Given the original instructions from DPMED *to compile, not to analyze,* the data from the lines of inquiry, steps were retraced back through information gathered earlier to prepare the analysis required for the final evaluation. The lack of a comprehensive and clear analytical mandate from the outset complicated the process and compounded time requirements in all areas.

- The province of Quebec declined any material involvement with the evaluation process, limiting access to project participants and the availability of information reported by the initiatives. Given the relative investment and range of initiatives, this limited the potential richness of the data available for the evaluation and adversely impacted the overall assessment of results.
- Decisions during the web survey phase impacted on the overall project timing, creating significant overlap in otherwise sequentially planned phases and reducing the overall data available for analysis. This in turn complicated the broader analysis of data, limiting the potential richness of valuable insights for comparison across all lines of inquiry.
- The evaluation is focused on *results, outcomes and lessons learned* as related to the PHCTF program. As such, it does not provide a review, inventory, evaluation or comparison of the PHCTF *initiatives* or a comparison of activities across jurisdictions.
- The evaluation did not include a focus on internal program financial, management or operational parameters, *except* as related to the results and impacts felt by those who participated in the initiatives (as revealed in every line of evidence). This omitted the option to consider, for example, outcomes or results as related to allocations or investments made.

Endnotes

1. Evidence from the Document Review
2. Evidence from the Stakeholder Interviews
3. Evidence from the Document Review
4. Of these, however, just 21 respondents felt this would be the case two years from now. (Web Survey)
5. PHCTF Evaluation Framework (2004)
6. Evidence from the Document Review
7. Evidence from the Stakeholder Interviews
8. Evidence from the Stakeholder Interviews
9. Evidence from the Web Survey
10. Evidence from the Web Survey
11. Evidence from the Stakeholder Interviews
12. Evidence from the Stakeholder Interviews
13. Evidence from the Literature Review
14. Responses to the Web Survey did not address this area.
15. Evidence from the Document Review
16. Evidence from the Document Review
17. Evidence from the Document Review
18. Evidence from the Document Review
19. Evidence from the Document Review
20. Evidence from the Stakeholder Interviews
21. Evidence from the Stakeholder Interviews
22. Evidence from the Document Review
23. Evidence from the Literature Review
24. Evidence from the Stakeholder Interviews
25. Evidence from the Stakeholder Interviews
26. Evidence from the Document Review
27. Evidence from the Stakeholder Interviews
28. Evidence from the Literature Review
29. Evidence from the Literature Review
30. Evidence from the Stakeholder Interviews
31. Evidence from the Document Review
32. Evidence from the Document Review
33. Evidence from the Document Review
34. PHCTF Synthesis Report *Information Management and Technology*
35. Evidence from the Document Review
36. Evidence from the Document Review
38. Evidence from the Document Review
39. PHCTF Synthesis Report *Collaborative Care*
40. Evidence from the Document Review
41. Evidence from the Stakeholder Interviews
42. Evidence from the Document Review
43. Evidence from the Document Review
44. Examples include *Enhancing Interdisciplinary Collaboration in Primary Health Care* project (N-8), *Canadian Collaborative Mental Health Initiative* (N-6), *Multi-Disciplinary Collaborative Primary Maternity Care* project (N-9) and *Increasing Support for Family Physicians in Primary Care* (N-16). (Document Review)
45. Evidence from the PHCTF Synthesis Report *Collaborative Care*
46. Evidence from the Document Review
47. Evidence from the Stakeholder Interviews
48. Evidence from the Stakeholder Interviews
49. Evidence from the Stakeholder Interviews
50. Evidence from the Stakeholder Interviews

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51. Evidence from the Literature Review
52. Evidence from the Stakeholder Interviews
53. PHCTF Synthesis Report *Collaborative Care*
54. Evidence from the Stakeholder Interviews
55. Evidence from the Literature Review
56. Evidence from the Literature Review
57. Evidence from the Literature Review
58. Evidence from the Document Review
59. Evidence from the Document Review
60. Evidence from the Stakeholder Interviews
61. Evidence from the Document Review
62. PHCTF Synthesis Report *Information Management and Technology*
63. Evidence from the Stakeholder Interviews
64. Evidence from the Document Review
65. Evidence from the Literature Review
67. Evidence from the Stakeholder Interviews
69. Evidence from the Web Survey
70. Evidence from the Document Review
71. Evidence from the Stakeholder Interviews
72. Evidence from the Stakeholder Interviews
73. Evidence from the Stakeholder Interviews
74. Evidence from the Document Review and Stakeholder Interviews
75. Evidence from the Document Review
76. Evidence from the Stakeholder Interviews
77. Evidence from the Stakeholder Interviews
79. Evidence from the Literature Review
80. Evidence from the Stakeholder Interviews
82. Evidence from the Document Review
83. Evidence from the Literature Review
84. Evidence from the Document Review and Stakeholder Interviews
85. Evidence from the Document Review and Stakeholder Interviews
86. Evidence from the Web Survey
87. Evidence from the Document Review
88. Evidence from the Stakeholder Interviews
89. Evidence from the Document Review
90. Evidence from the Stakeholder Interviews
91. Evidence from the Web Survey
92. Evidence from the Stakeholder Interviews
93. Evidence from the Literature Review
94. Evidence from the Literature Review
95. Evidence from the Document Review and Stakeholder Interviews
96. Evidence from the Web Survey
97. Evidence from the Literature Review
98. Evidence from the Stakeholder Interview
99. Regarding nurse practitioner-related legislation and policy, such as amendments to Nursing and Pharmacy Acts to allow for some prescribing (Stakeholder Interviews)
100. Evidence from the Document Review
101. Evidence from the Web Survey
102. Evidence from the Stakeholder Interviews
103. Evidence from the Literature Review
104. Evidence from the Document Review
105. Evidence from the Stakeholder Interviews
106. Evidence from the Web Survey
107. Evidence from the Literature Review
108. Evidence from the Document Review

109. Evidence from the Stakeholder Interviews
110. Evidence from the Document Review
111. Evidence from the Stakeholder Interviews
112. Evidence from the Document Review
113. Evidence from the Document Review
114. Evidence from the Literature Review
115. Evidence from the Stakeholder Interviews
116. Evidence from the Document Review
117. Evidence from the Stakeholder Interviews
118. Evidence from the Stakeholder Interviews
119. Evidence from the Web Survey
120. Evidence from the Stakeholder Interviews
121. Evidence from the Stakeholder Interviews
122. Evidence from the Stakeholder Interviews
123. Evidence from the Stakeholder Interviews
124. Evidence from the Web Survey
125. Evidence from the Stakeholder Interviews
126. Evidence from the Stakeholder Interviews
127. Evidence from the Stakeholder Interviews
128. Evidence from the Stakeholder Interviews
129. Evidence from the Stakeholder Interviews
130. Evidence from the Stakeholder Interviews