Health Canada Santé Canada

Health Care Strategies and Policy Grant and Contribution Programs (2002 - 2007)

Summative Evaluation Report

Approved by

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

January 23, 2008

Canada

TABLE OF CONTENTS

Health Care Strategies and Policy Grant and Contribution Programs
MANAGEMENT ACTION PLAN

In order to action the recommendations outlined in the evaluation report, the Health Care Policy Directorate has decided to develop a new governance structure. Effective April 1, 2008, a new governance structure (see RMAF-Figure 4) will be implemented that includes the establishment of a Program Executive Committee (PEC) composed of the DG of HCPD and Directors representing the Program components; an Accountability Committee (AC) to manage the performance measurement/evaluation, risk management and audit requirements of the Program; and an Operations Committee (OC) that will be tasked with coordinating general program management functions such as communications, finance and standard operating procedures/tools. Representatives from Departmental advisory services will be included as required.

Recommendations	Response	Key Activities	Responsibility	TimeFrame
Improving performance measurement data and monitoring				
Dedicate resources (e.g., FTEs and monetary) to performance measurement at the Program, component and project level.	Program Executive Committee PEC Identify members, outline their roles and responsibilities and obtain signed agreement on the terms of reference for the committee.		DG	January 2008
	Accountability Committee AC Identify members, outline their roles and responsibilities and obtain signed agreement on the terms of reference for the committee.		DG	
	Operations Committee OC Identify members, outline their roles and responsibilities and obtain signed agreement on the terms of reference for the committee.		DG	
	Project Manager Working Group PMG Identify key component level representatives to form a project manager working group. Define their responsibilities with respect to performance measurement and evaluation activities and obtain signed agreement on the terms of reference for the group.		AC Chair	

Recommendations	Response	Key Activities	Responsibility	TimeFrame
Develop a systematic approach to collecting performance information from the funded recipients in terms of type, frequency, and format of the information.	The performance measurement framework (PMF) has been developed within the revised RMAF and is undergoing further refinements. It will be ready for implementation April 1, 2008. Information will be collected from project inception to final outcome on both common Program indicators and key component and project level indicators, in formats that allow for consolidation of data to report at the program level. These information requirements will be articulated within Program information packages and the calls for proposals. They will be further specified within the contribution agreements themselves. Tools and templates will be developed to assist in data collection.	Complete refinements of the performance measurement framework as detailed below. Consultants will be engaged as required.	AC Chair	January to March 2008
Develop performance indicators (i.e., identify what success looks like) for each component in the Program logic model. This should be done in collaboration with Program stakeholders.	Program performance indicators will be refined, including details on the timing of data collection and reporting, draft logic models have been developed and will be validated for each component, and associated performance measurement strategies will be developed.	Refine Program level performance indicators. Validate with Program stakeholders. Validate component level draft logic models with project managers. Develop component level performance indicators for each component in the Program. Ensure they are consistent with Program level indicators. Validate component performance indicators with both project managers and DPMED. Validate component performance indicators with a representative group of external stakeholders.	AC Chair	January 2008 to March 2008

Recommendations	Response	Key Activities	Responsibility	TimeFrame
Creating guidelines and standards for funding recipients				
Develop guidelines and common criteria for the project proposals and evaluations to ensure that relevant information will be captured at the project level to inform the evaluations at three levels - project, component, and Program.	It is important to recognize that the Program houses a diverse collection of initiatives and that both common Program indicators as well as measures of unique project and component outcomes will be important.	In conjunction with refining the performance measurement and evaluation framework, common guidelines and criteria will be developed with the assistance of consultants through a series of workshops. The guidelines and criteria will be incorporated into Program management information packages and Program project solicitation packages. Templates will be developed to ensure the uniform collection and assessment of information.	AC Chair and OC Chair	January 2008 to March 2008
Solicitation packages should require proposals to demonstrate appropriate target audience(s), identification and provision of a specific strategies to be used for dissemination of knowledge and its uptake, evidence base or rationale for the use of the strategies, as well as the method for assessing the reach and uptake by the target audiences.	Information dissemination is a key activity of the Program components and knowledge transfer is an immediate outcome. Program management recognizes the importance of tailoring the dissemination strategy in order to deliver appropriate and useable information to the intended user. The achievement of intermediate and ultimate outcomes is dependent upon these.	Information dissemination strategies and activities will be drafted as part of the work to improve strategic planning and coordination. (See below) Develop the package utilizing existing materials as available and creating new or revised materials as required.	AC Chair and OC Chair	January 2008 to March 2008

Recommendations	Response	Key Activities	Responsibility	TimeFrame
Ensure that the target audience is appropriately identified - consider if the end users are in the right position to be able to meet the Program's objectives (e.g., are they able to effect change) Program should identify appropriate ways to disseminate information to specific target groups and ways to assess the uptake - to provide some guidance to projects/initiatives to be able to more critically assess new proposals. Solicitation packages should require projects to identify: • the method for evaluation of new approaches and tools • the method for identification of best practice • how their project relates to the Program objectives and the overall renewal of the health care system • how the project can be implemented or generalized to a larger population and/or other jurisdictions.	A solicitation package will be developed at the Program level. It will contain an overview of the Program with specific information on Program objectives, terms and conditions, stakeholders, target audiences, common definitions and concepts, financial and performance measurement and reporting requirements. The package will also contain a guidelines and templates to assist in the development of project proposals and to ensure that key criteria such as target audience, dissemination strategies and uptake assessment are identified. The Program solicitation package will accompany more specifically tailored Calls for Proposals.	Solicit input from Departmental advisory services were specialized knowledge is required. ie. evaluation, legal Launch the package by way of an information session for the PMG. Disseminate both in hard copy and electronically.		
Lessons learned from this summative evaluation should be incorporated into the proposal review process.	A program management information package will be developed and will include conclusions and recommendations of the summative evaluation. The package will also include: brief Program background; Program objectives; Terms and Conditions; common definitions and concepts; proposal solicitation and review process; and project assessment tools and templates which incorporate both evaluation recommendations and reporting requirements as documented in the Program RMAF.	Develop the package utilizing existing materials as available and creating new or revised materials as required. Solicit input from Departmental advisory services were specialized knowledge is required. ie. evaluation, legal Launch the package by way of an information session for the PMG. Disseminate both in hard copy and electronically.	AC Chair and OC Chair	January 2008 to March 2008

Recommendations	Response	Key Activities	Responsibility	TimeFrame
Improving strategic planning and coordination at the Program level				
Develop an overall Program strategy, including the level of funding to be allocated to specific funding priorities, taking into account the type of information already available on these priority areas, the status of the priorities with respect to knowledge translation, and the scope and magnitude of the health care renewal challenge to be addressed under each priority.	The expansion of Program initiatives in response to emerging government priorities and FMM Health Accords has meant that the Directorate requires more program management capacity than previously envisioned. Management systems, performance measures and performance feedback mechanisms have been developed and are in the final stages of refinement. Implementation is set to begin and will continue throughout the next year.	Develop annual agenda and schedule for regular meetings of PEC, AC, OC and PMG. Plan to alternate the focus to cover a variety of topics such as strategic planning (including periodic review of projects to ensure that priorities of the Program are being met), performance measurement, evaluation, information dissemination, knowledge transfer, financial reporting, agreement negotiation and legal issues. Include Departmental Advisory Services expertise as required.	AC Chair	January 2008 to March 2008
The strategy might consist of the following activities: • Conduct periodic reviews of the priorities/objectives of the projects receiving funding to ensure that the priorities/objectives of the Program and its components are being addressed. Calls for proposals could then be tailored to fill in any information gaps. • Focus on funding projects that encompasses a national approach right at the development stage (e.g., that are exploring ways to implement at a national level, or that are considering the generalizability to the rest of the country).		Draft a standardized Program level data collection templates which will provide the means by which pertinent project data can be collected from projects for input into the Program database. Develop a database which will serve as the information container and will facilitate the analysis of projects with respect to the Program's objectives and key reporting criteria. Draft specific component level content for the data collection templates. Validate and test templates with Program stakeholders.		

Recommendations	Response	Key Activities	Responsibility	TimeFrame
• Create a plan to coordinate, and to reduce duplication of, efforts within components (e.g., when they are addressing similar issues, but in different regions). • Create a plan for rolling up 'pilot project' tools, approaches, best practices, etc.		Design data analysis reports to be extracted from the database and tabled at committee meetings on a regular basis.		
• Collect common information from projects, and synthesize this information at the component level and share this information with the other projects/initiatives.	The database as described above will facilitate the synthesis of project information at the component level and the Program level.	This information will be shared through existing websites and print publications	OC Chair	Ongoing

Health Canada Santé Canada

Health Care Strategies and Policy Grant and Contribution Programs (2002 - 2007)

Summative Evaluation Report

December 2007

Prepared by:
Departmental Performance Measurement and Evaluation Directorate
Chief Financial Officer Branch

Canada

ACKNOWLEDGEMENTS

We would like to express our appreciation to the many individuals from both Health Canada and outside the Department who participated in the development of this evaluation. Without their cooperation, this report would not have been possible. In particular, we would like to acknowledge the following individuals.

From the Director General's Office (DGO), the Health Care Policy Directorate (HCPD), the Office of Nursing Policy (ONP), and the Applied Research and Analysis Directorate (ARAD), the project team consisted of the following individuals:

- Zelia Barbosa, Grants and Contributions Administrative Officer (ONP)
- Susan Spohr, Senior Public Accountability Coordinator (DGO)
- Gary Larkin, Manager (HCPD)
- Denise Boyle, Senior Policy Analyst (HCPD)
- Diana Kaan, Senior Policy Officer (HCPD)
- Robin Buckland, Senior Policy Analyst (ONP)
- Teklay Messele, Economist (ARAD)

From the Departmental Performance Measurement and Evaluation Directorate (DPMED), Chief Financial Officer Branch, the project team consisted of the following individuals:

- Tara Kuzyk, Senior Evaluator
- Jennifer Davidson, Senior Evaluator
- Helen Verhovsek, Senior Evaluator
- Kate Morgan, Evaluator
- Nana Amankwah, Senior Evaluator
- Donna Anderson, Evaluator
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TABLE OF CONTENTS

TABLE OF CONTENTS (cont'd)

Page

EXECUTIVE SUMMARY

Background

Health Canada's Health Care Strategies and Policy Grant and Contribution Programs (referred to as the 'Program' or HCSPG&CP) were created in 2002 to address commitments initially set out by First Ministers in 2000, and solidified in the 2003 Health Accord, and the 2004 10-Year Plan. The Program also supports previously agreed upon, and emerging Federal/Provincial/Territorial (F/P/T) commitments.

According to a policy document in support of its creation, the Program was created to broaden the base of the policy analysis and advice needed to work towards a more accessible, high-quality, sustainable and accountable health system that will be adaptable to the needs of Canadians.

The HCSPG&CP is an umbrella program that encompasses several components, including: the Canadian Agency for Drugs and Technologies in Health (CADTH); the Health Council of Canada; the Canadian Patient Safety Institute (CPSI); the Canadian Post-M.D. Education Registry (CAPER); Core Contributions (including Canadian Medication Incident Reporting and Prevention System (CMIRPS) and Best Practices Contribution Program (BPCP)); the Health Human Resource Strategy (HHRS); the Internationally Educated Health Professionals Initiative (IEHPI); and the National Wait Times Initiative (NWTI).

While each of these components have their own specific objectives, they all relate to the overall HCSPG&CP objectives to:

1. Foster the development and implementation of health care system policies and strategies to address identified health care system priorities;
2. Increase knowledge of factors determining the performance of the health care system and its responsiveness to users' needs;
3. Increase collaboration on, and coordination of, responses to health care system priorities amongst F/P/T governments, other health care policy makers, service providers, users, researchers, and other stakeholders;
4. Identify, assess, and promote new approaches and best practices that respond to identified health care system priorities;
5. Increase knowledge and application of evidence and best practices, leading to improved health care system planning and performance; and
6. Contribute to improvements in the accessibility, responsiveness, quality, sustainability, and accountability of the health care system.

Purpose of the Summative Evaluation

The current Terms and Conditions of the Health Care Strategies and Policy Contribution Program will expire March 31, 2008. In accordance with the Policy on Transfer Payments, Treasury Board requires an evaluation of the Program prior to renewal of their Terms and Conditions. This evaluation will assess the success of each of the Program's components in achieving its objectives, with a focus on the First Ministers' commitments. The evaluation findings will be a consideration in Treasury Board's decision regarding renewal of the Program's Terms and Conditions. Further, the findings will assist Program's management in decision-making regarding future directions of the Program and its components.

This evaluation has three objectives:

- Determine the relevance of the Program and its components;
- Examine Program's/components' progress and impacts (i.e., achievement of outcomes and objectives); and
- Examine lessons learned.

The evaluation set out to answer the following questions:

1. Do the Programs continue to reflect government and Health Canada priorities? Are the components funded under HCSPG&CP still relevant?
2. Do the Programs duplicate or overlap with any other initiative in Health Canada? What is unique about the knowledge and information produced?
3. To what extent have each of the components of HCSPG&CP contributed to the achievement of the following HCSPG&CP objectives?
4. Are there expected results of the components that have not been achieved? Why?
5. What are the lessons learned from HCSPG&CP and their components?

Methods

The analysis for this evaluation relied on multiple lines of evidence to discern the most comprehensive, valid, and reliable findings. The lines of evidence were generated using the following data collection methods: a document review, a survey, and a literature review.

The evaluation study was conducted between February and November 2007. Planning and instrument development took place between February and May, followed by the data collection for the three lines of evidence, which spanned three months (June through August). The data analysis and report writing were completed between September and November.

The document review included a review of 27 project files, 11 additional final/evaluation reports, and 4 component-identified projects. Data abstraction forms were created to systematically collect the information. For the survey, representatives from 127 projects were invited to participate in the electronic survey, and 67 of them responded. For the literature review, over 30 articles were reviewed using an information capture template.

The findings from these three lines of evidence were synthesized and presented in this report according to each evaluation question. Where possible, data were analysed at two levels - the overall Program level, and the component level.

Conclusions and Recommendations

Table I highlights the conclusions and recommendations that resulted from this evaluation. The recommendations are grouped into four broad categories: relevance, improving performance measurement data and monitoring, creating guidelines and standards for funding recipients and improving strategic planning and coordination at the Program level.

Table I
Summative Evaluation Conclusions and Recommendations

Conclusions	Recommendations
Relevance	
The Program and its components are aligned and reflect priority areas as identified by the FMMs, the Speech from the Throne, Health Canada, and shared F/P/T priorities. The Program has also demonstrated flexibility in addressing emerging health care system issues quickly.	• The Program should continue to demonstrate its flexibility in responding to emerging health care system priorities.
Improving performance measurement data and monitoring	
The project's annual and evaluation reports focussed on processes and outputs of the project as opposed to results/outcomes, making it difficult to assess the Program's success in achieving its objectives.	• Refine overall Program performance indicators and develop additional performance indicators (i.e., identify what success looks like) for each Program component. This should be done in collaboration with Program stakeholders. • Develop a systematic approach to collecting performance information from the funded recipients in terms of type, frequency, and format of the information. • In order to achieve the above recommendations, resources (e.g., FTEs and monetary) need to be dedicated to performance measurement at the Program, component and project level.

Conclusions	Recommendations
Creating guidelines and standards for funding recipients	
Many projects did not report on Program or component objectives, instead reported on their own project objectives.	• Develop guidelines and common assessment criteria for the project/initiative proposals and evaluations so that relevant information will be collected at the project-/initiative-level, which would then inform the evaluation at the component- and Program-levels. • Call for proposals should require the projects to state how the project relates to the Program objectives and the overall renewal of the health care system.
The target audiences identified by the projects/ initiatives were usually too broad and the dissemination strategies were usually not grounded in evidence from research or literature. Efforts to collect information on the reach and uptake of project's outputs (e.g., knowledge, tools, etc.) were very limited.	• The Program should identify appropriate ways to disseminate information to specific target groups as well as appropriate ways to assess uptake, to provide guidance to projects/initiatives and component representatives/staff. • Call for proposals should require the projects to identify or state: ‣ **an appropriate target audience**: Ensure that the target audience and the level (e.g., local, P/T, national) of the target audience is appropriately identified. Consider if the end users are in the right position to be able to meet the Program's objectives (e.g., are they able to effect change); ‣ **a rationale for the dissemination strategy**: why certain methods for dissemination were selected/used should be explained (e.g., based on research or theory?); ‣ **the method for assessing the reach and uptake**: the projects' evaluation plans should include the methods for assessing the reach and uptake of the projects' outputs (e.g., knowledge/products produced) among the target audience(s). • For standard items (e.g., dissemination strategies, target audience identification, evaluation methodology, etc.), proposal reviewers need to have common assessment criteria across components upon which to review the proposals received
Many projects/initiatives developed a new tool or approach. However, it was often unclear how the tool or approach was evaluated. Without this information, the Program would not be able to assess which projects/initiatives could be applied more broadly, even nationally.	• Call for proposals should require the projects to identify or state: ‣ the method of evaluation of new tools/approaches; ‣ how the project can be implemented or generalized to a larger population and/or other jurisdictions.

Conclusions	Recommendations
A few key 'lessons learned' have been identified in the document review and survey that may be applicable to, and useful for, other projects in the Program as well as for the proposal review process.	• Projects should include 'lessons learned' in their final reports. These lessons should indicate how they relate to, or could be helpful for, other projects or the overall Program (e.g., identification of strategies that supported uptake, or key barriers and how they were addressed); • When assessing new proposals, reviewers should also consider the lessons learned from previous projects and how they relate to the approaches being proposed (e.g., reviewers need to ensure that the proposed timelines are realistic).
Improving strategic planning & coordination at the Program level	
All three lines of evidence confirmed that collaboration and coordination at the national level is needed in order to create change at the health care system level. Many of the projects /initiatives, in particular the named grants, had established formal agreements with national and provincial organizations and governments. Coordination at the national level was less evident in the contribution programs. Within some of the HCSPG&CP components, there may be a risk of duplication across the individual projects, particularly when similar projects are being funded in different jurisdictions.	• Develop an overall Program strategy, including the level of funding to be allocated to specific funding priorities, taking into account the type of information already available on these priority areas, the status of the priorities with respect to knowledge translation, and the scope and magnitude of the health care renewal challenge to be addressed under each priority. • The plan might consist of the following activities: ‣ Conduct periodic reviews of the priorities/objectives of the projects receiving funding to ensure that the priorities/objectives of the Program and its components are being addressed. Calls for proposals could then be tailored to fill in any information gaps; ‣ Create formal opportunities to share information; ‣ Focus on funding projects that encompasses a 'national-level' approach at the development stage; ‣ Create a plan to coordinate, and to reduce duplication of, efforts within components; ‣ Create a plan for rolling up 'pilot project' tools, approaches, best practices, etc; ‣ Collect common performance measurement information from projects, synthesize this information at the component level, and share this information with the other projects/initiatives.
Very few of the completed projects had focussed on assessing the impact of the project on the health care system more broadly. While all components reported having a national-level focus many of the projects were not designed with a national-level strategy in mind or had the intention of applying its strategies or best practices at the provincial/territorial level.	• There needs to be a greater emphasis on broadened application of project results (i.e., application at the provincial/territorial or national levels) in order to achieve national-level health system changes.

INTRODUCTION

This report presents the findings and recommendations of the Health Care Strategies and Policy Grant and Contribution Programs (HCSPG&CP) summative evaluation. This evaluation was conducted for the HCSPG&CP by staff from Health Canada's Departmental Performance Measurement and Evaluation Directorate (DPMED). This report consists of four sections and begins with an introduction, which describes the components, the objectives, and the resource profile of the HCSPG&CP including the program logic model. The second section of the report focuses on the evaluation design; describing each of the lines of evidence, and their limitations. The third section, which comprises the bulk of the report, presents the findings and evidence of the evaluation, organized by the overall evaluation issues and questions. The final section presents the overall recommendations and conclusions.

PROGRAM PROFILE

Health Canada's *Health Care Strategies and Policy Grant and Contribution Programs* (referred to as the 'Program' or HCSPG&CP for the rest of this document) were created in 2002 to address commitments initially set out by First Ministers in 2000, and solidified in the 2003 Health Accord, and the 2004 10-Year Plan. The Program also support previously agreed upon, and emerging Federal/Provincial/Territorial (F/P/T) commitments.

According to a policy document in support of its creation, the Program was created to broaden the base of the policy analysis and advice needed to work towards a more accessible, high-quality, sustainable and accountable health system that will be adaptable to the needs of Canadians.

The Program consists of three distinct elements (or programs), namely:

- The Federal/Provincial/Territorial Partnerships Grant Program, which includes the Canadian Post-M.D. Education Registry (CAPER);
- The Named Grants, which include the Canadian Patient Safety Institute (CPSI), the Health Council, and the Canadian Agency for Drugs and Technologies in Health (CADTH) (formerly called the Canadian Coordinating Office for Health Technology Assessment (CCOHTA));
- The Contribution Program, which includes the Health Human Resource Strategy (HHRS), Internationally Educated Health Professionals Initiative (IEHPI), National Wait Times Initiative (NWTI), and the Core Contributions.

The Grant Program, which includes the F/P/T Partnership Grants (i.e., class grants) and the Named Grants, supports F/P/T agreements and collaboration in the renewal of Canada's health care system. The Contribution Program concentrates efforts to stimulate and facilitate health care policy analysis and development in areas of priority to Health Canada, by provincial/territorial governments and non-governmental organizations.

Program Components

As the Program evolved in response to the First Ministers' commitments, it grew to encompass six Treasury Board submissions (2002, 2003, 2004[1], 2005, 2006), each with their own evaluation commitments. With each subsequent submission, the Program has grown with respect to dollar value and the number of components that fall under the Program (see **Figure 1**).

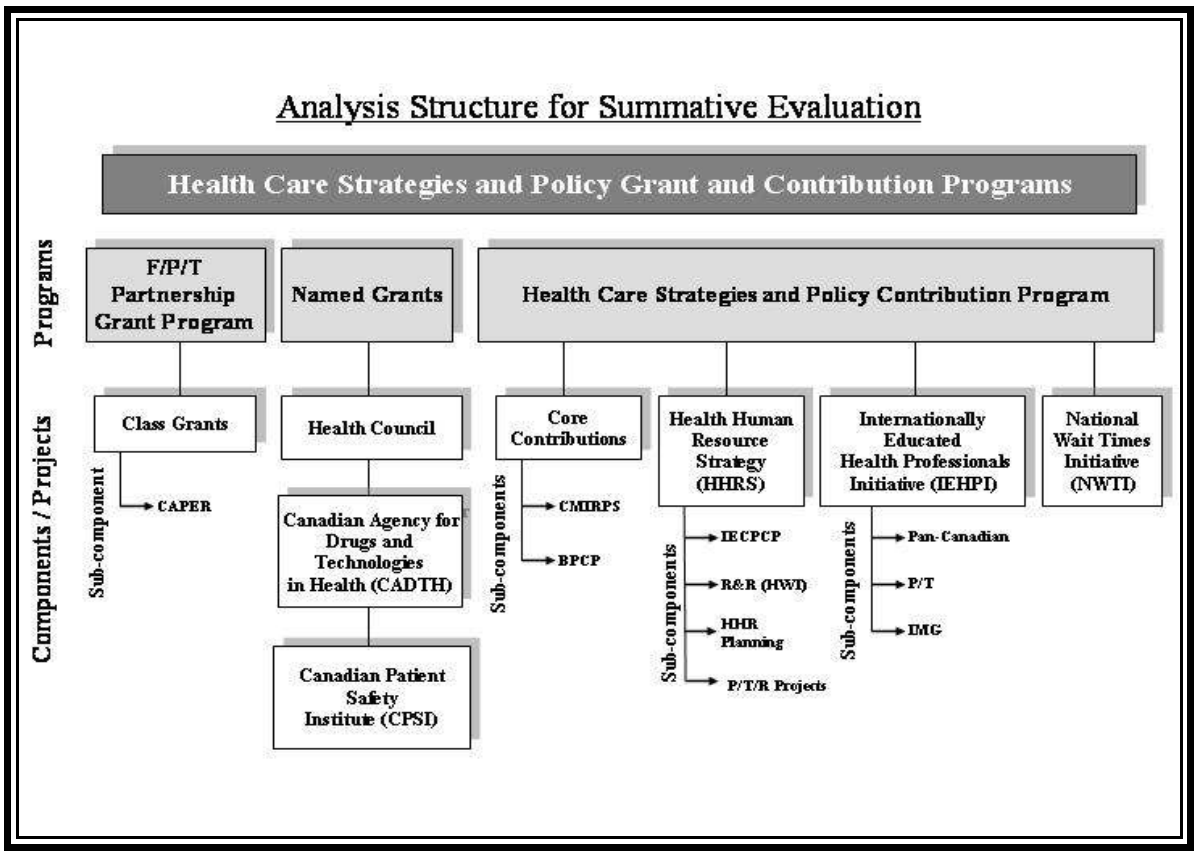
The components of the Program include:

- **Grants**:
  - Canadian Agency for Drugs and Technologies in Health (CADTH);
  - Health Council of Canada;
  - Canadian Patient Safety Institute (CPSI);
  - F/P/T Partnership Grant Program (or the Class Grants), which includes the Canadian Post-M.D. Education Registry (CAPER);

- **Contributions:**
  - Core Contributions (including Canadian Medication Incident Reporting and Prevention System (CMIRPS) and Best Practices Contribution Program (BPCP));
  - Health Human Resource Strategy (HHRS), composed of five sub-components: 1) Interprofessional Education for Collaborative Patient-Centred Practice (IECPCP); 2) Recruitment and Retention (R&R), which also includes the Healthy Workplace Initiative (HWI); 3) Pan-Canadian Health Human Resource Planning; and the 4) Provincial/ Territorial/ Regional (P/T/R) project funding;
  - Internationally Educated Health Professionals Initiative (IEHPI), which includes three sub-components: 1) Pan-Canadian Activities; 2) Provincial/Territorial (P/T) Activities; and 3) the International Medical Graduates (IMG) projects; and the,
  - National Wait Times Initiative (NWTI).

[1] There were two separate TB submissions in 2004.

Figure 1
Health Care Strategies and Policy Grant and Contribution Programs - Analysis Structure



Management

The Director General of the Health Care Policy Directorate (HCPD) is responsible for the overall program results and accountability. Directors (or Executive Director in the case of the Office of Nursing Policy) in the following divisions are also responsible for managing specific elements of the funding provided to funding recipients:

- Health Care System Division;
- Primary and Continuing Health Care Division;
- Health Human Resource Strategies Division;
- Office of Nursing Policy; and
- Pharmaceuticals Management Strategies.

Resource Profile

From a modest beginning of $1.6M/year for grants and $2.0M/year for contributions, the Program now (in 2006-07) incorporates $35.5M/year for grants and $29.1M/year for contributions. **Table 1** shows the distribution of the Program's *allocated* resources for each of the components based on information from the various TB submissions.

Table 1
Health Care Strategies and Policy Grant and Contribution Programs - budget allocation by fiscal year

	2002-2003	2003-2004	2004-2005	2005-2006	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011	Total all years
2002 SUBMISSION										
Grants (CCOHTA Core/CDR up to fiscal year 2004-2005)	$2,455,500	$2,000,000	$2,000,000	$96,000	$96,000	$96,000	*	*	*	$6,743,500
Contributions	$2,000,000	$2,000,000	$2,000,000	$1,000,000	$1,000,000	$1,000,000	*	*	*	$9,000,000
2003 and 2004 SUBMISSIONS										
Named Grants										
Health Council	$0	$0	$6,148,900	$10,000,000	$10,000,000	$10,000,000	*	*	*	$36,148,900
CPSI	$0	$2,200,000	$8,000,000	$8,000,000	$8,000,000	$8,000,000	*	*	*	$34,200,000
CCOHTA (HTS)	$0	$5,000,000	$10,000,000							$15,000,000
CCOHTA (Core, CDR, HTS, COMPUS)				$16,903,967	$17,403,967	$17,403,967	*	*	*	$51,711,901
CCOHTA (COMPUS) +	$0	$1,500,000	$3,000,000							$4,500,000
Contributions										
HHRS	$0	$1,475,000	$15,079,308	$15,885,908	$14,628,685	$15,425,637	*	*	*	$62,494,538
C-MIRPS	$0	$1,600,000	$1,600,000	$1,600,000	$1,600,000	$1,600,000	*	*	*	$8,000,000
Best Practices Contribution Program +	$0	$200,000	$500,000	$1,000,000	$700,000	$700,000	n/a	n/a	n/a	$3,100,000
NPDUIS (CIHI) +	$0	$150,000	$800,000	$800,000	n/a	n/a	n/a	n/a	n/a	$1,750,000
2005 SUBMISSION										
Contributions										
IEHPI	$0	$0	$0	$9,414,407	$9,419,155	$16,677,555	$16,677,555	$16,677,555	*	$68,866,227
National Wait Times Initiative	$0	$0	$0	$750,000	$1,750,000	$3,750,000	$3,750,000	n/a	n/a	$10,000,000
TOTAL	**$4,455,500**	**$16,125,000**	**$49,128,208**	**$65,450,282**	**$64,597,807**	**$74,653,159**	**$20,427,555**	**$16,677,555**	*	**$311,515,066**

+ Therapeutics Access Strategy (TAS) Funding

* Ongoing funding subject to subsequent TB submissions and Terms and Conditions renewal (for contributions), or Funding Agreement renewal (for grants).

Terms and Conditions under the 2002 TB Submission will expire in fiscal year 2006-2007 (extended to fiscal year 2007-2008).

Program Objectives

The revised[2] objectives of the Program are to:

1. Foster the development and implementation of health care system policies and strategies to address identified health care system priorities;

2. Increase knowledge of factors determining the performance of the health care system and its responsiveness to users' needs;

3. Increase collaboration on, and coordination of, responses to health care system priorities amongst F/P/T governments, other health care policy makers, service providers, users, researchers, and other stakeholders;

4. Identify, assess, and promote new approaches and best practices that respond to identified health care system priorities;

5. Increase knowledge and application of evidence and best practices, leading to improved health care system planning and performance; and

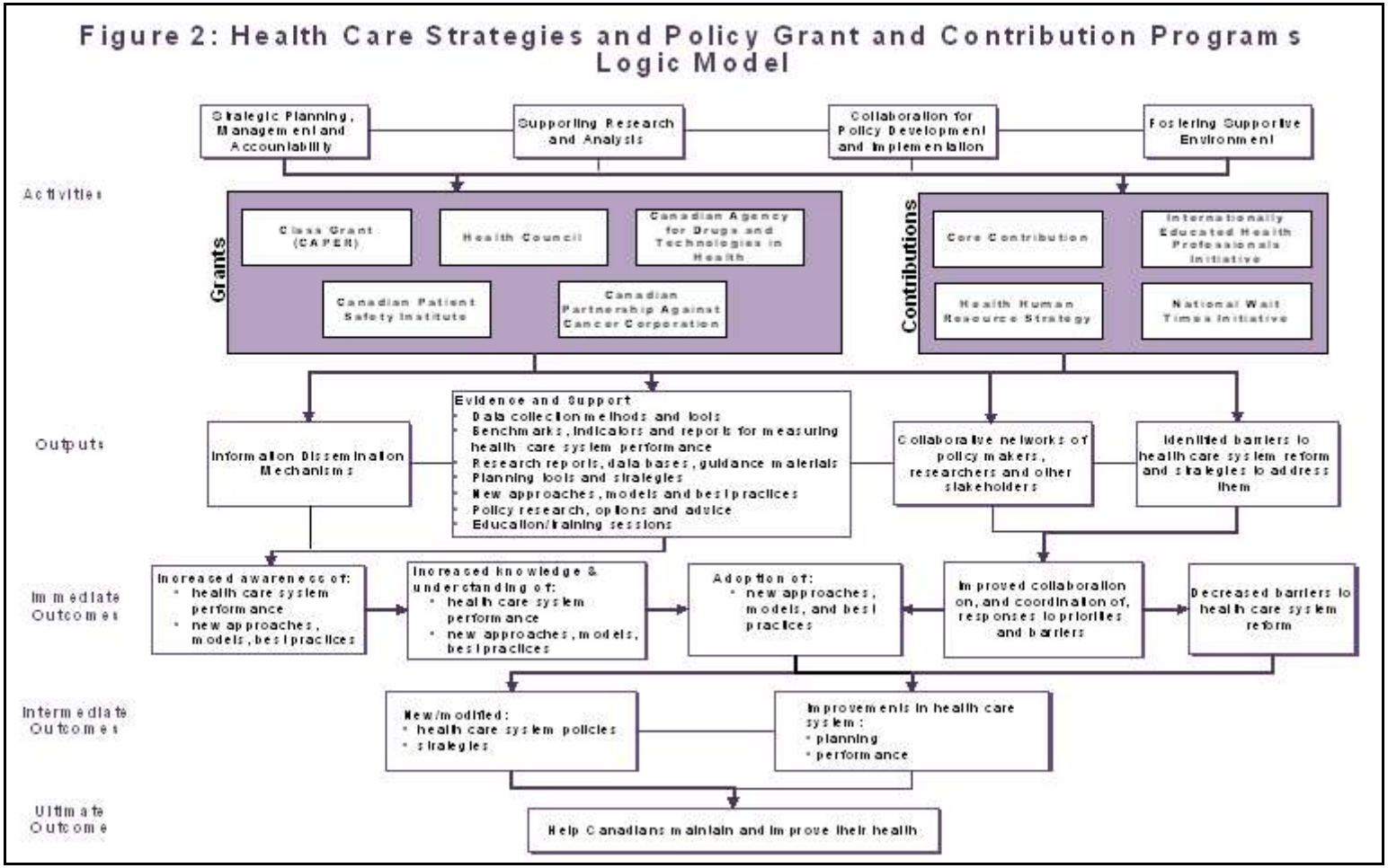
6. Contribute to improvements in the accessibility, responsiveness, quality, sustainability, and accountability of the health care system.

Program Logic Model

The Program logic model presented in **Figure 2** covers the time period between the years 2002 and 2007, and describes how the Program's activities and outputs lead to the immediate, intermediate, and ultimate outcomes.

[2] In 2007, these objectives were revised in response to the findings from the Health Care Strategies and Policy Performance Measurement System Review (see section 3.1)

Figure 2: Health Care Strategies and Policy Grant and Contribution Programs Logic Model



PURPOSE OF EVALUATION

The current Terms and Conditions of the Health Care Strategies and Policy Contribution Program will expire March 31, 2008. In accordance with the Policy on Transfer Payments, Treasury Board requires an evaluation of the Program prior to renewal of their Terms and Conditions. This evaluation will assess the success of each of the Program's components in achieving its objectives[3], with a focus on the First Ministers' commitments. The evaluation findings will be a key consideration in Treasury Board's decision regarding renewal of the Program's Terms and Conditions. Further, the findings will assist Program's management in decision-making regarding future directions of the Program and its components.

Evaluation Objectives

This evaluation has three objectives:

1. Determine the relevance of the Program and its components;
2. Examine Program's/components' progress and impacts (i.e., achievement of outcomes and objectives); and
3. Examine lessons learned.

The evaluation issues and specific questions addressed in this study are included in **Table 2**.

Table 2
HCSPG&CP Summative Evaluation Issues and Questions

Relevance
1. Do the Programs continue to reflect government and Health Canada priorities? Are the components funded under HCSPG&CP still relevant?
2. Do the Programs duplicate or overlap with any other initiative in Health Canada? What is unique about the knowledge and information produced?
Success
3. To what extent have each of the components of HCSPG&CP contributed to the achievement of the following HCSPG&CP objectives? *i. Foster the development and implementation of health care system policies and strategies to address identified health care system priorities.* *ii. Increase knowledge of factors determining the performance of the health care system and its responsiveness to users' needs.* *iii. Increase collaboration on, and coordination of, responses to health care system priorities amongst F/P/T governments, other health care policy makers, service providers, users, researchers, and other stakeholders.* *iv. Identify, assess, and promote new approaches and best practices that respond to identified health care system priorities.* *v. Increase knowledge and application of evidence and best practices, leading to improved health care system planning and performance.* *vi. Contribute to improvements in the accessibility, responsiveness, quality, sustainability, and accountability of the health care system.*
4. Are there expected results of the components that have not been achieved? Why?
5. What are the lessons learned from HCSPG&CP and their components?

[3] The components are at various stages of implementation, which may influence the extent to which they have achieved the Program objectives.

Scope

With the exception of two components, the evaluation study assessed each Program component. The Canadian Partnership Against Cancer Corporation, whose funding only began in fiscal year 2006/07, was not included in this evaluation, since it was too early to assess their achievement of results. Also, as per an agreement between the Treasury Board Secretariat, HHRS and FNIHB, the FNIHB HHRS-funded projects were not included in this evaluation; instead they will be evaluated under the Aboriginal Health Human Resource Initiative (AHHRI) evaluation process.

Time Frame for Evaluation Study

The evaluation study was conducted between February and November 2007. Planning and instrument development took place between February and May, followed by the data collection for the three lines of evidence, which spanned three months (June through August). The data analysis and report writing were completed between September and November.

Table 3 identifies the timing of key evaluation activities and deliverables.

Table 3
Timing of the Summative Evaluation Activities and Deliverables

Activity	Time
Initial Planning Commenced	February 2007
Terms of Reference Signed	June 2007
Literature Review Conducted	June - September 2007
Literature Review Finalized	September 2007
Document Review Conducted	June - September 2007
Document Review Finalized	September 2007
Survey Administered	August 2007
Synthesis of the 3 Lines of Evidence	October 2007
Preliminary Finding submitted to the Program	October 2007
Summative Evaluation Draft Report submitted to the Program	November 2007

METHODS

The analysis for this evaluation relied on multiple lines of evidence to discern the most comprehensive, valid, and reliable findings. The lines of evidence were generated using the following data collection methods:

i. Document Review,
ii. Survey, and
iii. Literature Review.

The detailed methodology for each line of evidence is described below.

Document Review

The document review was conducted in four parallel parts:

Part 1) general Program documentation;
Part 2) a random sample of project files;
Part 3) project evaluation reports (where available); and
Part 4) component-identified projects.

Part 1: Review of General Program Documents
Program documents were reviewed to obtain background information about the Program (e.g., Program components, objectives, resources, etc.). This information helped inform the responses to some of the evaluation questions and helped provide details for the Program profile.

Part 2: Random Sample of Project Files
A sample of project files were reviewed to assess the relevance and success of the Program and each of its components. Given that the units of analysis for this evaluation are the Program components, the sample of projects was selected to be representative of the components. As such, all of the Grants (N=4, 100%) were included in the review[4] and a sample of Contribution Program-funded projects was selected. There were 123 Contribution Program-funded projects. However, due to time constraints of this evaluation, it was not feasible to collect and review documentation on each project. Thus, a random stratified sample of 27 projects (approximately 20% from each component/sub-component) were selected. Projects from each component/sub-

[4] With the exception of the Canadian Partnership Against Cancer Corporation, as stated on page 8.

component were stratified by dollar amount, thus ensuring project representation across varietyof dollar values. A stratified sampling approach "ensures that the different groups in the population (strata) are represented in the sample in the proportions in which they appear in the total population."[5]

Program staff were asked to identify and collect relevant documentation on the selected projects. A Document Review Guide was developed to assist staff with this process. To expedite the review process, staff were asked to highlight and flag pertinent information within the documentation that addressed guided questions contained in the Document Review Question Sheet.

Part 3: Review of Project Evaluation Reports
As a requirement for funding, each funded project was to submit an evaluation as part of their final report. All available evaluation reports were reviewed to gain additional insight into the success of the components.

Part 4: Review of Component-Identified Projects
Contribution Program components[6] were invited to identify one additional project as an example of a best practice, demonstration of results achievement, or a noteworthy challenge. Due to time restrictions, this part of the review only included one project per component/sub-component. Results from this part were used to highlight some good examples and provide context to the other parts of the review.

Survey

An electronic survey was administered to the funding recipients of *all* HCSPG&CP funded projects, and 67 responses were returned. The survey questionnaire contained 23 questions (9 closed and 14 open-ended), and which related to: the project's objectives, relevance, and success; the collaborations formed as part of the project; how projects share information, and the barriers that projects expected, encountered, and reduced/eliminated.

Two weeks prior to survey administration, an e-mail notice was circulated to all funding recipients informing them about the survey and the anticipated timing of administration. Recipients were asked to identify an alternate contact in the event that they would not be able to respond during that time. The survey questionnaire was developed in Adobe Acrobat (8.0) and was administered through personalized e-mail invitations, indicating the recipient's name and

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[5] Bowling, A. (1997) *Research Methods in Health: Investigating Health and Health Services*. Buckingham: Open University Press, page 165.

[6] All Named Grants were already included in the review, and therefore, could not identify an additional project to include in the review.

the title of the funded project. Completed surveys were returned via e-mail or fax and were originally due on August 17, 2007, but to increase the response rate, the date was extended until September 7, 2007 to accommodate recipients who were away on leave.

The open-ended survey responses were reviewed to identify emerging themes, including an 'other' category to capture responses beyond the identified themes. All survey responses were coded according to these themes. Survey findings and associated percentages presented will be based on the 67 returned responses unless otherwise indicated.

Literature Review

A literature review was conducted in four parts to:

1) collect information on the relevance and success of the Program and their components,
2) explore theoretical models of knowledge transfer,
3) explore methods for identifying best practices,
4) identify other programs in Health Canada that may duplicate or overlap with the Program.

A literature review protocol was developed that outlined the specific search strategies to be used for each part (including which data sources to search, search terms to use, inclusion and exclusion criteria for literature). This protocol was circulated to Program representatives prior to data collection in order to improve the breadth and depth of the search. The search strategy was also reviewed by a library information specialist. Upon reviewing the literature identified through the search, relevant information was abstracted by DPMED using a data abstraction template, which helped to ensure that data was collected in a comprehensive and consistent manner.

Limitations/Challenges

From the stages of initial planning, this evaluation was designed and completed in less than 9 months. The time available for data collection and analysis was therefore a key challenge. This limitation was mitigated by outlining the type of information needed a priori (e.g., developing clear inclusion/exclusion criteria, indicators, etc.) and getting support from Program representatives prior to data collection. Also, this evaluation focussed on answering a few key evaluation questions that could be addressed in the given time period. Other limitations of this evaluation stem from the methods used to collect the information. The limitations specific to each line of evidence are outlined in Table 4. **Table 4** also highlights the scope, tools developed, inclusion/exclusion criteria, limitations/ challenges, and mitigation approach for each line of evidence.

Table 4 Summary of Data Collection Methods			
	Document Review	**Survey**	**Literature Review**
Scope	- 27 project files reviewed - 11 additional final/evaluation reports reviewed - 5 component-identified projects highlighted	- 127 surveys went out - 67 included in final sample	- 21 articles reviewed for Program relevance and success - 6 articles reviewed for best practice identification - 7 articles reviewed for knowledge transfer
Tools Developed	- Document Review Guide and Question Sheet - Data Abstraction Forms - Roll-up Matrices	- Survey questionnaire	- Literature Review Information Capture Templates (one for each part of the review)
Inclusion Criteria	- Documentation dated between 2002 and June 1, 2007; - Answers evaluation questions; - Treasury Board submissions; - Evaluations of funded projects; - Calls for Proposals, Guides for Applicants, proposals for funding and funding approval forms; and - Annual or final reports.	- Lead on a project identified on the Program Contact List	Each part of the review had specific criteria, based on the general parameters below: - Publication date: 2002 to 2007 (two parts included literature from 1998 to 2007) - Language: English or French - Publication Type: Journal articles, government publications, conference proceedings, reports published by the Health Council of Canada. - Content: Content is relevant to or addresses one of the specific evaluation questions for the HCSPG&CP Summative Evaluation.
Exclusion Criteria	- Draft documentation; and - Authorization documents without signatures.	- Surveys received after September 7th, 2007.	- Literature that did not meet the inclusion criteria.
Limitations/ Challenges	- Limited timelines: could only review a limited number of documents per project.	- 53% response rate: Survey was administered over the summer, when many respondents were on holiday.	- Secondary data may not always be relevant or compatible with the scope of the review.
Mitigation of Limitations	- Most relevant documents were selected for review.	- An email notice was circulated to respondents a couple weeks prior to survey administration. Respondents were asked to identify an alternate contact if they would not be able to respond.	- All articles retrieved were systematically reviewed to determine their relevancy to include in the review; - Efforts were made to include the original source of data, where possible.

Synthesis of Lines of Evidence

The findings from these three lines of evidence were synthesized and presented in this report. For each evaluation question, data were analysed at two levels - the overall Program level, and the component level. Where possible, the findings were presented according to the appropriate level.

Table 5 provides a summary of the data collection methods that were used to answer each evaluation question.

Table 5
Summary of the Evaluation Issues, Questions, and Data Collection Methods

Evaluation Issues and Questions	Literature Review	Document Review	Survey
Relevance			
1. Do the Programs continue to reflect government and Health Canada priorities? Are the components funded under HCSPG&CP still relevant?	✔	✔	✔
2. Do the Programs duplicate or overlap with any other initiative in Health Canada? What is unique about the knowledge and information produced?	✔	✔	✔
Success			
3. To what extent have each of the components of HCSPG&CP contributed to the achievement of HCSPG&CP objectives?	✔	✔	✔
4. Are there expected results of the components that have not been achieved? Why?		✔	✔
5. What are the lessons learned from HCSPG&CP and their components?		✔	✔

EVIDENCE

The findings of this evaluation have been organized to address each evaluation question. For each question, a brief description of its significance to the Program (i.e. why the question was posed) is provided. Next, evidence from the document review, surveys, and literature review is provided to form a response to each of these questions. The conclusions and recommendations are then presented.

RELEVANCE

QUESTION 1

Do the programs continue to reflect government and Health Canada priorities? Are the components funded under the HCSPG&CP still relevant?

Answering this question provides a rationale for the continued involvement of Health Canada in these programs. As well, it helps to identify the extent to which Program objectives are still relevant by examining the consistency between Program objectives with current government and health care system priorities.

FINDINGS

The document review noted that the HCSPG&CP was established in large part in response to the First Ministers' Meetings (FMM) commitments identified below. In 2002, the Program was created to support the development of policy and policy capacity related to health care renewal, including federal commitments pursuant to F/P/T agreements. The Program has expanded over the years to address emerging issues and priorities.

The provincial, territorial and federal government priorities on health care renewal have been identified and agreed upon during a number of meetings with the First Ministers. The first meeting was held in 2000 and the Communiqué on Health agreed to collaborate on the following priority areas:

- health promotion and wellness;
- access to care;
- appropriate health care services - primary health care;
- supply of doctors, nurses and other health professionals;
- home and community care;
- pharmaceutical management;
- health information & communications technology; and
- health equipment and infrastructure.

The 2003 First Minister's Accord on Health Care Renewal identified additional areas to invest in and focus on. The following specific areas were identified:

- **primary health care**: ensuring access to the appropriate health provider when needed;
- **home care**: short-term acute care including acute community mental health and end-of-life care;
- **catastrophic drug coverage and pharmaceutical management**: promote optimal drug use, best practices in drug prescription and better manage cost of drugs;
- **diagnostic/medical equipment:** availability of diagnostic care and treatment services;
- **information technology and an electronic health record:** implementation of the electronic health card and telehealth applications;
- **patient safety**;
- **health human resources**: national planning to increase the supply of health professionals, inter-disciplinary provider education and strategies to improve recruitment and retention;
- **technology assessment**: impact of new technologies and effective utilization in the future;
- **innovation and research**: applied research and knowledge transfer;
- **healthy Canadians:** healthy living strategies to reduce disparities in health status;
- **aboriginal health:** addressing the gap in health status through integration of health services;
- **reporting to Canadians:** better and comparable information on health care services, health outcomes and health status.

Building on the renewal agenda set out by the FMM commitments, the 2004 Meeting on the Future of Health Care agreed to a 10-Year Plan to Strengthen Health Care. The plan focuses on ensuring that Canadians have access to the care they need, when they need it. The priority areas were identified as:

- reducing wait times and improving access;
- strategic health human resources action plans;
- home care;
- primary health care reform;
- access to care in the North;
- national pharmaceutical strategy;
- prevention, promotion and public health;
- health innovation; and
- accountability and reporting to citizens.

The Health Canada priorities from the years 2003 - 2007 have consistently identified the need to work collaboratively with the P/Ts to ensure FMM commitments are implemented as well as to strengthen accountability to Canadians. The Speech from the Throne in 2004 and 2006 identified patient wait times as a priority and the need to work with the provinces and territories to reduce wait times for medically necessary services.

The literature review outlined that there has been some improvements in the health care system since the inception of the Program but change is happening slowly and there is still much work required. The Romanow report stated that transforming the health care system is not a simple task. Refocusing a system as large and complex as health care means revisiting decisions that were made many years ago about how the system should be organized and what types of services should be provided.

The Program has been modified over the years to reflect emerging priority areas identified by the FMMs, the Speech from the Throne and Health Canada. For example, the Canadian Patient Safety Institute component was added to the Program in 2003 in response to the Accord on Health Care Renewal, which put aside additional funding to focus on patient safety. The IEHPI and NWTI components were added in 2005 in response to the 10-Year Plan to Strengthen Health Care, specifically allocating additional money to reduce wait times and improve access to health care services.

The lines of evidence for this question were analysed and reported on by component to give greater detail about how each of the components reflect current government priorities. The grants are described first, followed by the contributions.

Grants

Canadian Agency for Drugs and Technologies in Health

The literature review noted that the technology advancements and the heightened public expectation with respect to health care are the primary sources of escalating costs which threaten the sustainability of the health care system. Also, the pace of technology development is outpacing the health system's ability to operationalize it.[7] Furthermore, expenditures for drugs have increased almost 10% in the last 30 years.[8] The limited resources and increased choice and competition regarding products implies that difficult decisions need to be made on the adoption

[7] Challenges, Choices and Canada, International Journal of Technology Assessment in Health Care, 2002.

[8] Care in Canada, CIHI Report, 2007.

of new technologies and drugs. There is a need for evidence-based data to help make informed decisions. The Canadian Agency for Drugs and Technologies in Health (CADTH) is charged with coordinating and centralizing reliable information on drugs and technology in Canada through the following three initiatives:

- Health Technology Assessment and Analysis (HTA): which evaluates medical devices, health systems and pharmaceuticals.
- Canadian Optimal Medication Prescribing an Utilization Service (COMPUS): will gather, critically assess and disseminate best practices on appropriate prescribing and utilization of medication.
- Common Drug Review (CDR): establishment of a common drug review program.

The above initiatives address the FMM priorities of pharmaceutical management, technology assessment, health innovation and to some extent, heath equipment and infrastructure.

Health Council of Canada

Accountability to Canadians is a very important issue for the federal government. Improving accountability and reporting to Canadians has consistently been included in either the FMM commitments, Health Canada's priorities, the Budget, and/or the Speech from the Throne each year between 2001 to 2006. The Health Council was established as an independent body to provide a national, system-wide perspective, monitoring and constructive advice on how to improve access, quality, sustainability, accountability and responsiveness of the health system. In fulfilling its mandate, the Health Council is responsible for providing Canadians with an annual status report on health care renewal. While this continues to be an important issue to address, there is some debate concerning the extent to which the Health Council has achieved its mandate. This will be discussed later in this section.

Canadian Patient Safety Institute

The Canadian Patient Safety Institute (CPSI) is an independent not-for-profit corporation that was established in 2003, in response to the 2003 FMM Accord that identified patient safety as a priority. Its mandate is to provide a leadership role and to implement a national strategy with respect to patient safety to improve health care quality in Canada. Emerging evidence from research has indicated that the incidence of patients experiencing some kind of adverse event[9] that results in lengthened hospital stay or death is quite frequent. It is estimated that 9,000 -

[9] An adverse event is defined as 'unintended injuries or complications that are caused by health care management, rather than by the patient's underlying disease, and that lead to death, disability at the time of discharge or prolonged hospital stays.'

24,000 patients die each year from preventable adverse events.[10] The 2006 Health Council annual report noted that the reporting of adverse events is still profoundly under reported and spotty due to the lack of standards. While there is significant activity around patient safety in Canada, the literature suggests there is limited coordination and collaboration across jurisdictions. The institute will provide leadership and coordination of patient safety standards and activities across Canada.

Canadian Post-M.D. Education Registry

The objective of the Canadian Post-M.D. Education Registry (CAPER) is to provide a central area for the coordination of accurate information on medical manpower training on a national basis. It is a database that tracks physicians both geographically and by area of practice. This information feeds into the HHRS component and allows human resource planners to continue to monitor and make appropriate changes to affect physician supply.

Contributions

Core Contributions

The 'Core' contributions include a number of different projects involving key policy issues that address the FMM priorities which relate to patient safety, home and community care, mental health, primary health care, palliative and end-of-life care. As stated in the FMM commitments and in the literature, there is still a need for transformation in these areas. For example, mental health is becoming a prominent issue in health care and as a result, the Mental Health Commission has been formed. In primary health care, despite the repeated calls for change, the basic structure, organization, funding and delivery remains intact and has resulted in missed opportunities for change at the system level.[11] There is also every reason to assume that the demand for home, palliative and community care services will increase because it is driven by new advances in technology, the aging population, new primary health care models, trends towards early hospital discharge and the focus on reducing health care costs.

[10] Canadian Adverse Events Study: The incidence of adverse events among hospital patients in Canada, Baker, Norton et al., CMAJ. 170 (11): 1678-86, 2004.

[11] Primary Health Care Renewal in Canada: Are we nearly there?, Brian Hutchinson, 2004.

Health Human Resource Strategy and Internationally Educated Health Professionals Initiative

The 2000, 2003 and 2004 FMM commitments and the Speech from the Throne in 2004, have all identified addressing the shortage of health care professionals in the health care system as a priority. The literature review confirms that there is still a shortage of health professionals in some communities in Canada, particularly those in rural areas.[12] Also, Internationally educated health professionals (IEHPs) face many challenges in Canada when trying to find employment in their chosen profession.[13] Each province and territory has developed its own standards and programs for training and licensing its health providers, including IEHPs. The Health Human Resource Strategy (HHRS) seeks to improve the national planning, recruitment, retention, education and coordination of health human resources on a pan-Canadian basis. The Internationally Educated Health Professionals Initiative (IEHPI) seeks to integrate IEHPs into the health care system to alleviate the shortage dilemma. Together these components are striving to secure and maintain an optimal health workforce in Canada.

National Wait Times Initiative

Although there has been significant investment and activity around the reduction of wait times for treatments in the health care system, waiting for care remains the number one barrier to access to health care in Canada.[14] The literature states that long wait times are the main and in many cases, the only reason some Canadians say they would be willing to pay for treatments outside the public system.[15] Reducing wait times for surgical and other therapeutic treatments continue to be an important issue in the health care system.[16] Also, there is no standard method to collect wait time data so it is not comparable across jurisdictions. Thus a pan-Canadian approach to measuring and monitoring wait times is critical. The objective of the NWTI is to assist and engage relevant players in delivering on commitments for wait times management and reduction as well as establish national common indicators and create acceptable common benchmarks.

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[12] The use of provisionally licensed international medical graduates in Canada, Ross & Vardy, 2005.

[13] First results from Canada's Labour Force Survey, Statistics Canada, 2007.

[14] Access to health care services in Canada, Jan-Dec 2005, Statistics Canada Report, pages 1-25.

[15] Improving Access, Ensuring Quality, Romanow Report, 2002, Chapter 6.

[16] Waiting for health care in Canada: What we know and What we don't, CIHI, 2006, pg.45.

Other FMM Priorities

There are a number of FMM priorities not being addressed by the Program but which are being addressed by other agencies or programs and are therefore not represented in the HCSPG&CP. The priority areas of health promotion, prevention and wellness, healthy Canadians and public health are being addressed by the Public Health Agency of Canada.[17] Also, Canada Health Infoway Inc., which is a federally-funded independent, not-for profit corporation, has a mandate to accelerate the development and adoption of electronic health information systems including the electronic health card.[18]

CONCLUSIONS

These findings illustrate that the issues that were relevant in the health care environment at the Program's inception are still being faced by the health care system today. The components' objectives and roles directly align with and reflect the areas of concern outlined in the FMM commitments, the Speech from the Throne, Health Canada priorities, and shared F/P/T priorities. In addition, the Program has demonstrated its flexibility by accommodating emerging health care system issues quickly.

RECOMMENDATIONS

The Program should continue to demonstrate its flexibility in responding to emerging health care system priorities.

Question 2

Do the HCSPG&CP duplicate or overlap with any other initiative in Health Canada? What is unique about the knowledge and information that is produced?

[17] http://www.tbs-sct.gc.ca/rpp/0607/phac-aspc/phac-aspc_e.asp

[18] http://www.infoway-inforoute.ca/Admin/Upload/Dev/Document/AnnualReport0607-E.pdf

Answering this question will contribute toward determining the Program's relevance and continued government involvement. Also, assessing whether duplication or overlap exists across Health Canada initiatives can help identify areas where increased collaboration and coordination could help reduce duplication.

Determining the unique contribution of each Program component toward the development of new knowledge is important to ascertain the extent to which the Program is meeting related objectives.

FINDINGS

Two other programs funded by Health Canada, the *Primary Health Care Transition Fund* (PHCTF) and the *Contribution Program to Improve Access to Health Services for Official Languages Minority Communities* (OLMC), addressed similar issues as the HCSPG&CP Program.

Similar to the Program, the PHCTF was created in response to the FMM 2000 commitments, which made primary health care renewal a priority. The PHCTF received $800 million dollars between the fiscal years 2001/2002 and 2006/2007 to support primary health care renewal initiatives across Canada. The PHCTF and the HHRS are contributing to improvements in the accessibility of the health care system. But unlike the HHRS, the objectives of the PHCTF were focussed specifically on primary health care (e.g., emphasizing health promotion, disease and injury prevention, establishing interdisciplinary health care teams, and facilitating the coordination and integration with other health services). The initiatives in these programs were complementary, rather than duplicative. Also, with the ending of the PHCTF (March 2007), the Program is the funding mechanism available to address primary health care issues.

The other program addressing similar issues as the HCSPG&CP is the OLMC. The OLMC received $89 million over five years (2003/2004 to 2007/2008) for the implementation of projects to improve access to health services (in the official language of choice) for individuals living in official language minority communities. Funded projects were addressing issues related to the training and retention of health professionals that are able to work in the minority official language. While the HHRS component of the Program also aims to improve access to the health care system and funds projects related to the training and retention of health care professionals, it does not have a specific focus on training in official languages in targeted communities. However, there is potential for the HHRS to help contribute to the achievement of OLMC objectives. It would be beneficial for both programs to coordinate and share information about the projects they fund in order to minimize the risk for duplication.

So while no other programs in Health Canada duplicate the work being conducted by the Program, there remains a need for integration *within* Program components. This need becomes apparent when strategies are developed separately in different jurisdictions without an overall

plan to coordinate their design, development and implementation. For instance, 2 out of the 6 projects reviewed in the IEHPI component were conducted in different regions, but both related to creating resource centres/offices to provide IEHPs with information, tools, resources to help them increase their knowledge on the Canadian health care system. Also HHRS projects in multiple provinces were developing health professional registry databases and health human resource forecasting models.

Federal Role

The document review findings suggest that there is a need for pan-Canadian strategies for health care renewal, prompted by the lack of comparable data across jurisdictions (e.g., related to wait times, patient safety, health human resources), and a lack of coordination of efforts and best practices. This focus on national approaches underlines the importance of having the federal government provide a leadership role to coordinate the Program. All of the Program components identified a national focus or approach in their objectives statements. This type of focus on the national objective was highlighted by all components in the survey responses as one of the unique features of the component/project. Other unique features commonly identified were: the output produced (e.g., tools, information, training, etc.), the issue being addressed, and the people involved in the project.

Additionally, the survey discovered that without the funding through the HCSPG&CP, many of the initiatives could not have been carried out (87%, n=58), and some would not have been able to collaborate so widely (28%, n=19). The survey responses also indicated that Health Canada's contribution to the projects was not purely financial (99%, n=66), but also added credibility (72%, n=48) and provided leadership (42%, n=28).

CONCLUSIONS

The findings did not suggest that there are any other programs in Health Canada that are duplicating the efforts of the HCSPG&CP. Two other programs, the PHCTF and OLMC, are also addressing issues related to health human resources, but they are not the same issues as those being addressed in the HHRS. However, within some of the HCSPG&CP components, there may be a risk of duplication across the individual projects, particularly when similar projects are being funded in different jurisdictions.

All components identified that there is a need for pan-Canadian approaches and coordination for health care system renewal.

RECOMMENDATIONS

The Program needs to create a plan to coordinate, and to reduce duplication of, efforts within components (e.g., when they are addressing similar issues, but in different regions).

SUCCESS

Question 3

To what extent have each of the components of HCSPG&CP contributed to the achievement of the Program objectives:

- **Foster the development and implementation of health care system policies and strategies to address identified health care system priorities**
- **Increase Knowledge of factors determining the performance of the health care system and its responsiveness to users' needs**
- **Increase collaboration on, and coordination of, responses to health care system priorities amongst F/P/T governments, other health care policy makers, service providers, users, researchers, and other stakeholders**
- **Identify, assess and promote new approaches and best practices that respond to identified health care system priorities**
- **Increase knowledge and application of evidence and best practices leading to improved health care system planning and performance**
- **Contribute to improvements in the accessibility, responsiveness, quality, sustainability and accountability of the health care system.**

Identifying the extent to which Program components contribute to the achievement of Program objectives allows one to determine program success. It is important to determine which objectives are being addressed, how components contribute to the objectives, and whether any gaps exist.

Knowledge transfer and uptake is the underlying method employed by this Program to create health care system change. Knowledge transfer is defined as " the complex process of the 'exchange, synthesis and ethically sound application of research findings (knowledge) within a complex set of interactions among researchers and knowledge users."[19] Principles of knowledge transfer are well established and have been described as a continuum.

Theoretically the knowledge transfer process includes six stages:

- Transmission: creating and disseminating the knowledge
- Cognition: evidence that the knowledge has been understood by the target audience
- Reference: knowledge/research findings are cited in strategies, reports, etc.
- Effort: evidence that effort is being made to adopt and apply the knowledge
- Influence: knowledge has some influence on decision making
- Application: knowledge has given rise to activities

The Program was assessed according to knowledge transfer stages to determine where the Program is situated along the continuum. This information will be useful in advising Program components on their current stage and what steps need to be taken to move to the next stage.

For the purposes of this evaluation, the knowledge transfer continuum will be examined according to three broad categories because there was not enough performance measurement data to assess the subtle changes from one stage to the next in the continuum noted above. The three broad categories that will be examined are:

- Development of new knowledge (e.g., new approaches, best practices, research findings);
- Dissemination of knowledge to the target audience; and
- Application of new knowledge.

Also, the extent to which the Program was able to increase collaboration and coordination (as this is one of the most important facilitators in the knowledge transfer process) and contribute to improvements in the health care system will be examined.

[19] Canadian Institutes of Health Services Research. Knowledge Translation Strategy. Ottawa: Canadian Institutes of Health Services Research, 2004.

FINDINGS

Overall Program

Development of Knowledge

The components consistently identified the need for better information to inform national planning and policy development. The documents reviewed indicated that there is considerable activity in the area of knowledge generation for each of the component areas. All the projects reviewed had at least a portion of activity geared towards the development of a product (research paper, website, tool, conference report, etc.), or an approach. The activities varied significantly both within a component and across components and ranged from environmental scans to identify emerging health care priorities, to pure research to address a particular need in the health care system, to the identification of a best practice. It was often unclear how the approach or tool was evaluated or what methods were used to identify a best practice.

The literature states that to identify a best practice, either a systematic review (research methodology that pulls together, pools and synthesized the best available existing evidence) or a synthesis review (the use of an international panel of experts and a conceptual model to guide the process including an assessment of scientific rigour) should be used. In absence of those two options, one of the following methods could also be used:

1) Replication of program/principle has appeared in several refereed professional journals;
2) The programs/principles have undergone either a quantitative meta analysis or an expert/peer consensus process in the form of a qualitative meta-analysis;
3) The program's source documents have undergone thorough scrutiny in a expert/peer consensus process for the quality of implementation and evaluation methods or;
4) A paper has appeared in a peer-reviewed journal.[20]

The evaluation or assessment of new approaches as well as the systematic identification of best practices is key to identifying potential projects that could be applied more broadly given the proper assistance from the Program or another national organization. Without this information, the Program would not be able to assess with any accuracy which projects/initiatives would benefit from increased collaboration with national organizations who could possibly implement the new approach or practice at a systems level.

[20] http://casat.unr.edu/bestpractices/types.htm (Accessed October 2, 2007)

Dissemination of Knowledge

By identifying the target audience and knowing the type of information they are interested in, and the means by which they typically access information, one can tailor the dissemination strategy and the message/product to suit the intended user.

The document review found that approximately 90% (n=24) of the projects from our sample identified a target audience for project outputs. However, the intended audience was usually very broad encompassing an exhaustive list of stakeholders or 'the entire medical community' including the general public. Other times the target audience was described in very general terms. For example, the 'government' was identified without any specification as to the level of government (federal, provincial/territorial, or municipal) involved or 'professional associations' were identified without details on the most important associations. Of particular note, the survey respondents rarely identified the federal government as the intended principal user of their project outputs (15% of respondents, n=10). From the survey results, the three most frequently mentioned target audiences were health professionals (e.g., physicians, nurses, etc.) (52%, n=35), health care delivery sites (e.g., hospitals, clinics, community health providers, etc.) (45%, n=30) and provincial/territorial governments (e.g., ministry decision-makers and policy makers) (42%, n=28).

For the Grants, the expected users identified by the survey respondents are listed in **Table 6**, for the Contributions, these are presented in **Figure 3.**

Table 6
Expected Principal Users of Grant's Outputs

EXPECTED USERS	CADTH	Health Council	CPSI	CAPER
Regional Health Authorities	✔		✔	
Provincial/ Territorial Governments	✔	✔	✔	✔
Federal Government		✔		
Health Care Delivery Sites	✔	✔	✔	✔
Professional Associations	✔			✔
Non-Government Organizations				
Health Professionals	✔		✔	
General public		✔	✔	

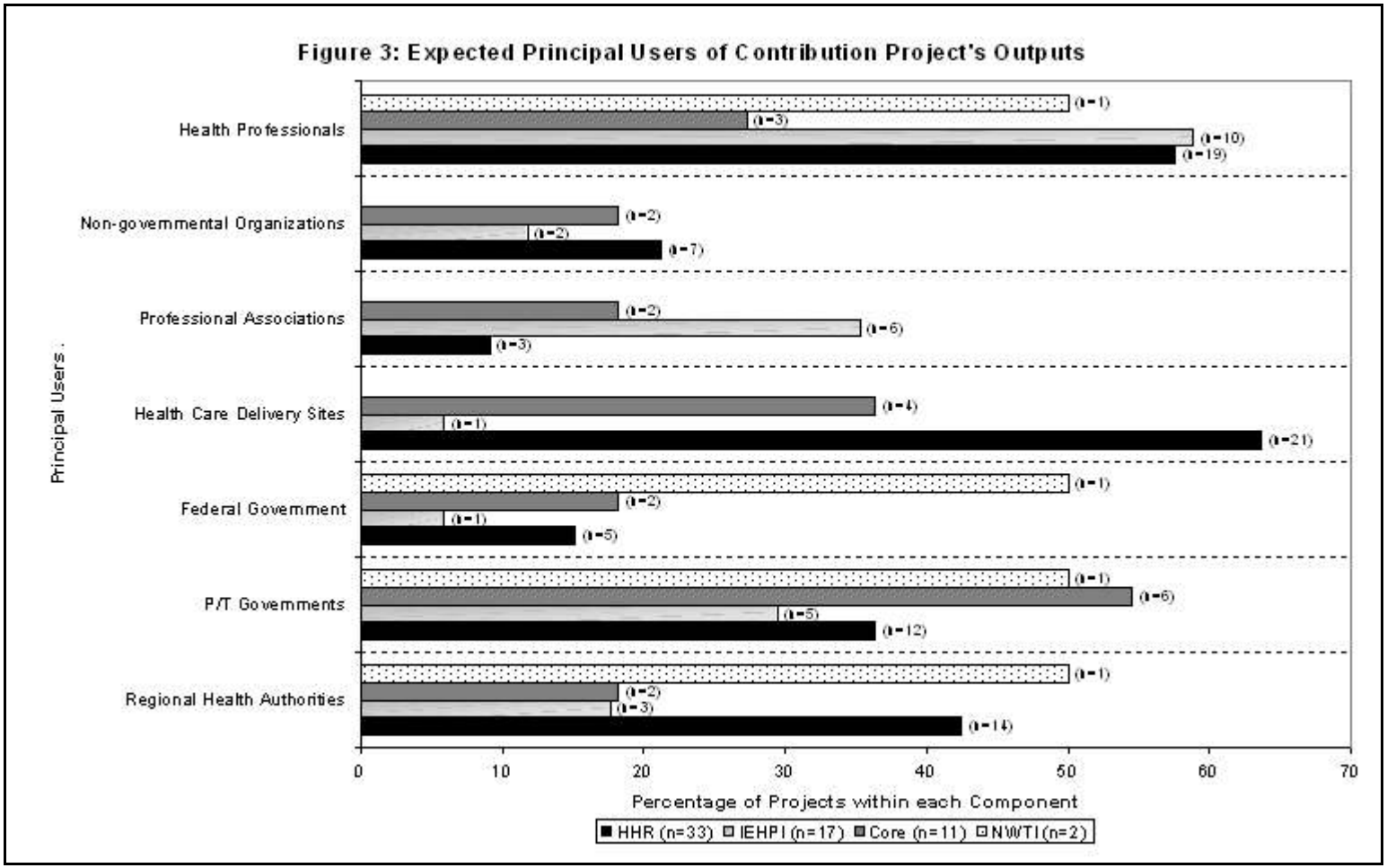
Figure 3: Expected Principal Users of Contribution Project's Outputs
Health Professionals
Non-governmental Organizations
Professional Associations
Health Care Delivery Sites
Federal Government
P/T Governments
Regional Health Authorities
Principal Users .
(n=1)
(n=3)
(n=10)
(n=19)
(n=2)
(n=2)
(n=7)
(n=2)
(n=6)
(n=3)
(n=4)
(n=1)
(n=21)
(n=1)
(n=2)
(n=1)
(n=5)
(n=1)
(n=6)
(n=5)
(n=12)
(n=1)
(n=2)
(n=3)
(n=14)
0
10
20
30
40
50
60
70
Percentage of Projects within each Component
HHR (n=33)
IEHPI (n=17)
Core (n=11)
NWTI (n=2)

The findings from the document review and the survey noted that almost all projects identified a dissemination plan which incorporated a combination of three to four of the following dissemination mechanisms: websites, bulletin boards, academic publications, conferences, training/workshops, newsletters and other print material. However, the rationale for selecting specific mechanisms was missing. The survey results indicated that none of the 67 projects/initiatives' dissemination strategies were grounded in research evidence, theory, or a best practice approach. The survey findings indicated that the dissemination methods were used mainly because it would create the widest distribution (42%, n=28); it was accessible to the target audience (40%, n=27); or because the method was selected/tailored to the objectives the project intended to achieve (n=7). Whereas the document review discovered that 3 of the 27 reviewed projects (11%) based their dissemination strategies on evidence in the literature.

Most of the above mechanisms (except training/workshops) are considered passive types of dissemination and effective dissemination strategies should not rely solely on one form of dissemination but instead a combination of passive and active.[21] According to Rogers' diffusion of innovation theory, there is a systematic process by which innovations, including knowledge, practices, programs, technology are spread through channels over time and between social systems. While some diffusion processes can be characterised as passive or natural, other involve a planned process of directed diffusion. Dissemination is an active concept implying calculated and active efforts to influence the diffusion process - this is what research groups are interested in - actively contributing to the uptake and use of research findings & applications in public health.[22]

There are a few initiatives - CPSI, Health Council and CMIRPS - that chose innovative dissemination mechanisms to target different groups. These will be highlighted below in the appropriate component sections.

Almost all projects/initiatives, including the above noted initiatives, showed little effort to assess the reach or effectiveness of their dissemination strategies. A few of the projects/initiatives tracked the number, source and type of information requests received, website hits and surveys. Although these measures are not perfect, they do provide some indication as to the type of audience who generally requests information, the frequency and type of information usually requested, and any significant trends over time.

The survey noted that projects received several requests for information from a variety of groups, including non-governmental organizations (NGOs), provincial governments, and professional associations. The type of information most commonly requested related to: the

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[21] Lavis, J.N., Robertson, D., Woodside, J.M., McLeod, C.B., Abelson, J. et al., How can research organizations more effectively transfer research knowledge to decision makers? The MilBank Quarterly. 2003 Vol 81, No. 2: 221-248.

[22] Steckler A, Goodman RM, McLeroy KR, Davis S, Koch G., Measuring the diffusion of innovative health promotion programs. American Journal of Health Promotion. 1992 Jan-Feb;6(3):214-24.

scope or objectives of the project, the project's outputs/products, and the findings/implications of the project. Very few requests for information on system integration or system application were received. Shifts in the trends over time were not identified as many projects are newer or have not tracked these types of requests until recently.

In the documents reviewed, it was noted that there was little dissemination and coordination of materials at the Program level. The Program did not appear to regularly aggregate information or lessons learned across projects into synthesis reports or facilitate collaboration between projects with similar objectives. In addition, there was some confusion from the funded recipients around the responsibility for information sharing and dissemination (the project or the Program), particularly with the smaller projects and the projects with multiple partners.

Knowledge Application

It is important to examine how the project/initiative products are being used - and to what extent - to assess whether the program is achieving its objectives.

There were a number of projects that focussed on the development and implementation or application of a new approach or tool. The implementation was often done on a very small scale (similar to a pilot project) at the local/community level or at times at the provincial level . There was little evidence of a strategy to broaden the application of the initiative nationally across the health care system.

The expected results for the Grants identified in the survey are presented in **Table 7**; those for the Contribution projects follow in **Figure 4**.

Table 7
Expected Impacts of the Grants

EXPECTED RESULTS	CADTH	Health Council	CPSI	CAPER
Increased Awareness/ Knowledge of Health	✔	✔	✔	
Increased Change in Behaviour/Practice Used				
Increased Access to Outputs by Target Group(s)	✔	✔		✔
Broadened Application/ Uptake of Best Practices and Strategies	✔		✔	
Increased Provincial/Territorial Application of Best Practices and Strategies	✔		✔	

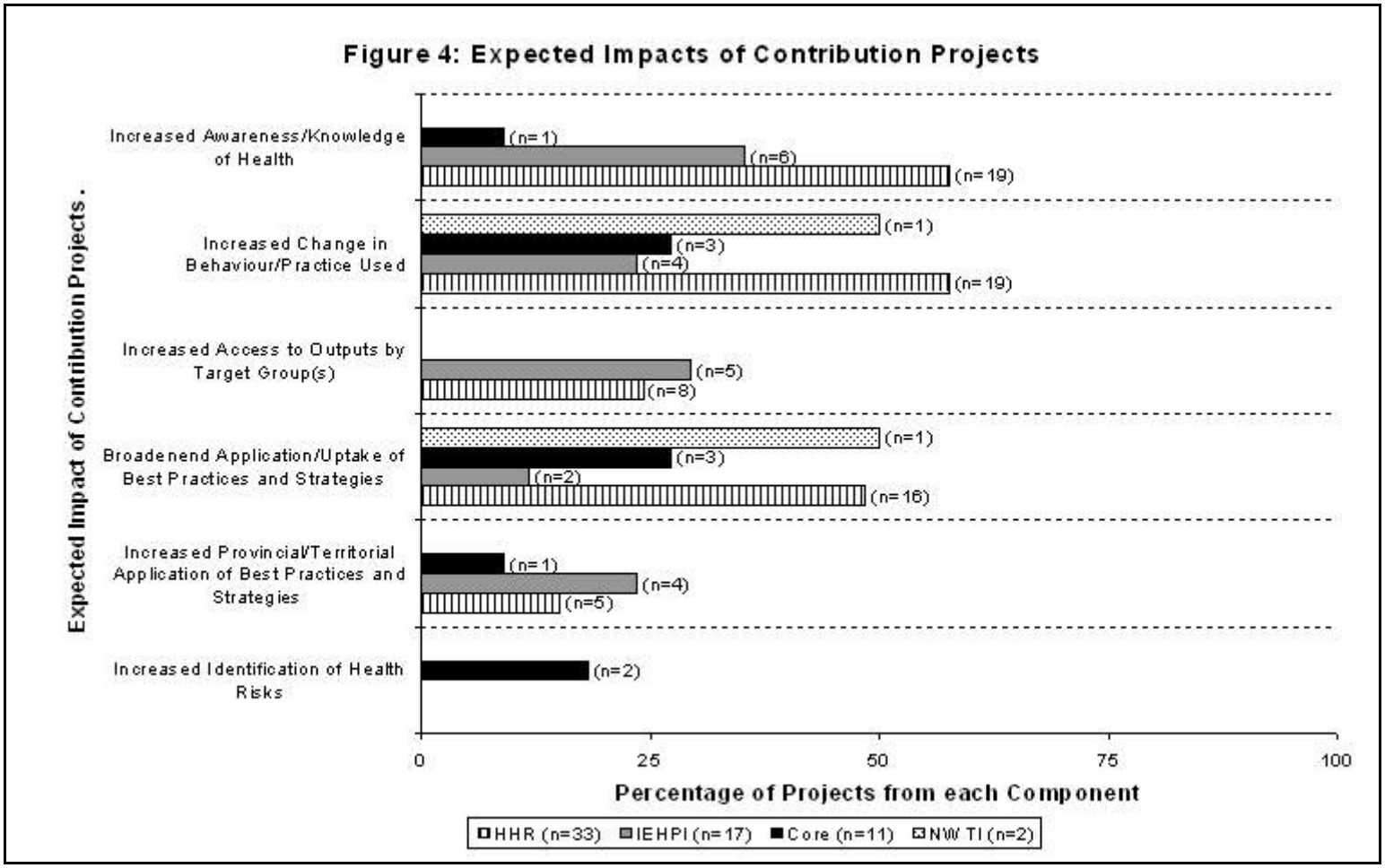
Figure 4: Expected Impacts of Contribution Projects
Expected Impact of Contribution Projects
Increased Awareness/Knowledge of Health
(n=1)
(n=6)
(n=19)
Increased Change in Behaviour/Practice Used
(n=1)
(n=3)
(n=4)
(n=19)
Increased Access to Outputs by Target Group(s)
(n=5)
(n=8)
Broadenend Application/Uptake of Best Practices and Strategies
(n=1)
(n=3)
(n=2)
(n=16)
Increased Provincial/Territorial Application of Best Practices and Strategies
(n=1)
(n=4)
(n=5)
Increased Identification of Health Risks
(n=2)
0
25
50
75
100
Percentage of Projects from each Component
HHR (n=33)
IEHPI (n=17)
Core (n=11)
NWTI (n=2)

A review of the literature has resulted in the identification of a number of factors (they are referred to as 'facilitators') that can contribute to the successful application of new knowledge. The facilitator most frequently mentioned is collaboration and relationship-building with partners and stakeholders. Increased collaboration and coordination of responses to health care system priorities is also one of the Program objectives. Other facilitators are the identification of change agents and potential barriers. The evaluation examined the use of these facilitators as means to show progress towards creating an environment in which change (the application of new knowledge) can occur. The literature states that 87% of change initiatives fail on implementation, therefore creating an environment, or culture, of change is important.[23]

The identification of barriers and challenges to knowledge application was a common element across components. Many components were required in the project proposals to identify barriers and challenges and ways to mitigate them. The most common barrier to project output application was 'engaging target audience in the planning and implementation of new tools, approaches, etc.', according to 30 (45%) of the survey respondents. The second most common barrier was 'reaching specific target groups for knowledge application and uptake', according to 13 (19%) of respondents. These barriers are focussed at the local or project level rather than broader, system-level barriers like legislative, regulatory or liability issues.

The survey findings indicate that 85% (n= 57) of respondents identified an agent of change. However, there was some confusion around the definition of an agent of change with some respondents identifying an entire system (i.e., the 'government') as opposed to specific representatives or individuals of an organization. The type of change agent most commonly identified was a local agency (45%, n= 30). This type of change agent would be appropriate for changes at the local or project level but to create change at the system level, the change agent needs to be someone in an organization that has influence nationally across the system.

Collaboration and Coordination

All the lines of evidence indicated that there was a significant amount of activity forming new and maintaining existing collaborations. All twenty-seven projects reviewed included some sort of collaborative effort. These efforts varied from meetings/consultations, workshops, conferences, coalitions, committees, Memoranda of Understanding (MOUs) and Letters of Understanding (LOUs), fellowships, networks, etc. Often times the collaborations identified in the document review were purposeful and action oriented (particularly those with formal agreements). Examples of purposes for collaboration include: to centralize and share data, to identify barriers, to develop national strategies and to create benchmarks.

[23] Canadian Patient Safety Institute. Advancing Patient Safety: Progress through Partnership. 2006 Annual Report.

The survey and document review revealed that several of the projects/initiatives (69%, n = 46) had formal agreements usually with national health organizations and provincial governments - particularly the initiatives linked with the named grants. The survey respondents identified that there were a number of necessary elements that were incorporated into their agreements (listed by ranking of importance): purpose of the arrangement, roles and responsibilities, access to resources, decision making procedures and assessment mechanisms.

The document and literature review repeatedly stated that in order to see a system-level change, significant coordination of health care renewal efforts at the national level is needed. The survey also identified the need for the projects to coordinate nationally. Some of the components, like CADTH, CPSI, or HHRS, are striving to develop and implement national frameworks and strategies, which will facilitate the reduction of duplication, the creation of opportunities for sharing lessons learned and the identification of priority areas that are not being addressed. However, many of the components do not have this coordination element built into the program and are therefore in jeopardy of missing opportunities for knowledge uptake and application.

At the project-level in the Contribution Program, the focus on developing national-level knowledge or strategies was much less evident. Of the projects reviewed in the document review, most of the projects in the Contribution Program were targeted at the 'local-level' (e.g., hospitals, universities, etc.), and a few were targeted at the provincial-level. There was little evidence across projects of planned efforts for knowledge dissemination and uptake at the provincial/territorial health system level. From the survey, only 16% (n=11) of the project respondents intended to achieve provincial/territorial application of the results. For example, one project from the IEHPI component funded a national organization to encourage the use and dissemination of educational materials across 17 faculties of medicine in Canada.[24] Yet, most of the funding recipients in this component targeted local-level organizations/groups. Often organizations at the local-level do not have the capacity to coordinate national-level dissemination and uptake of new approaches or best practices. Without a proper coordination and implementation strategy at the component or Program level, the knowledge, information, or evidence produced by these projects will be limited to the local level with little potential for broader application.

Contributions to improvements in the health care system

At this point in the evolution of the Program, it is difficult to assess whether the HCSPG&CP has contributed to improvements at the system level. Also, due to the number of other programs trying to improve the health care system, attempting to determine if changes in health care system performance are attributable to this Program will be challenging. In the components' section below, a number of examples will be provided to illustrate how the initiatives plan to affect improvements in the health care system.

[24] Interesting to note that the dissemination and promotion of uptake was not part of original project that developed the materials.

As stated previously, there are a number of stages of knowledge transfer that must occur before change happens - particularly on a health care system level. Most projects/initiatives funded by the Program are currently focussing their efforts on developing knowledge and disseminating it. Some projects/initiatives that were reviewed are applying new approaches, tools, or practices, but generally not at the system level. So there are some efforts at the application/adoption of the new knowledge that has been generated, but impacts on the accessibility, responsiveness, quality, sustainability and accountability of the health care system are yet to be captured.

The next sections provide a more detailed examination into each of the Program's components and how each contributes to the achievement of Program objectives. Again, the grants will be discussed first, followed by the contributions.

Grants

Canadian Agency for Drugs and Technologies in Health

CADTH has provided a leadership role in the review of drugs and health technologies across Canada. It has developed three national initiatives to improve coordination and assist jurisdictions: the Health Technology Assessment (HTA) strategy, which is an overarching framework for all HTA activities in Canada; the Common Drug Review (CDR), which provides a centralized evidence-based drug review process for all jurisdictions to enable them to make decisions on which drugs to cover; and the Canadian Optimal Medication Prescribing and Utilization Service (COMPUS), which is a centralized system providing information on optimal medication prescribing and utilization.

The document review provided some evidence of uptake of CADTH's products by the target audience. For example, the drug plans, in particular the smaller drug plans, have benefited from the increased information sharing and expertise of the CDR. Overall uptake of CDR advice is high -- jurisdictions have accepted approximately 90 per cent of its recommendations in their reimbursement decisions. The comprehensive health technology assessment reports were externally assessed for their purposefulness for making health care decisions. The results stated that the time required to produce reports of this nature (up to 18 months) was too lengthy for the policy decision-making process, and thus the information was not applied as often as it could have been. As a result, CADTH launched a timelier, though less in-depth service, the Health Technology Inquiry Service (HTIS), in 2005. It provides rapid responses (24 hours to 30 days) to help with day-to-day decisions specific to the inquirer's needs. An assessment of its impact on decision-making was not available in time for this evaluation.

CADTH provides decision makers with information to make evidence-based decisions about the adoption of drugs and health technologies and their cost-effectiveness. The intention of providing effective treatments that lower the overall cost of health care delivery is to improve the sustainability of the health care system.

Health Council of Canada

Health Council's mandate is to monitor and report on the implementation of the FMM Health Accord. Health Council has collaborated with government officials and local organizations to get an idea of national and regional priorities, challenges and successes to provide information in the following theme areas: wait times and access, home care, healthy Canadians, pharmaceutical management, primary health care and HHR in the form of technical reports.

Due to its visible profile, Health Council has been able to engage the media in news conferences and call-in shows. Over 150 stories have been generated from the media attention reaching all major markets through daily and community newspapers. A series of short documentaries highlighting best practices have also been created.

Health Council has created 3 annual reports on the status of health care system renewal in Canada. However, the lack of consistent and comparable data available across Canada has limited the Council's ability in providing a pan-Canadian assessment of the health care system. Findings from the document review indicated that the Health Council reports did not assist the average Canadian in understanding the status of the health care system. It may be beneficial for the Health Council to explore ways to improve its effectiveness in fulfilling its monitoring and reporting mandate.

It is still to be determined if Health Council has been able to contribute to improvements in accountability of the health care system.

Canadian Patient Safety Institute

The document and literature review noted that there has been significant knowledge development and empirical research in the area of patient safety. The main causes of adverse events have been identified and now approaches and tools are being developed and implemented to address these causes. The CPSI was established to provide national leadership and to coordinate efforts related to patient safety across jurisdictions.

According to the document review, CPSI has been singled out for its achievements over the past 3 years: establishing the institute, assuming a visible leadership role, raising awareness and launching successful initiatives that build upon partnerships and the success of others. According to Dr. Ross Baker, a prominent researcher in patient safety, one initiative called the *Safer Healthcare Now!* campaign was 'seen as the largest network of organizations coming together to improve patient safety in Canada'. 150 health care organizations, 75% of hospitals across the nation and 480 clinical teams came together to implement six targeted interventions in patient care.

CPSI has been instrumental in coordinating a number of different workshops, conferences, meetings and educational/training opportunities for specific target groups. For example, consultation workshops were held with F/P/T representatives to identify priorities across jurisdictions and a series of conferences were held for health care executives to bring about cultural change in their organizations. Also, working relationships have been developed with several formal agreements (e.g., MOUs and LOUs) with provincial, national and international organizations.

CPSI has developed a number of interventions or approaches to reducing adverse events in the areas of care for heart attack patients, medication reconciliation, surgical-site infections, blood stream infections, ventilator associate pneumonia and the deployment of rapid response teams. Each intervention has a 'getting started' kit which includes relevant literature, measurement tools, and the intervention strategy. A variety of educational opportunities are made available to health care providers on each of the interventions as well as travelling expert teams visit different facilities to offer assistance.

The literature review stated that patient safety is receiving more attention, and the awareness and interventions have increased as a result of CPSI, but it is still too early to tell if there has been any effect on mortality and morbidity of Canadians.[25] Reducing the incidence of adverse events means better quality of care for patients. It also means that length of hospital stays are reduced, thus lowering the overall health care costs and improving the sustainability of the system.

Canadian Post-M.D. Education Registry

The registry, which tracks physician supply across Canada, was developed through a collaborative effort of six national organizations and provincial and federal governments. CAPER is a good example of how governments, faculties of Medicine and medical organizations can work together towards a common goal. This data is expected to inform F/P/T governments decision-making processes in order to help ensure that Canada has the appropriate number and mix of health providers required to meet the health needs of the population.

Contributions

Core Contribution Component

The projects reviewed under this component fit into either the general Core Contribution component, or the Best Practices Contribution Program (BPCP), or the Canadian Medication Incident Reporting and Prevention System (CMIRPS) initiative. The Core Contribution and

[25] Health Care Renewal in Canada: Measuring up? Annual report to Canadians, 2006, Health Council, page 45.

BPCP projects varied significantly from the development of an electronic prescribing tool to be implemented at two hospitals in the near future to the implementation of a regional-wide multi-disciplinary team approach using pharmacists to provide treatment to diabetics.

The document review sample included 2 of the 6 BPCP projects, and revealed that neither of these projects were identified as a best practice using a systematic approach grounded in research evidence or theory. They were more similar to pilot projects that were being developed and implemented on a very small scale.

CMIRPS is a example of a national initiative that is closely aligned with the CPSI and is an integral part of the bigger patient safety movement. It has successfully collaborated (and has formal agreements) with a number of different national organizations including CIHI, the coroner's office and regulatory colleges in order to provide the most thorough and representative information on prevention and management of adverse drug events. So far, it has also engaged 293 hospitals and 27 long-term care centres to participate in the medication safety self-assessment process.

The document review demonstrated that, unlike most of the other initiatives, CMIRPS identified their target audience on three different levels (which they called primary, secondary and tertiary stakeholders) according to the audience's significance of involvement. Messaging was tailored to meet each target audience's needs.

Many of the projects/initiatives reviewed in this component focussed on improving access and the quality of care. For example, CMIRPS: by providing information on methods to prevent adverse drug events, and the frequency of these events occurring, which will in turn provide better patient outcomes and increase the quality of care provided. Providing diabetics with a multi-disciplinary team which include a pharmacist, is expected to allow them to get treatment more quickly and conveniently, thereby improving accessibility of care.

Health Human Resource Strategy

The findings from the survey and the document review noted the majority of projects funded under this component aimed to identify or assess a new approach (i.e., create new knowledge). Some of the types of approaches included: identifying new healthy workplace practices; developing interprofessional education models; and creating new recruitment strategies targeted for health care professionals.

All projects/initiatives included a collaborative effort, usually at the local-level. Less than 25% of the projects involved national level stakeholders. Collaborations at the national level usually involved the formation of expert committees coordinated by HCSPG&CP staff. These committees had formal agreements (e.g., terms of reference).

The HHRS component recognizes that jurisdictions cannot plan in isolation and require a collaborative pan-Canadian approach to certain aspects of HHR planning. In response, a Framework for Collaborative Pan-Canadian Health Human Resources Planning was recently developed that will support system planning. This plan was developed in late 2005, thus it was difficult to determine how the Framework was applied and the extent to which it has influenced the design and development of the projects (many of those reviewed were initiated before the Framework was developed). As well, the Framework does not specify how the projects will be developed in a coordinated manner in order to reduce duplication and ensure transferability across jurisdictions. No other components have developed a plan articulating how the component will 'roll-up' the project data (e.g., outcomes) in order to facilitate a coordinated, national-level approach to the strategies developed.

The uptake and application of the new approaches or new knowledge was not assessed in most projects, likely because a number of the projects are still in progress and have not disseminated information concerning the new approach yet. However, the literature review did note that medical and nursing school enrollment has increased in all jurisdictions where medical and nursing programs are available and according to the document review, interest in family medicine has also increased among medial resident candidates. These changes may help provide an increased supply of trained health professionals in the near future to address the issue of accessibility to health services, and may also help improve the sustainability of the health care system.

Internationally Educated Health Professionals Initiative

Almost all projects reviewed from the Internationally Educated Health Professional Initiative (IEHPI) were either identifying or assessing a new approach. This was supported in the survey, which found that over 82% (n= 14)of the projects were identifying a new approach and only 12% (n=2) of these projects were assessing a new approach.

Most projects collaborated with partners within the same province. One project established an Advisory Committee which had regional /provincial/ national representation but otherwise the collaborations were most often at the local or community level. There was no evidence in the document review that the projects are being coordinated nationally or that the new approaches are being developed due to an overall strategy at the Program level.

This component is working in tandem with the HHRS to accelerate the increase in supply of health professionals across Canada. By increasing the number of health professionals, the accessibility to care will presumably also increase. It is not possible at this time to say whether IEHPI has created improvements in the health care system, but this initiative has only recently (2005) been established and most of its programming is still in progress.

National Wait Times Initiative

The findings from the document review revealed that the projects funded under this component are generally pilot projects aimed at reducing backlogs, developing approaches to facilitate more efficient patient flow, measuring and monitoring wait times and better overall management.

The findings from the survey and document review demonstrated a discrepancy in the target audience identified and the those seeking the knowledge (measured by requests for information). This initiative identified health professionals and regional health authorities as the main target audiences but those most often requesting information were professional associations and non-governmental organizations (NGOs). It would be important in this case to know if the dissemination strategy geared to health professionals is ineffective or if the indicator 'requests for information' is the problem.

According to the literature, there is more information on wait times than ever before, but we are far from the vision of systematic tracking of wait times. The literature also noted that wait times are being reduced in most of the five targeted areas - cancer treatment, heart procedures, diagnostic imaging, joint replacement and sight restoration. Although it is unclear whether this progress can be sustained beyond the funding commitment. However, the latest annual report from the Fraser Institute indicated that wait times have increased slightly in some of the provinces for certain procedures in 2007.

Achievement of Overall Program Objectives

Reporting on the extent to which the Program components contributed to achieving the Program objectives proved quite difficult for a number of reasons. Firstly, the HCSPG&CP has evolved significantly over the past five years. Many new components, and additional funding for previous components, have been added over the years and the subsequent projects funded by the additional investment have varying start dates and are therefore in different stages of readiness to be evaluating their outcomes.

Secondly, there is limited performance measurement data available to address the outcomes of the Program. The projects and components are so diverse, and the data was often inconsistent and uncomparable, which made it not possible to systematically aggregate the findings at the Program level. The Program relied on progress/annual and evaluation reports from the projects and named grants as its ongoing performance measurement data. The requirements and guidelines provided to the project recipients concerning these reports did not provide a significant amount of direction and were inconsistent across components. Many of the projects reported on their project objectives or outputs without making the link to how the project relates to the component, the overall Program, or even the health care system. There was a lack of

direction from the Program regarding what information that was required in these reports. It was also unclear whether the project recipients were aware and understood the objectives of the Program and how their projects connect and contribute to the national effort to reform the health care system.

CONCLUSIONS

Due to the varying start dates of the components and projects, the diversity of the initiatives, and the inconsistency of the performance data, systematically aggregating the data at the component or Program level was not feasible. Many projects did not report on Program objectives, instead relied on their own project objectives to report on without making the link to the component or overall Program. Also, the project's annual and evaluation reports focussed on processes and outputs of the project as opposed to results/outcomes, making it difficult to assess the Program's success in achieving its objectives.

Many projects/initiatives developed a new tool, a new approach or identified a best practice. However, it was often unclear how the approach or tool was evaluated or what method was used to identify the best practice. Without this information, the Program would not be able to assess which projects/initiatives could be applied more broadly given the proper assistance from the Program or an appropriate national organization.

Collaboration and coordination is key to the adoption of new knowledge. All three lines of evidence confirmed that collaboration and coordination at the national level is needed in order to create change at the health care system level. All projects identified some sort of collaborative effort. Many of the projects /initiatives, in particular the named grants, had established formal agreements with national and provincial organizations and governments. Coordination at the national level was less evident in the contribution programs. Most projects in the contribution programs involved collaborations with local-level organizations (sometimes provincial level organizations) that may not have the capacity to coordinate national-level dissemination and uptake of new approaches or best practices. Some coordination was occurring in one of the components (through the development of a Framework), but this did not include a plan to roll-up the projects on a national scale. Without a proper coordination strategy at the component or Program level, the knowledge, approach, tool or evidence produced by these projects will be limited to the local level with little potential for broader application.

In terms of the knowledge transfer (KT) stages, the Program is focussing most of its efforts on stage 1: 'Transmission' which is the creation and dissemination of new knowledge. The target audiences identified by the projects/ initiatives were usually too broad and the dissemination strategies were usually not grounded in evidence from research or literature. Also, efforts to collect information on the reach and uptake of projects' outputs (e.g., knowledge, tools, etc.) were very limited. Many projects did not know who received or adopted their outputs. In order to move along the KT continuum, it is critical to: identify an appropriate target audience that will

affect change; create a dissemination strategy geared to the target audience that is based on research or literature, evaluate the dissemination strategy to verify the target audience was reached and understood the message; and lastly, track efforts of uptake and adoption of the new knowledge. As the new knowledge that is generated and disseminated by this Program is adopted, impacts to the health care system in terms of accessibility, responsiveness, quality, accountability and sustainability will be demonstrated.

RECOMMENDATIONS

The following recommendations are grouped into three categories: improving performance measurement data and monitoring, creating guidelines and standards for funding recipients, and improving strategic planning and coordination at the Program level.

Improving performance measurement data and monitoring:

- Refine overall Program performance indicators and develop additional performance indicators (i.e., identify what success looks like) for each Program component. This should be done in collaboration with Program stakeholders.
- Develop a systematic approach to collecting performance information from the funded recipients in terms of type, frequency, and format of the information.
- Dedicate resources (e.g., FTEs and monetary) to performance measurement at the Program, component, and project level.

Creating guidelines and standards for funding recipients:

- Develop guidelines and common assessment criteria for the project/initiative proposals and evaluations so that relevant information will be collected at the project/initiative level, which would then inform the evaluation at the component and Program levels.

In terms of guidance material:

- The Program should identify appropriate ways to disseminate information to specific target groups as well as appropriate ways to assess uptake, in order to provide guidance to projects/initiatives and component representatives/staff.
- Call for proposals should require the projects to identify or state:
  - **an appropriate target audience**: Ensure that the target audience and the level (e.g., local, P/T, national) of the target audience is appropriately identified. Consider if the end users are in the right position to be able to meet the Program's objectives (e.g., are they able to effect change);

- **a rationale for the dissemination strategy:** why certain methods for dissemination were selected/used should be explained (e.g., based on research or theory?);
- **the method for assessing the reach and uptake**: the projects' evaluation plans should include the methods for assessing the reach and uptake of the projects' outputs (e.g., knowledge/products produced) among the target audience(s);
- **the method of evaluation** of new tools/approaches, and/or the method for identifying a best practice;
- **how the project relates to the Program objectives** and the overall renewal of the health care system;
- **how the project can be implemented or generalized** to a larger population and/or other jurisdictions.

In terms of common assessment criteria:

- For standard items (e.g., dissemination strategies, target audience identification, evaluation methodology, etc.), proposal reviewers need to have common assessment criteria across components upon which to review the proposals received.

Improving strategic planning and coordination at the Program level:

- Develop an overall Program strategy, including the level of funding to be allocated to specific funding priorities, taking into account the type of information already available on these priority areas, the status of the priorities with respect to knowledge translation, and the scope and magnitude of the health care renewal challenge to be addressed under each priority.

Question 4

Are there expected results of the components that have not been achieved? Why?

An exploration of the extent to which expected results have been achieved for each component will help to assess the Program success. As well, identifying unmet expected results will help the projects reflect on their current practice and make informed decisions as to what changes or adjustments are required in order to achieved expected results.

FINDINGS

Many of the component projects are still in progress, thus limiting the amount of information available to answer this question. From the document review and survey, less than half of the components/projects identified results not achieved. CMIRPS reported that due to the limited time frame, a few features (e.g., automated tool to scan text fields) were not included in the system. For the HHRS and IEHPI components, many projects were focussed on producing outputs/deliverables, and were not assessing the impact that the project had on the health care system more broadly. With this focus, it is not surprising that few projects reported on 'results not achieved' (since this might suggest that the output/deliverable was not produced).

From the components that did report on results not achieved, one theme emerged. While all components reported having a national-level focus, many of the funded projects were not designed with a national-level strategy in mind. Results from the survey indicate that only 34% (n=23) of the projects surveyed expected to achieve broadened application/uptake of best practices or new approaches outside of the original project site(s); and only 16% (n=11) of the projects surveyed intended to develop strategies or best practices that would be applied at the provincial/territorial level. Three projects surveyed indicated that 'broadened application/uptake of best practices or new approaches' was not achieved.

An internal review of the Health Council found that stakeholders did not believe that the Health Council reports were effective in informing Canadians on progress in implementing the 2003 and 2004 Accord. While the Health Council has published reports each year since 2005 outlining the progress made on FMM commitments, challenges they face in achieving their objectives relate to: the lack of consistent, comparable data across Canada; the lack of formal information sharing (i.e., successful pilot projects are not shared and adopted more broadly); and the lack of transparency and comprehensiveness of reporting, mostly due to the lack of quality data.

One project from the IEHPI component reported that it was not successfully engaging the target groups in the intervention/project (e.g., low number of applicants for recruitment programs, which is inconsistent with the numbers of potential applicants in the region). Efforts to expand the geographic recruitment area, and broaden the eligibility criteria were made to increase the number of applicants; however, little improvement was achieved.

Findings from the literature review suggest that the progress in establishing interprofessional (IP) teams is not occurring as fast as the Health Council had expected. While there has been good progress in implementing interprofessional education programs, the composition of interprofessional teams in practice differed greatly from region to region. Mostly, these IP teams consist of doctors and nurses, and less frequently nurse practitioners, pharmacists, or other professionals. The literature review also found that neither the 2003 or 2004 FMM commitments

identified home care services for people with chronic conditions as a priority area, even though it has been identified by the Health Council as an emerging priority for health care renewal. Similarly, little attention has been given to patient safety in community or home care settings, despite the increasing number of seniors in the population.

CONCLUSION

Overall, many of the projects are still in progress, and few identified any expected results that they had not achieved. Very few of the completed projects had focussed on assessing the impact of the project on the health care system more broadly. While all components reported having a national-level focus, many of the projects were not designed with a national-level strategy in mind, or had the intention of applying its strategies or best practices at the provincial/territorial level. Some areas (e.g., establishing interprofessional teams) have been identified where progress has been slower than anticipated, but overall, improvements are being made to the health care system.

RECOMMENDATIONS

- There needs to be a greater emphasis on broadened application of project results (i.e., application at the provincial/territorial or national levels) in order to achieve national-level health system changes.

Question 5

What are the lessons learned from the HCSPG&CP and its components?

Lessons learned are important to identify so that corrective action can be taken to contribute toward the planning and implementation of new and improved practices.

FINDINGS

Almost all components noted some 'lessons learned' in the documentation reviewed, or in response to the survey. The three main themes that emerged from the 'lessons learned' related to: project planning and management, stakeholder engagement, and defining objectives and key terms.

Learnings related to project planning and management related to the processes of developing a project, and the implementation and management of projects activities. Almost all of the components found that planning and implementing national level approaches was complex and time intensive. They often needed to overestimate the amount of time and resources required to deliver large and/or interprofessional projects/initiatives. Another component noted that projects need significant lead times in the development phase due to delays in funding once contracts have been signed. These issues might have implications on the timelines of the project, their ability to conduct the project on time, and the risk of eliminating the dissemination phase if time runs out. The timelines of the proposed projects/initiatives need be realistic and include how time adjustments will be made if needed.

Other 'lessons learned' related to the extent to which stakeholders should be engaged in the project. While most projects/initiatives recognized the importance of engaging stakeholders, and many stakeholders were identified as agents of change that would help move the project forward and increase outcome success, it is time consuming to collaborate broadly. One project/initiative noted the importance of engaging stakeholders early and keeping them informed about the project. Two components identified concerns with engaging a wide variety stakeholders, since this could introduce bias/influence on the reports produced, or it could significantly increase the amount of time and resources required for research writing/editing. However, another project noted that the involvement of federal and provincial/territorial governments is essential to ensure relevance across Canada. Overall, projects/initiatives need to balance the trade-off between the time to produce outputs and the extent of stakeholder involvement.

The last theme relates to the importance of defining objectives and key terms when working with multiple partners. For example, an IEHPI project noted that clear articulation of project goals and objectives is essential to manage expectations of stakeholders. Similarly, projects from CMIRPS and the HHRS component highlighted the importance of having shared and clearly understood definition and interpretation of key terms (e.g., collaboration, interprofessional, errors) when working on collaborative projects. Health Council noted that when identifying objectives, determinants of success, and defining priorities among a variety of interests, the importance of collaboration, transparency, and clarity was paramount. These are important lessons to consider when multiple groups are involved in a project, since having a clear and common understanding of objectives and key terms were critical factors for success.

CONCLUSIONS

Several key 'lessons learned' have been identified in the document review and survey. Many of these lessons are applicable to, and may be useful for, other projects in the Program as well as for the proposal review process. It would be helpful for the Program to continue to encourage recipients to share these lessons with other projects by providing them formal opportunities to do so (e.g., conferences, committees, or in their progress reports). Also when reviewing project proposals, it is important for reviewers to consider how these lessons could relate to the

approaches being proposed (e.g., many projects noted the extensive time and resources required for a national approach, thus, reviewers need to ensure that new projects proposing this type of approach have considered these issues).

RECOMMENDATIONS

- Projects should include 'lessons learned' in their final reports. These lessons should indicate how they relate to, or could be helpful for, other projects or the overall Program (e.g., identification of strategies that supported uptake, or key barriers and how they were addressed).
- Provide formal opportunities to share lessons learned among funding recipients.
- When assessing new proposals, reviewers should also consider the lessons learned from previous projects and how they relate to the approaches being proposed (e.g., many projects noted the extensive time and resources required for a national approach, thus, reviewers need to ensure that new projects proposing this type of approach have considered these issues).

OVERALL RECOMMENDATIONS

This report is a synthesis of findings from the summative evaluation of the HCSPG&CP. It is based on evidence from three lines of evidence (document review, literature review and surveys). The report provides the Program with information on progress to date and suggestions on how to improve program performance. It stresses the importance of strategic planning, priority setting and coordination with respect to the Program. It also focusses on the need for performance measurement data and monitoring to be able to assess the Program's success.

The following recommendations are based on the findings and analysis of evidence that were developed to address the summative evaluation questions. The recommendations are grouped into four broad categories: relevance, improving performance measurement data and monitoring, creating guidelines and standards for funding recipients and improving strategic planning and coordination at the Program level.

Relevance

- The Program should continue to demonstrate its flexibility in responding to emerging health care system priorities.

Improving performance measurement data and monitoring

- Refine overall Program performance indicators and develop additional performance indicators (i.e., identify what success looks like) for each Program component. This should be done in collaboration with Program stakeholders.
- Develop a systematic approach to collecting performance information from the funded recipients in terms of type, frequency, and format of the information.
- Dedicate resources (e.g., FTEs and monetary) to performance measurement at the Program, component and project level.

Creating guidelines and standards for funding recipients

- Develop guidelines and common assessment criteria for the project/initiative proposals and evaluations so that relevant information will be collected at the project-/initiative-level, which would then inform the evaluation at the component- and Program-levels.

In terms of guidance material:

- The Program should identify appropriate ways to disseminate information to specific target groups as well as appropriate ways to assess uptake, in order to provide guidance to projects/initiatives and component representatives/staff.
- Call for proposals should require the projects to identify or state:
  - **an appropriate target audience**: Ensure that the target audience and the level (e.g., local, P/T, national) of the target audience is appropriately identified. Consider if the end users are in the right position to be able to meet the Program's objectives (e.g., are they able to effect change);
  - **a rationale for the dissemination strategy:** why certain methods for dissemination were selected/used should be explained (e.g., based on research or theory?);
  - **the method for assessing the reach and uptake**: the projects' evaluation plans should include the methods for assessing the reach and uptake of the projects' outputs (e.g., knowledge/products produced) among the target audience(s);
  - **the method of evaluation** of new tools/approaches, and/or the method for identifying a best practice;
  - **how the project relates to the Program objectives** and the overall renewal of the health care system;
  - **how the project can be implemented or generalized** to a larger population and/or other jurisdictions.

- Projects should include 'lessons learned' in their final reports. These lessons should indicate how they relate to, or could be helpful for, other projects or the overall Program (e.g., identification of strategies that supported uptake, or key barriers and how they were addressed).

In terms of common assessment criteria:

- For standard items (e.g., dissemination strategies, target audience identification, evaluation methodology, etc.), proposal reviewers need to have common assessment criteria across components upon which to review the proposals received.
- When assessing new proposals, reviewers should also consider the lessons learned from previous projects and how they relate to the approaches being proposed (e.g., many projects noted the extensive time and resources required for a national approach, thus, reviewers need to ensure that new projects proposing this type of approach have considered these issues).

Improving strategic planning & coordination at the Program level

- Develop an overall Program strategy, including the level of funding to be allocated to specific funding priorities, taking into account the type of information already available on these priority areas, the status of the priorities with respect to knowledge translation, and the scope and magnitude of the health care renewal challenge to be addressed under each priority.

- The plan might consist of the following activities:

  - Conduct periodic reviews of the priorities/objectives of the projects receiving funding to ensure that the priorities/objectives of the Program and its components are being addressed. Calls for proposals could then be tailored to fill in any information gaps.
  - Create formal opportunities to share information.
  - Focus on funding projects that encompasses a 'national-level' approach right at the development stage (e.g., that are exploring ways to implement at a national-level, or that are considering the generalizability to the rest of the country).
  - Create a plan to coordinate, and to reduce duplication of, efforts within components (e.g., when they are addressing similar issues, but in different regions).
  - Create a plan for rolling up 'pilot project' tools, approaches, best practices, etc.
  - Collect common performance measurement information from projects, and synthesize this information at the component level and share this information with the other projects/initiatives.

- There needs to be a greater emphasis on broadened application of project results (i.e.,application at the provincial/territorial or national levels) in order to achieve national-level health system changes.