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Primary Health Care Renewal and Canada's Regional Health Authorities

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Acknowledgements

We express our great appreciation to the respondents from throughout Canada who completed this survey. The survey was exploratory and the instrument long and time-consuming to fill in. However, respondents completed it admirably. It is a testament to their commitment not only to primary health care renewal itself, but also to the value of sharing their experience and views.

We are also grateful to Health Canada Primary and Continuing Health Care Division for funding the survey.

Executive Summary

Primary health care (PHC) is growing in importance as part of Canadian health reform. In regionalized provinces, implementation of PHC initiatives is mainly the responsibility of regional health authorities (RHAs). RHAs are therefore key to the success of PHC renewal.

In early 2004, CCARH conducted a national survey of PHC strategies and activities in RHAs, under contract with the Primary and Continuing Health Care Division of Health Canada. In addition to identifying plans and activities, we inquired about barriers and facilitators to their implementation, including how regionalization affects PHC. To our knowledge, this is the first such comprehensive effort to document the national picture of PHC renewal.

Findings show that it is still early in the process of PHC renewal and many initiatives are in the planning stages. Even among those initiatives that were described as being in the implementation stage, there were some that were not very far along at all.

However, it is evident that PHC renewal is widespread in Canada. Even if we made the very conservative assumption that all the RHAs who did not respond had no initiatives, we could still conclude that almost half of Canadian RHAs are undertaking PHC renewal.

In those RHAs that are undertaking renewal, there is support and enthusiasm for it, in spite of an awareness of the challenges. PHC renewal is seen by many as key to increasing access to health services, especially for some under-served populations. It is also seen as a way to bring a more integrated and client-focused approach to health care delivery.

Multidisciplinary teams were reported in all provinces, although there were differences in the type of teams being implemented and teams on the whole remained predominantly physician-centred. Chronic disease management figures prominently in primary health care renewal.

There was activity reported in every regionalized province and our data did not reveal any province to be significantly ahead of or behind other jurisdictions. It became evident through respondent comments that the provincial frameworks and approaches are influential in the way RHAs develop strategies and initiatives, and many RHAs depend on provincial initiatives and support for the success of their plans.

The largest issue was providers. Although there were reports of providers being very enthusiastic about the changes, the issue of provider resistance was predominant. Several RHAs indicated they were waiting for provincial negotiations with medical associations to be completed in order to have a clearer path to follow. The question of "buy-in" by all providers looms large for RHAs. Will providers be able to practice in multidisciplinary groups? Can they learn to work as teams, abandoning former behaviours of turf protection? Respondents saw organizational change strategies of education and communication as being paramount in dealing with this resistance. They also expressed the need for leadership support at the regional and provincial levels. Sustained funding and appropriate funding mechanisms were also important.

RHA respondents overwhelmingly considered regionalization as a positive force for change with PHC renewal. The authority to bring all players together and to reallocate resources to areas of need was seen as key to the success of PHC renewal. Respondents expressed a strong desire for more examples and models of how PHC can be organized and delivered.

Just as there were no strong patterns emerging as yet among the provinces, there were none evident between urban and rural RHAs, other than pacing. Many RHAs are operating simultaneously in both urban and rural environments. However, because provincial initiatives have significant implications for regional ones and because of the differences in rural and urban settings, these two patterns will be important for us to monitor as PHC renewal unfolds.

We will also monitor the pattern of initiatives in PHC. In particular we will be interested in the extent of multidisciplinarity and integration they effect in the system. And finally, we will examine the evolution of barriers and facilitators. Have the change management and other strategies been effective? Are providers working together better? Have incentives been aligned? Is there better use of information in planning and allocating resources? And finally, the most important pattern to assess will be the extent to which the goals of PHC renewal of improving access, appropriateness and quality have been realized, with of course the expectation that PHC reform will have a positive impact on the population's health.

The World Health Organization (WHO) describes PHC's core principles as being community involvement in defining and implementing health agendas; equal access to comprehensive health care for all; integration with other sectors; and commitment to health equity and social justice. For optimal impact, PHC initiatives will be challenged in the upcoming years to grow along this continuum. Some RHAs are whole-heartedly embracing PHC philosophies and implementing initiatives consistent with this way of thinking, while others have not yet realized their full potential.

In a regionalized system, the leadership role of RHAs in developing PHC is key. We will continue to report the progress of both primary health care itself and the role of RHAs in implementing it.

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A. Introduction

Primary health care (PHC) is growing in importance as part of Canadian health reform. In regionalized provinces, implementation of PHC initiatives is now the responsibility of regional health authorities (RHAs). RHAs are therefore key to the success of PHC renewal.

Regional health authorities are key to the success of PHC renewal.

For this reason, the Canadian Centre for Analysis of Regionalization and Health (CCARH) was interested in documenting and disseminating developments throughout the country. We contracted with the Primary and Continuing Health Care Division of Health Canada to conduct a national survey of PHC strategies and activities in RHAs.

We conducted the survey in January to March of 2004. In addition to identifying plans and activities, we inquired about barriers and facilitators to their implementation, including how regionalization affects PHC. To our knowledge, this is the first such comprehensive effort to document the national picture of PHC renewal. We are grateful to the respondents for providing us with the information we requested. This report summarizes the main findings of the survey.

Primary Health Care

PHC has important implications for the way we practice health care. Although it includes interventions and services that are part of everyday health services, it is more than medical care and more than the first contact with health care. It includes diagnosis and treatment of illness and injury, but also prevention and promotion and aspects of rehabilitative, supportive and palliative care. Further, PHC is not limited to clinics and health facilities, but includes environments such as schools and workplaces. As a result, it requires health practitioners to respond in more collaborative ways, with a wider range of strategies. PHC requires a reorientation to a spectrum of health services where the determinants of health and the health of communities are integral.

PHC is not a new concept world-wide, but its adoption has been gradual. As a result of the Declaration of Alma-Ata (1978), PHC became a core concept for the WHO (2). Worldwide implementation of PHC was seen as key to obtaining “Health For All by 2000”. PHC renewal in Canada, as in many countries, has emerged largely within a climate of cost-containment, demand for better quality health services and need for increased continuity of care (3). PHC reform promotes an integrated and client-focused approach to the delivery of health services to ensure that Canadians receive the most appropriate care, by the most appropriate

PHC reform promotes an integrated multidisciplinary and client-focused approach to the delivery of health services to ensure that Canadians receive the most appropriate care, by the most appropriate providers, in the most appropriate settings.

providers, in the most appropriate settings (4). Canada's overarching goal for its PHC renewal strategy is to develop a sustainable, accessible, affordable, accountable and client-focused health care system (5).

Survey Method

CCARH conducted the survey by mail from January to March of 2004, using a questionnaire designed in response to specific requests by the contractor (Primary and Continuing Health Care Division of Health Canada) and in relation to the definitions and expected outcomes of PHC as documented in the Canadian literature. We used Canadian Institute for Health Information (CIHI) reports and definitions in formulating the questions based on providers and expected outcomes. We tested an initial draft of the questionnaire with several decision makers and researchers involved in PHC and revised it accordingly.

Our target group for the survey was regional health authorities (RHAs) throughout the country. We surveyed Ontario District Health Councils as well, but with an adapted instrument and as a supplementary exercise. The conditions of District Health Councils differ from those of RHAs and it is not appropriate to treat RHAs and District Health Councils in the same group for the purposes of this analysis. We provide a brief commentary on Ontario DHC responses in the appendices to this report.

We sought one questionnaire per RHA, having identified the actual recipient of the survey in each RHA in different ways. In all provinces except Alberta, Ontario and Quebec, we succeeded in obtaining a list of RHA-based persons responsible for PHC from a provincial contact in each province. This was typically the PHC manager or coordinator for the region. We sent a letter to these individuals in early January explaining the survey and confirming their suitability. In the other provinces, we mailed the letter to the CEO requesting the name of the appropriate person. In late January, we mailed the questionnaires to the appropriate recipients and where possible, also emailed them to facilitate a timely response. We received most completed surveys by the end of March.

The final response rate was 50% excluding Ontario and 48% including it (Table 1). Quebec's particularly low response rate was due in part to the changes in regional structure the RHAs were undergoing at the time. Survey respondents represented a good distribution of urban and rural RHAs.

Table 1: Survey Response Rate by Province and Urban-Rural RHA

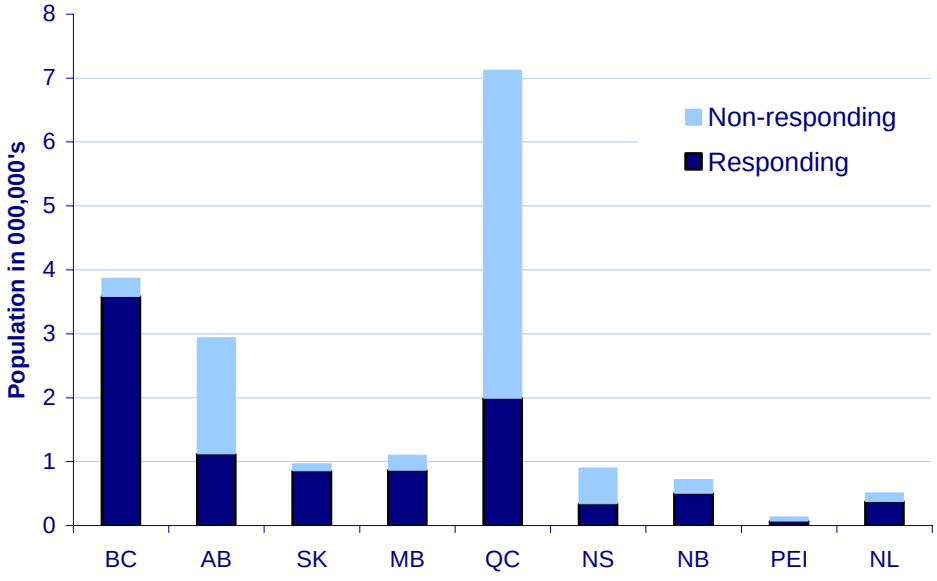
PROVINCE	# MAILED	# RETURNED	RESPONSE RATE
BC	5	4	80%
AB	9	3	33%
SK	12	9	75%
MB	11	6	55%
ON	16	6	38%
QC	18	3	17%
NS	9	3	33%
NB	8	5	63%
PE	4	3	75%
NL	7	5	71%
NT	8	4	50%
TOTAL	107	51	**48%**
W/O Ontario	91	45	**50%**
TYPE OF RHA	**# MAILED**	**# RETURNED**	**RESPONSE RATE**
Urban	9	5	56%
Mixed	14	7	50%
Rural	68	33	49%
TOTAL	91	45	50%

Note: The urban-rural portion of Table 1 excludes Ontario. A list of responding RHAs is provided in the appendices.

The final response rate was 50%.

The population of responding RHAs in the nine regionalized provinces represented 53% of the population of those provinces. BC's high response rate and more populous RHAs combined to give it the relatively best representation in the survey (Figure 1).

Figure 1: Population by Responding And Non-Responding RHAs, Regionalized Provinces



For many if not most RHAs, it is still very early to assess the implementation of initiatives.

Limitations

There are several factors limiting the survey findings. One is that only half the RHAs responded. Although this may be considered reasonable for a mail survey, especially one with such a short time frame, 45 responses limit our ability to draw generalizations and conduct more advanced analysis, in particular for subgroups of respondents.

We attribute non-response to several factors. For many provinces, PHC is just getting underway, and many regions may have felt it premature to complete this survey. As well, some provinces are undergoing structural change (i.e. Quebec), which would limit the time and enthusiasm for completing the survey. Finally, the survey length may have limited the response rate. We knew from the pilot exercise that the survey was time-consuming. Although we made some adjustments in response to this feedback, the survey remained long. Given the exploratory nature of the exercise, we concluded many of the questions had to be posed in the way they were, that is, open-ended and asking for a lot of information.

Another limitation was the time constraints for completion of the survey – a condition of the contract with Health Canada. If more time had been available, we likely would have attained a higher response rate and been able to follow up with respondents to obtain supplementary information.

Given these qualifications, we consider this report to be an exploratory rather than a definitive study, but still providing valuable insights into the progress of PHC renewal initiatives at the RHA-level.

Finally, we wish to draw the reader's attention to the fact that there is variation in the number of RHAs per province, in the population served by each RHA and by the number of persons served or targeted by each PHC initiative. Our report provides results in terms of numbers of RHAs and numbers of initiatives, but these are not equivalent to persons served or targeted.

We selected the respondent excerpts to supplement the trends and analytical information we reported.

Excerpts from Responses

The report provides excerpts from respondents about their initiatives and views. We selected the excerpts to supplement the trends and analytical information we reported. They are not intended to be comprehensive. The excerpts are verbatim except for minor editing to improve readability and to eliminate information revealing the identity of the RHA that responded.

B. The Findings

Although it is still early in the process of primary health care renewal and many initiatives are still in the planning stages, findings show that PHC renewal is widespread in the country, with a variety of initiatives being undertaken. Some RHAs have progressed more deeply into the change process than others.

All respondents to the survey were either undertaking or planning PHC renewal initiatives.

Initiatives

All respondents to the survey were either undertaking or planning PHC renewal initiatives: 35 (78%) were undertaking and the remaining 10 (22%) were in the planning stages only. Many RHAs reported that they were simultaneously in the planning and implementation stages for different initiatives.

Our questionnaire specifically asked about five types of initiatives. Of these, multidisciplinary teams were the most frequently reported (Table 2). Chronic disease management projects followed, and then collaborations with sectors outside of the health care system, information technology (IT) initiatives, and finally those geared towards increasing access. In addition, 20 RHAs were planning initiatives not belonging to any of these five categories. Examples of *other* initiatives included resource teams in each community; community clinics offering specialized care to individuals and families for treatment or prevention activities; Community Health Advisory teams to improve public participation; Regional PHC newsletters; PHC education and awareness campaigns for health providers and other sectors; and research and evaluation projects.

Table 2: Number of RHAs Planning or Undertaking Initiatives, by Type of Initiative

	TYPE OF INITIATIVE						
PROGRESS (# OF RHAS)	**ANY**	**MULTIDISCIPLINARY TEAMS**	**CHRONIC DISEASE MANAGEMENT**	**INTERSECTORAL COLLABORATION**	**INFORMATION TECHNOLOGY**	**24/7 ACCESS**	**OTHER**
UNDERTAKING	35	30	22	27	16	17	8
PLANNING	10	13	21	10	20	7	10
TOTAL	45	43	43	37	36	24	18

There were initiatives throughout the country.

There were initiatives throughout the country, with no single province having a significantly higher or lower activity rate (Table 3). The responding RHAs in BC and Quebec, however, cover the largest number of persons (Figure 1).

Table 3: Number of RHAs Planning or Undertaking Initiatives, by Province

TYPE OF INITIATIVE	BC	AB	SK	MB	QC	NS	NB	PE	NL	NT	ALL
Undertaking	3	2	6	6	3	2	4	3	3	3	**35**
Planning only	1	1	3	0	0	1	1	0	2	1	**10**
Total	**4**	**3**	**9**	**6**	**3**	**3**	**5**	**3**	**5**	**4**	**45**

Initiatives: Goals

We asked respondents at the beginning of the questionnaire to describe their goals for PHC renewal in their own words. Their most frequently reported set of goals was to increase the integration and coordination of health care services through collaboration and by working in multidisciplinary teams and practice networks. A second set of goals was to increase access to a more comprehensive range of services. Third was to reorient health services toward promotion and wellness. And fourth was to increase the appropriateness and responsiveness of services, through use of client-centred and targeted services.

The respondents' goals are consistent with the broader goals of PHC systems as set out by the WHO and as adapted by Canadian governments (6):

- increase the proportion of the population having access to primary health care organizations accountable for the planned provision of a defined set of comprehensive services to a defined population;
- increase emphasis on health promotion, disease and injury prevention, and management of chronic diseases;
- expand 24/7 access to essential services;
- establish interdisciplinary primary health care teams of providers, so that the most appropriate care is provided by the most appropriate provider; and,
- facilitate coordination and integration with other health services, i.e. in institutions and in communities.

RHAs stated that they wanted to improve the deployment and capacity of providers, as well as the involvement and satisfaction of providers. They also hoped that PHC renewal would increase

public involvement and participation, so members of the public could better inform health providers about their needs, increase their own satisfaction with the health system, and improve their knowledge of health and capacity for self-care.

Respondents sometimes referred to specific health conditions or programs in describing their goals. Improved management of chronic disease was by far the most frequently mentioned goal in this category.

In addition to asking respondents to describe their goals for PHC, we asked them two supplementary questions about their intentions – what results they anticipated from their initiatives and what problems their initiatives were intended to resolve. Although generally complementary to their goals, respondents' list of the problems to be resolved elicited their assessment of the most difficult issues. These were access, fragmented services and the predominance of the medical model.

Initiatives: Multidisciplinary Teams

Multidisciplinary teams were the most frequent PHC initiative reported.

Multidisciplinary teams were the most frequent PHC initiative reported. One of the main objectives of PHC teams is to provide better and more coordinated access to a more comprehensive range of services. It is also hoped that providers will work interdependently with others. Almost all respondents reported strategies for such teams (43/45), with 30 currently undertaking and the remaining 13 planning for implementation. One difference that did emerge was the number of teams in each region, their composition and focus.

During the process of categorization, it became evident that respondents were using different terms when referring to types of multidisciplinary teams (Table 4). Many of the teams included a broad range of practitioners, including physicians and other providers. Several teams had only physicians and nurses or nurse practitioners and some teams had no physicians. A few teams were actually networks – called shared care, physician, or practice networks.

Most frequently mentioned – by half the respondents – was the more comprehensive PHC team, typically involving many different types of practitioners. Program teams and networks were also relatively prevalent – each reported in 19% of the responding RHAs. Program teams are created to address specific health outcomes and appear to have a mix of both treatment and prevention orientations. An example is the diabetes team, which was the most common of the program teams, addressing prevention, treatment and management issues. Doctor-nurse teams were in existence in 14% of RHAs responding.

Table 4: Team-Based Initiatives

TEAM TYPE	TEAM DESCRIPTION	RHAs* # (%)
PHC Team Also referred to as "interdisciplinary teams" or "primary health care organizations".	One or more physicians and other providers such as social workers, mental health, dental care workers, dentists, LPNs, nurse practitioners, nurses, public health nurses, physiotherapists.	21 (50%)
Program Teams Also referred to as "sub-teams".	Focus on diabetes, cardiovascular health, and cancer. Include a range of providers.	8 (19%)
Network	Physician Network, Practice Network. Very little information provided.	8 (19%)
PHC Team Supported By GP Practice(s)	Same as above; however, it was specified that the physicians involved were in private practice and not employees of the RHA.	6 (14%)
Physician & Nurses / Nurse Practitioners Also referred to as "collaborative practice approach".	One physician teamed with one or more nurses.	6 (14%)
PHC Team, No Physicians	Same as above, without a physician.	5 (12%)
Planning Team	Examples of teams include: Strategic planning; design/development/ implementation; steering committee.	4 (10%)
Shared Care Networks	No detail provided.	3 (7%)
Team Make-up Still Being Planned	–	3 (7%)
Management / Supervisory Team Also referred to as "regional leadership teams".	Supervisors of PHC front-line staff/ teams.	2 (5%)
Client-Centred Team	Infant/child/youth, women's, men's, and seniors' health.	1 (2%)
Satellite Team	No detail provided.	1 (2%)

*RHAs with teams.

Most PHC teams reported in the survey were physician-centred and focused more on the curative/ rehabilitative aspects of illness.

PHC is intended to reduce the focus on the biomedical model, to the extent that it fosters community participation, focuses on prevention and increases consideration of the non-medical determinants of health. However, most PHC teams reported in the survey were physician-centred and focused more on the curative/rehabilitative aspects of illness. Indeed, primary health strategies in Canada have emphasized the inclusion of physicians. Some provinces have explicit requirements stipulating the number of physicians for each funded team.

The composition of primary health care team will be important to monitor in the progress of primary health care renewal. The types and numbers of providers making up the teams will no doubt respond to provincial frameworks. However, team composition will also reflect local needs and resources.

Respondents reported substantial variation in the size of teams. Team size appears to be partly a function of the types of providers included in the team, and partly dependent on staff availability.

Teams ranged in size from a minimum of two providers (e.g. one nurse and one physician) all the way to 26 members in one team. In one Northern RHA, each team was highly inclusive with a number of different providers, representatives from other sectors, and community members participating. Therefore the team was larger than average. Team membership and size will be an important area of future study in seeking to identify best practices.

… The plan for the PHC team is in the formative stage but it is conceived that initially a group will be convened by the Director of Primary Health Care. Team members will include the Director of Community Services, the Manager of Primary Health Care, the physicians of the [local] Medical clinic, Community Managers, and the Primary Care Nurses [of 3 local centers]. Other core team members will be community health educators, mental health counselors, addictions counselors, home health aides, public health nurses, and clerical staff working at the Primary Care sites. Local community leaders and other human service workers will be invited to join with us as we discuss the issues and challenges facing each primary care site. Other teams/ providers that will work closely / interdependently with the PHC Team include the Diabetes Prevention Team, the Prenatal Team, the Dental Services Team, Health Educators, Mental Health and Addictions Teams, ECIP, Speech Language Pathology and others.

…Teams will be a mix of central teams, program teams and satellite teams. The teams will network as appropriate and practical to allow for sharing of staff, resources and information.

…We have also developed a PHC Regional Planning Team that is intersectoral with physicians, nurses, administrative personnel, the director of human resources, the Medical Health Officer, public representation, a representative from First Nations as well as a representative from the Regional Intersectoral Committee. The purpose of this team is to provide overall leadership and direction in the implementation of primary health care in the … Region.

…the program involves client-centred teams as opposed to program-centred delivery. Teams are Infant/Child/Youth Health, Women's Health, Men's Health and Seniors Health.

…A Health Promotion Team has been formed … to provide health promotion presentations to all four … schools with a focus on grades four to nine. This team includes staff from Addictions, Mental Health, Sexual Wellness, Nutrition, Public Health, and Dental Health. A menu of health education topics will be made available to all teachers in these schools. Teachers will then book

the specific resource person for each topic. In addition to these presentations, Addictions and Sexual Wellness workers will spend four days a week at [one specific] high school to be available for one to one education and counseling. An office has been set up in the school for this purpose.

…To support our targeted plan for PHC renewal, a Collaborative Champion team will be established. This health professional team will work in liaison with PHC physicians to address target areas as identified in the PHC plan. The PHC Champions will support our key targeted strategic messages: tobacco reduction, bone health, heart health, primary cancer detection through education & awareness as requested by Primary Care Physician offices. It is likely that the underlying issues such as healthy eating and physical activity will be identified as support needs. The operational plan to deliver this concept is a work in progress, and will need input from various stakeholders.

Initiatives: Target Populations for Multidisciplinary Teams

Most target groups were intended to serve a general, rather than specific, population, such as the region's catchment area.

PHC philosophy advocates initiatives that are targeted at communities in addition to individuals. This requires a rethinking of how services are provided to RHA residents. Thirty-four respondents replied they had primary target populations for their multidisciplinary teams. Most target groups were geographically based (i.e. rural areas) and intended to serve a general, rather than specific, population (i.e. the region's catchment area) (20/34). Several initiatives targeted high-risk groups or those with existing health conditions such as diabetes or COPD, while a small number were more generally geared towards men's, women's, senior's or children's health issues (6/34). Some regions had not yet determined what their population needs were or were developing teams based on knowledge specific to the communities they were serving. Notably, differences were found in each team's orientation, with some focusing more heavily on treatment and management of illness and others being more prevention oriented – the former being the most common approach.

Target populations will be defined via community specific needs assessments.

Children at high-risk for FAS/FAE; developmental delays literacy, speech difficulties…

… largely specialized (e.g. Mental health, addictions, diabetes prevention, acute care)

All are targeting populations with chronic disease, with a focus on diabetes/CHF.
Target populations are defined by geography (community areas) and then further refined to those with chronic diseases – diabetes, CHF, mental health, asthma …

Most are geographic based … rural …

Initiatives: Chronic Disease Management

Following multidisciplinary teams, chronic disease management (CDM) was the most common PHC initiative. Of the 45 respondents, 43 RHAs reported either planning or implementing a CDM project, although almost half were still in the planning stages. That chronic disease figures so prominently in PHC renewal may reflect that it is an area poorly addressed by conventional medical approaches. CDM requires a multidisciplinary approach, focusing on care rather than cure and on patient education and involvement.

Of the 45 respondents, 43 RHAs reported either planning or implementing a chronic disease management project.

Initiatives reported in the survey were predominantly geared toward prevention and management of diabetes. Many were part of a provincial initiative. A majority of CDM projects involved a range of health providers and often collaborated with other sectors, overlapping with the strategy of multidisciplinary teams.

New Beginnings is a family intervention project … Its goal is to prevent FASD births. Services are aimed at supporting women of childbearing years who wish to make healthy lifestyle changes and participation in the program is voluntary. Services include home visits, advocacy and support, group programming, problem solving, goal setting, addictions services, and referrals.

Established a **Chronic Disease Framework** within which we will implement a range of chronic disease prevention and management strategies, including: a diabetes initiative; standardized diabetes education; establish a single point of access to diabetes education and referral to appropriate provider; and launching a shared-care model in partnership with primary care physicians where patients are registered in this program, followed and monitored by a team of health professionals (e.g. diabetic nurse, dietician, pharmacist). Care is guided by best practice and facilitated through electronic sharing of information.

Saskatchewan Health has partnered with Manitoba, Alberta and British Columbia in a **Western Health Information Collaborative** (WHIC) to develop an innovative and sustainable Chronic Disease

Management Infostructure. The focus of the WHIC project for SK will be on diabetes as the chronic disease. We have members on this team from our Regional Diabetes Team.

We are integrating chronic disease prevention initiatives under the broad umbrella of PHC. We are using transition funding to continue community development programs aimed **at reducing risk factors for chronic diseases**.

Planning for **Risk Reduction Program** focusing on Diabetes, Hypertension, Obesity, Arthritis and other CIHI indicators which support high incidence in our region.

As part of our project we hope to increase the **emphasis on health promotion and prevention**. Our major health problem in the region and the province is cardiovascular disease. We hope to address lifestyle issues that increase risk of developing cardiovascular disease, diabetes and cancer. We are doing this but indirectly through prevention.

The Region is planning to implement a **chronic disease prevention strategy** beginning in 2004/05. Building on the successes of the Heart Health Project, the RHA will be hiring Community Facilitators for a number of small rural elderly communities. These individuals will work with the communities and other members of the interdisciplinary teams in developing primary prevention activities with a focus on physical activity, healthy nutrition, tobacco reduction as well as injury prevention.

Initiatives: Increased Access

Many access initiatives were related to provincial telehealth initiatives.

Access initiatives were reported in just over half (24/45) of the RHAs. Seventeen had strategies in place and another seven were in the planning process. Many access initiatives were related to provincial telehealth initiatives. However, increased access was not always conceived as the result of a specific access initiative, but as a byproduct of other PHC reforms. For example, improving the interface between primary and secondary levels of care will result in increased access to appropriate care. Including a nurse practitioner in the team will not only increase access to primary care directly, but can also contribute to accessing other services appropriately.

All Primary Health Care Organizations will be required to have 24/7 response to patient rosters. It is anticipated that there will be telephone first contact, and follow-up as required post triage of calls.

Health Link is a toll-free, around the clock telephone service. It is staffed by experienced registered nurses and is available 24 hours a day, seven days a week. Health Link is available to all residents … providing confidential advice and information on common health concerns, and information about local health services and programs. …24/7 access to nurses/physician…

Primary health care clinics – provide access to interdisciplinary teams to address primary health care needs in a local community after regular physician offices close.

…Community Clinic has a Primary Health Nurse who shares on-call equally with physician group.

Ambulance services have been strengthened in a number of small communities… eliminating previous disruptions in services that were occurring. The Region has created on new satellite ambulance service … and are in the process of creating a second …

Initiatives: Information Technology

Over a third (16/45) of all RHAs had undertaken information technology (IT) initiatives as part of PHC renewal and another 20 were planning them. Most commonly, these were pilot projects in specific locations within the region. Some were designed for specific programs, such as diabetes management. Many initiatives, but not all, were part of a provincial plan. Several respondents mentioned the comprehensive electronic health record and its overall significance, but a few were also using new technology to enable provider integration.

The preferred solution will provide the ability to create a client roster, schedule service providers/clients, bill for non-insured services, track provision of services by provider and program, and create an electronic client record. This solution is intended to be available to all members of the multidisciplinary team, including physicians, nurses, midwives, dietitians, counselors, and administrative staff.

Western Health Infostructure Collaborative on Chronic Disease Management – a [RHA] Primary Care clinic is under consideration as a pilot site for this project, modeling a chronic disease management tool for diabetes.

A region wide electronic chart has been implemented to include 3 facilities. Physicians have access to this chart from their offices. All of the patient charting is done electronically by all health care providers except physicians. A provincial initiative is in place to extend e-record to primary care.

Comprehensive electronic health records are being investigated at the provincial level.

Initiatives: Intersectoral Collaboration

Because population health is strongly affected by factors outside the health sector, health improvement requires attention to a range of social, economic and environmental determinants (7). Health planners are increasingly aware that other sectors (e.g. education, justice, social services and community-based groups) are important partners in what may have been traditionally viewed as health activities. Working with other sectors enhances PHC practitioners' capacity to deal with a broader range of health determinants and outcomes. Other sectors will often have financial and staff resources, knowledge bases, and an infrastructure in place to effectively contribute to social initiatives (8). Intersectoral collaborations need not be initiated within the health care system, as those involved in PHC may themselves be invited to work with other sectors.

Approximately 80% of RHAs reported being currently involved or planning to become involved in intersectoral intiatives.

Approximately 80% (37/45) of RHAs reported being currently involved or planning to become involved in intersectoral initiatives. Most had already engaged in them (27/37), although a number of RHAs were still in the planning stages. Of the various intersectoral collaborations reported, many were within the health sector itself (15/37). Others were with human services sectors, especially social services and education (12/37). Nine RHAs reported that collaboration was taking place with sectors such as agriculture, municipalities, community organizations, and non-governmental not-for-profit organizations.

Members of the [Regional] PHC portfolio are involved with the [City] Regional Intersectoral Committee. This committee receives regular information on PHC initiatives. The PHC Strategic Planner is a member of the [Local] Inner City Community Partnerships Steering Committee, an intersectoral committee overseeing the implementation of recommendations made in a report on improving quality of life for inner city residents. Amongst the recommendations were those referring to healthcare services. This committee will provide many opportunities for partnering. Shared

space between PHC services and other organizations is one potential example. [The RHA] PHC representatives are also involved with initiatives led by other sectors such as In Motion, Kids First and Schools Plus.

… a new primary health centre is in the planning stages. A community input session included intersectoral representatives i.e. police, the [City], community associations, Tribal Council

… established a partnership between the RHA and [Provincial] Family Services and Housing to implement an integrated approach to delivery of health and social services. This has resulted in the establishment of integrated teams in each of the 12 community areas. Each team offers the following range of services: Home Care, Mental Health, Public Health, Primary Care, Housing, Income Assistance, Child Daycare, Community Living, Child and Family Services (child protection). The establishment of the community area teams required massive reassignment of resources in both organizations, and patriation of these services to the local community areas. Implementation is well underway.

A regional Working Group has been established to guide the development and implementation of the regional initiatives. Membership is comprised of the four health boards, private physicians, academic and community stakeholders. Professional organizations, labor unions, government, government agents and others will be involved as the plan is rolled out. Formal consultations and communication strategies are in progress.

Promoting work with municipalities on sustainable communities issues.

Often respondents' engaged in intersectoral collaboration because it improved care, led to an increased focus on wellness, and modeled team efforts. A handful of respondents recognized that collaboration with other sectors enhanced the region's capacity to affect the broader determinants of health and promoted public participation and community capacity.

Initiatives: Overall Change in Services

For some RHAs who responded to our survey a change in services meant doing things differently, while for others, it meant the decision to offer a new program altogether. As expected, PHC renewal has increased focus on certain services more so than others (Table 5).

Table 5: Change in Health Services

	# OF RESPONSES			
SERVICE	IMPLEMENTED	PLANNED	DO DIFFERENTLY	TOTAL
Specific services related to population needs, as identified by community consultation	9	12	9	30
Case management	8	9	9	26
Education and support for self-care	7	6	11	24
Maintenance of comprehensive client health record	10	9	5	24
Nutritional and lifestyle counseling	7	8	8	23
Diagnosis and treatment of chronic illness and injuries	9	9	5	23
Health promotion	10	5	7	22
Community development	6	9	7	22
Illness and injury prevention	5	6	7	18
Mental health care	6	5	7	18
Telephone triage	4	7	3	14
Diagnosis and treatment of episodic illness and injuries	5	-	9	14
Health assessment	4	4	5	13
Reproductive care	4	4	5	13
Palliative care	4	4	5	13
Screening tests and vaccinations	4	1	7	12
Public health	5	2	5	12
Coordination and provision of rehabilitation services	2	4	5	11
Supportive care in hospital, at home, and in long-term care facilities	5	2	3	10
Pre-hospital emergency medical services	1	3	4	8
School health	3	3	2	8
Environmental protection	-	2	5	7
Occupational health	2	1	1	4

Mentioned most frequently by respondents as services that PHC renewal had increased or would soon increase, were community consultation to identify service needs in the population, case management, education and support for self care, maintenance of comprehensive client health records, nutritional and lifestyle counseling, diagnosis and treatment of chronic illness and injury and health promotion. Respondents also reported that many services were now done differently as result of PHC renewal.

Factors Affecting Change

We asked respondents to name the most significant barriers and facilitators to PHC renewal.

Factor: Government Support and Policy

Leadership and support at the regional and government levels were frequently raised as facilitators. Funding was also frequently identified. Respondents referred positively to targeted funding, such as the Primary Health Care Transition Fund, as well as general support for reform activities. Respondents also identified funding *mechanisms* as facilitators – to align funding such that it flows appropriately to PHC needs. Conversely, there were concerns that funding for on-going program support would not be sustained at adequate levels.

> Strong leadership at both the federal and local levels is key to achieving the goals. Understanding by the Federal, Provincial and RHAs of the key drivers to achieving the goals is necessary. Transitional and baseline funding is critical.
>
> The Primary Health Care Transition Fund has provided a jump-start to PHC renewal in the Region, not only for the development of expanded services, but also to the planning regarding shifts in roles of current care providers to better meet the needs of the population.
>
> The lack of funding mechanisms to hire and integrate nurse practitioners in communities underserved by family practitioners.
>
> … While there is funding now for implementing changes, sustainable funding will be key in being successful in achieving the goals of primary health care renewal.
>
> Funding, funding, funding – secure funding that can be focused on implementing incremental changes.
>
> Access to data, and interpreted information about determinants of health and health status has been a key ingredient in moving people to action. There is support at the district, provincial, and federal level, as well as growing understanding of key issues within the community. We have the support of senior management and the District Board to make these changes. We are a small, rural community that makes it easier to implement change and to measure the outcomes, and we have a foundation of strong partnerships on which to build.

Respondents often referred to provincial policy in PHC reform.

Respondents often referred to provincial policy in PHC reform. One area where provinces appeared to have a significant impact was in setting goals. In describing their own goals, many RHA respondents reiterated their province's goals as often set out in a provincial framework or plan. When speaking about change to remuneration structure, several RHAs spoke about provincial negotiations taking place between the province and the medical association. Mixed and rural RHAs reported relying on provincial negotiations more so than urban RHAs, none of whom claimed to be doing the same. And many RHAs cited provincial telehealth or 24/7 information lines as part of their initiatives for expanding access. However, some RHAs with access to provincial telehealth lines did not make reference to its use.

Although RHAs in some provinces appeared to be relatively more involved in certain types of PHC initiatives than others, the data did not reflect clear provincial patterns.

Factor: Regionalization

The large majority of respondents believed regionalization contributed to the success of their efforts in primary health care renewal.

The large majority of respondents (80%) believed that being a regional health authority, or other features of regionalization, contributed to the success of their efforts in PHC renewal.

The most frequent explanation for this was that regionalization has integrated many services and sectors within the health care system. Respondents stated that regionalization has the mandate and responsibility to consider the health of the population, and the authority to bring all the players and resources together to achieve it. In essence, regionalization has "eliminated turf."

> Regionalization has also placed all the health players across the continuum of care under the same administrative structure and forced the development of integrated approaches.

Respondents stated that under regionalization, the needs of the region could be brought together within one plan, priorities set and resources reallocated. Regionalization also was able to develop a regional plan and prioritize needs.

> Regionalization allowed for the big picture to be seen. It allowed us to provide a more comprehensive consistent approach within the region instead of each sector competing.
>
> Regionalization has provided an opportunity to recognize both services and needs on a broad spectrum. Both rural and urban practice issues can be addressed, with many programs and services

considered. There is great opportunity for rural and urban complementing each other's assets.

Finally regionalization was said to encourage more collaborative and intersectoral approaches.

Regionalization in itself is consistent with the principles of PHC and reform. The establishment of regional health authorities has permitted a more focused and consistent effort in Primary Health Care reform. It has allowed for more meaningful engagement of community members and stakeholders, compilation of health data and assessments specific to a community of interest, and greater creativity and flexibility in project implementation.

Most respondents viewed regionalization's effect in a positive light. However, a small number of RHAs expressed concerns about urban centers in the region dominating rural concerns and swallowing up resources within the region, as well as physician and community distrust of RHAs. One respondent said that the RHA had not been able to recover from the distrust created among residents with the earlier closure of facilities.

Factor: Dealing with Change – Providers and Community

Provider buy-in and resistance to change were factors most commonly identified as barriers to PHC renewal.

When respondents were asked to describe what they viewed as the most significant barriers and facilitators to PHC renewal, provider buy-in and resistance to change were factors most commonly identified as barriers. When specific reference to physicians was made, barriers included a lack of appropriate incentives and the traditionally dominant role of physicians. Several RHAs spoke about providers' lack of willingness or capacity to practice in multidisciplinary teams, some citing "turf" as a problem.

When describing the positive attitudes of providers, respondents spoke about provider's motivation to offer better service for clients and to work collaboratively. Some RHA respondents described provider support as being in pockets, rather than widespread. Others said many providers were "enthused but uncertain".

Professional development was mentioned as a facilitator. Some respondents noted partnerships with universities and post-secondary institutions as a way to raise capacity in the long term.

On the negative side, several RHAs talked about skepticism among providers about the changes, and a few talked about general resistance to change.

Staff express excitement regarding many aspects of PHC Renewal, including opportunities to strengthen their involvement related to the determinants of health, increased participation in the planning of needs based services and expansion of services to our more isolated and/or Aboriginal communities. Physicians have been supportive in our discussions regarding strengthening primary health care services and their involvement in interdisciplinary teams and in collaborative practice with nurse practitioners.

As this is a huge departure from current delivery the majority of staff at the beginning had a great sense of loss. Felt they were losing their identity. Some staff had been in their current role for many years and were resistant to this change.

It is too early to tell at this time. I think it is a mixture of fear, frustration and excitement about the possibility of providing better health care services and actually promoting health.

The main changes that I have seen within our system and the care providers is a greater desire to work together. This includes trying to understand each other's roles, sharing both human and other resources, trying to work "out of the box" even though there are many union issues surrounding this initiative.

It continues to be a challenge for the acute care system to understand their "supporting" role to primary health care and for adequate attention (and funding) to be made available. Like all provinces in Canada, the issues of emergency waiting times, access to diagnostic services, and access to acute care services dominate the agenda.

The incorporation of several disciplines to front-line primary care vs. physician-dominated model.

The community was identified as an important link in the PHC chain of success. Public education in primary health care, community engagement and community development were all seen as facilitating PHC renewal. In addition, adequate data and the use of evidence in making decisions were seen as important, reinforcing the importance of community-level data or needs assessments and evaluation of initiatives, as we discuss later.

Shifting community perceptions regarding the value of community programs over institutional programs.

> Shifting public's perceived needs that they need to see a physician in all cases.

Change management challenges and strategies were congruent with the barriers and facilitators. The most frequent group of change management strategies was building provider capacity for change, in particular through professional development, and to a lesser extent organizational development, including workshops on change, conflict resolution, and so on. The need for early adopters and early examples of success was noted.

The most frequent group of change management strategies was building provider capacity

> In order to implement our changes in a timely fashion there is a need for others to understand what is meant by primary health care – why it is important, and what the changes will be. There are potential barriers created when the concepts of primary health care are not well understood, and are too often communicated at a conceptual level. There is also a challenge to managing expectations that could create a barrier. While there is funding now for implementing changes, sustainable funding will be key in being successful in achieving the goals of primary health care renewal.
>
> Choose early adopters in the family physician community, the community to be served, and the staff working in the formal health region.
>
> We are focusing our efforts on initial site development for communities and physician groups that have the interest, willingness and capacity to implement a change in how health care is provided. In order for PHC to grow and be accepted as a method and philosophy of health service delivery, it is essential that the first sites and teams are successful and sustainable. As such, we have developed a document entitled Selection of Communities of Interest for Development of Primary Health Care Teams: Items for consideration to guide community selection.

A second group of change management strategies involved building relationships, such as involving physicians and other providers in planning, or creating steering and advisory committees that include community members. Communication strategies were aimed at both public and providers and included newsletters, forums, and media efforts.

A second group of change management strategies involved building relationships, such as involving physicians and other providers in planning, or creating steering and advisory committees that include community members.

Among the change management strategies for physicians, a few respondents referred to monetary incentives for physicians to participate in primary health care.

Involve physicians and community members at the very beginning of the planning process.

Build a relationship between authority staff, physicians, the medical association and the government by involving them in the process, communicating on a regular basis. We provide funding to support project manager and attendance and planning to learning seminars.

Pay physicians to participate.

Engaging physicians with "volume based" incomes in the primary health care process

Thirty-four respondents reported either undertaking or planning some form of alternative remuneration for physicians in team-based initiatives.

A need for changes to physician remuneration was evident and was generally viewed by respondents as a prerequisite to enhancing physician involvement in prevention and planning activities. Thirty-four respondents reported either undertaking (25) or planning (9) some form of alternative remuneration for physicians in team-based initiatives. Many regions were awaiting a provincial model to be developed. Indeed, provinces are predominantly taking the lead in negotiating with the provincial medical associations to determine suitable solutions. However, each region had different payment models in place, at times with physicians being compensated in different ways within the RHA. Several RHAs reported using an alternative payment plan, denoting a variety of approaches including block payments, sessional payments, contracts, and fee-for-service, depending on the physician and the initiative. Seven regions had salaried physicians. The remainder were using capitation and fee-for-service.

Factor: Information-Based Planning and Practice

An important part of PHC is to identify the needs of specific populations (4). Therefore community needs assessments become required tools for planning. Using a variety of data sources, community needs assessments inform residents, providers and decision-makers about the health status and social environments of their communities.

Of the 45 regions responding, 35 (78%) reported having conducted a needs assessment. However, the nature of the assessment and the methodology employed varied considerably across RHAs. Most RHAs (39%) used a single source or form of data to inform the assessment. Data sources included local surveys, statistical profiles of communities (either obtained from outside reports or by using larger databases), consultation with physicians and other RHA staff and focus groups with the community, staff or physicians.

Another 30% of RHAs used a more comprehensive needs assessment, including combinations of activities such as statistical profiling of communities within the region; government reports; literature reviews; engagement of stakeholders including the public through focus groups, community input sessions, surveys and key informant interviews; and for some, the inclusion of other sectors (e.g. community, education, public health) as stakeholders.

Some regions (9%) did not engage in a large-scale general needs assessment, but rather conducted more focused assessments. Generally, this meant looking at specific sub-groups in the region (women, children/youth, seniors, aboriginals), particular health conditions/ issues (e.g. addictions, mental health, bone health, cardiovascular health) or particular initiatives (e.g. Community Health Centre).

We note that the CCARH survey did not assess the fit between the needs identified and the issues targeted by PHC initiatives. However, this is an important line of inquiry for the future. A strong PHC system requires evidence-based decision-making, as well as public participation in both identifying needs and setting the agenda. Community needs assessments can help RHAs to plan strategies that address factors affecting health and health outcomes.

Evaluation of PHC initiatives is also key to understanding their impact at the community level – on service provision and on the population. Although we asked RHAs about evaluation, we were aware that because PHC renewal projects are mostly still in the process of planning and early implementation, not much evaluation would have yet been possible. Overall, 23 of the 45 RHAs (55%) had not yet evaluated the PHC initiatives in their respective regions. Encouragingly, almost all of the RHAs not having done evaluations indicated that they had plans to evaluate in the future.

Respondents emphasized the need for practice examples.

Throughout their answers, respondents emphasized the need for practice examples. Models of PHC and examples of success and early adopters were a recurrent theme. Because there are many different models of PHC, determining a best fit for each RHA can be challenging. Best practices can be gained from other RHAs' experiences where there have been successes with different models. RHAs expressed the desire to learn from one another by sharing knowledge about and experiences with the variety of new and often untested models of PHC.

Factor: Urban-Rural Setting

Data on each region's population and population density was used to group RHAs into urban, rural and mixed categories. In general, urban RHAs were farther ahead in their initiatives, but did not necessarily have a wider range of initiatives in play. For example,

In general, urban RHAs were farther ahead in their initiatives, but did not necessarily have a wider range of initiatives in play.

while all RHAs were either undertaking or planning PHC renewal initiatives, all of the urban RHAs responding had implemented PHC initiatives, while only 58% of rural regions and 50% of mixed regions had done the same. This was the case for all of the major initiative types: multidisciplinary teams, IT, access, and chronic disease management. In addition, relatively more urban RHAs had undertaken initiatives with respect to physician remuneration. However, many of the mixed and rural regions reported being in the planning stages on all of these, so it appeared to be a pacing issue.

Nevertheless, although all regions showed much room for improvement in implementing initiatives geared towards improving access, rural regions fared the worst. And while evaluation projects were relatively rare overall, mixed RHAs were least likely to have conducted any form of evaluation.

These differences may be due to the challenges associated with rural settings. For example, regions with dispersed populations cannot achieve the economies of scale of those with more clustered populations. Transportation is also more of an issue in rural settings. Rural regions have greater difficulty with the recruitment and retention of new health professionals and fewer groups to partner with. Indeed respondents identified limited resources as a challenge to PHC renewal in rural areas. One respondent voiced concerns that the larger centre within the region would swallow up the lion's share of resources available.

On the other hand, several respondents noted that it was easier to begin initiatives in smaller communities where "people are closer knit" and "fewer intersectoral players are involved". Regions that are predominantly urban were seen as being more complex and the change process more difficult. Some respondents did not want to make generalizations about urban or rural settings, but rather emphasized the importance of PHC initiatives responding to individual communities.

Outcomes

About one-quarter of respondents saw some change in the overall quality of care, and in its continuity, comprehensiveness, appropriateness, efficiency, and in terms of its evidence base.

As reported earlier, most PHC renewal projects are still in the process of planning and early implementation. Not surprisingly then, a limited number of respondents were able to comment on perceived outcomes resulting from PHC initiatives. The responses indicate that PHC initiatives in the regions improved the care 'somewhat', with a smaller number seeing 'a great deal' of change (Table 6). About one-quarter of respondents saw some change in the overall quality of care, its continuity, comprehensiveness, appropriateness, efficiency, and evidence base.

Most of the respondents' goals described earlier do not yet have corresponding results, even at an interim level, in particular those having to do with population change. Changes that were reported have to do with improved coordination and collaboration and increased motivation for and understanding of PHC. Presumably since few regions have evaluated initiatives, there is a limited evidence base with which to draw any definitive conclusions. Nonetheless, there is an impression that PHC renewal strategies are initiating more micro-level changes, such as with how providers work together and with other sectors.

Table 6: Outcomes of Primary Health Care Renewal So Far

OUTCOME	# OF RESPONSES		
	NOT AT ALL	SOMEWHAT	A GREAT DEAL
Overall quality of care:	1	9	3
Continuous	2	10	5
Comprehensive	2	10	5
Appropriate	2	10	4
Accessible	1	10	7
Effective	1	9	6
Efficient	4	9	4
Evidence-based	3	9	4
Health promotion	1	10	6
Disease and injury prevention	2	10	4
Management of chronic diseases	1	10	6
Self-care	7	5	6
Patient/client satisfaction	5	6	6
Overall health in the region	5	9	1
Sustainability of the region's health services	5	6	4

> The main changes that I have seen within our system and the care providers is a greater desire to work together. This includes trying to understand each other's roles, sharing both human and other resources, trying to work "out of the box" even though there are many union issues surrounding this initiative.
>
> There is also an increased awareness of other services in the community that our caregivers can access, and work in partnership with.

The most significant areas of change (and challenge) relate to new roles for some professionals and reframing of roles for other professionals. For those staff participating in the projects, they have been excited and encouraged by the multidisciplinary model. New roles such as the primary care dietitian and primary care nursing roles have been well received.

Some natural synergies have been created as a result of the convergence of the previous health districts. Networks and collegial relationships that previously may have only been informal are now enhanced. With its large size there is a critical mass resulting in some economies of scale in terms of service provision.

C. Conclusion

It is still very early in the process of PHC renewal and many initiatives are in the planning stages. Even among the initiatives reported as being in the implementation stage, there were some that were not very far along at all. However, it is evident that PHC renewal is widespread in Canada. Even if we made the very conservative assumption that all the RHAs who did not respond had no initiatives, we could still conclude that almost half of Canadian RHAs are undertaking PHC renewal. In those RHAs that are undertaking renewal, there is support and enthusiasm for it, in spite of an awareness of the challenges. PHC renewal is seen by many as key to increasing access to health services, especially for some under-served populations. It is also seen as a way to bring a more integrated and client-focused approach to health care delivery.

Multidisciplinary teams were reported in all provinces, although there were differences in the type of teams being implemented and teams on the whole remained predominantly physician-centred. Chronic disease management figured prominently in primary health care renewal.

There was activity reported in every province and our data did not reveal that any province was significantly ahead of or behind other jurisdictions. It became evident through respondent comments that the provincial frameworks and approaches are influential in the way RHAs develop strategies and initiatives, and many RHAs depend on provincial initiatives and support for the success of their plans.

The largest issue was providers. Although there were reports of providers being very enthusiastic about the changes, the issue of provider resistance was predominant. RHAs are waiting in many cases for provincial negotiations with medical associations to be completed in order to have a clearer path to follow. The question of "buy-in" by all providers looms large for RHAs. Will providers be able to practice in multidisciplinary groups? Can they learn to work as teams, abandoning former behaviours of turf protection? Respondents saw organizational change strategies of education and communication as being paramount in dealing with this resistance. They also expressed the need for leadership support at the regional and provincial levels. Sustained funding and appropriate funding mechanisms were also important.

RHA respondents overwhelmingly considered regionalization as a positive force for change with PHC renewal. The authority to bring all players together and to reallocate resources to areas of need was

seen as key to the success of PHC renewal. Respondents expressed a strong desire for more examples and models of how PHC can be organized and delivered. Just as there were no strong patterns emerging as yet among the provinces, there were none evident between urban and rural RHAs, other than pacing. Many RHAs are operating simultaneously in both urban and rural environments. However, because provincial initiatives have significant implications for regional ones and because of the differences in rural and urban settings, these two patterns will be important for us to monitor as PHC renewal unfolds.

We will also monitor the pattern of initiatives in PHC. In particular we will be interested in the extent of multidisciplinarity and integration they effect in the system. And finally, we will examine the evolution of barriers and facilitators. Have the change management and other strategies been effective? Are providers working together better? Have incentives been aligned? Is there better use of information in planning and allocating resources? And finally, the most important pattern to assess will be the extent to which the goals of PHC renewal of improving access, appropriateness and quality have been realized, with of course the expectation that PHC reform will have a positive impact on the population's health.

The World Health Organization (WHO) describes PHC's core principles as being community involvement in defining and implementing health agendas; equal access to comprehensive health care for all; integration with other sectors; and commitment to health equity and social justice. For optimal impact, PHC initiatives will be challenged in the upcoming years to grow along this continuum. Some RHAs are whole-heartedly embracing PHC philosophies and implementing initiatives consistent with this way of thinking, while others have not yet realized their full potential.

In a regionalized system, the leadership role of RHAs in developing PHC is key. We will continue to report the progress of both primary health care itself and the role of RHAs in implementing it.

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Appendices

I. Lists of Providers, Services and Outcomes Used in the Survey

PROVIDERS	SERVICES	OUTCOMES
Ambulance attendants	Illness and injury prevention	Quality of care:
Audiologists	Screening tests and vaccinations	▪ Continuous
Chiropractors	Health promotion	▪ Comprehensive
Dental care workers	Nutritional and lifestyle counseling	▪ Appropriate
Dentists	Education and support for self-care	▪ Accessible
Dietitians/nutritionists	Health assessment	▪ Effective
Licensed practical nurses	Telephone triage	▪ Efficient
Mental health workers	Pre-hospital emergency medical services	▪ Evidence-based
Midwives	Diagnosis and treatment of episodic illness and injuries	Health promotion
Nurse practitioners	Diagnosis and treatment of chronic illness and injuries	Disease and injury prevention
Public health nurses	Coordination and provision of rehabilitation services	Management of chronic diseases
Nurses	Supportive care in hospital, at home, and in long-term care facilities	Self-care
Occupational therapists	Reproductive care	Patient/client satisfaction
Opticians	Mental health care	Overall health in the region
Optometrists	Palliative care	Sustainability of the region's health services
Pharmacists	Occupational health	
Physicians	School health	
Physiotherapists	Public health	
Psychologists	Environmental protection	
Social workers	Community development	
	Case management including coordination of and referral to other health care services (such as specialists' services, home and long-term care, etc.)	
	Maintenance of comprehensive client health record	
	Specific services related to population needs, as identified by community consultation	

II. Classification of Responding RHAs: Urban/ Rural/ Mixed

RURAL RHAs

Interior Health, BC
Palliser Health Region, AB
East Central Health, AB
Prince Albert Parkland Health Region, SK
Five Hills Health Region, SK
Prairie North Health Region, SK
Sunrise Health Region, SK
Heartland Health Region, SK
Cypress Health Region, SK
Mamawetan Churchill River Health Region, SK
NOR-MAN Regional Health Authority, MB
Parkland Regional Health Authority, MB
Regional Health Authority – Central Manitoba Inc, MB
North Eastman Health Association, MB
Guysborough Antigonish Strait Health Authority, NS
Cape Breton District Health Authority, NS
South Shore Health, NS
Régie régionale de la santé Beauséjour, NB
Atlantic Health Science Corporation, NB
South-East Regional Health Authority, NB
Restigouche Health Services Corporation/
Corporation de services de santé de Restigouche, NB
Miramichi Regional Health Authority, NB
West Prince Health Region, PE
Kings Health Region, PE
East Prince Health Region, PE
Central East Health Care Institutions Board, NF
Central West Health Corporation, LF
Grenfell Region Health Service, NL
Health and Community Services Western Region, NL
Fort Smith HSSA, NT
Hay River HSSA, NT
Inuvik Regional Health & Social Services Authority, NT
Sahtu HSSSA, NT

MIXED RHAs

Vancouver Island Health Authority, BC
Regina Qu'Appelle Health Region, SK
Saskatoon Health Region, SK
Brandon Regional Health Authority, MB
RRSSS des Laurentides, QC
RRSSS de l'Estrie, QC
Health and Community Services – St. John's Region, NL

URBAN RHAs

Vancouver Coastal, BC
Fraser Health Authority, BC
Capital Health, AB
Winnipeg Regional Health Authority, MB
RRSSS de la Montérégie, QC

III. Additional Data Tables

TYPE OF INITIATIVE BEING PLANNED AND UNDERTAKEN BY PROVINCE

Type of Initiative	BC	AB	SK	MB	QC	NS	NB	PE	NL	NT	TOTAL
Any											
Undertaking	3	2	6	6	3	2	4	3	3	3	**35**
Planning	1	1	3	0	0	1	1	0	2	1	**10**
Total	*4*	*3*	*9*	*6*	*3*	*3*	*5*	*3*	*5*	*4*	***45***
Multidisciplinary Teams											
Undertaking	4	3	7	5	1	1	3	1	2	3	**30**
Planning	0	0	2	1	2	2	1	1	3	1	**13**
Total	*4*	*3*	*9*	*6*	*3*	*3*	*4*	*2*	*5*	*4*	***43***
Chronic Disease Management											
Undertaking	3	2	6	2	2	1	2	0	1	3	**22**
Planning	1	0	3	4	1	2	3	3	4	0	**21**
Total	*4*	*2*	*9*	*6*	*3*	*3*	*5*	*3*	*5*	*3*	***43***
Intersectoral Collaboration											
Undertaking	1	2	7	5	2	1	2	1	3	2	**26**
Planning	1	0	2	1	0	2	1	0	2	1	**10**
Total	*2*	*2*	*9*	*6*	*2*	*3*	*3*	*1*	*5*	*3*	***36***
Information Technology											
Undertaking	3	1	0	2	3	1	3	0	1	2	**16**
Planning	1	1	5	4	0	2	2	2	3	0	**20**
Total	*4*	*2*	*5*	*6*	*3*	*3*	*5*	*2*	*4*	*2*	***36***
Access 24/7											
Undertaking	2	2	4	3	1	1	1	0	1	2	**17**
Planning	2	0	0	1	1	1	1	0	1	0	**7**
Total	*4*	*2*	*4*	*4*	*2*	*2*	*2*	*0*	*2*	*2*	***24***
Other											
Undertaking	1	1	2	0	0	1	1	0	1	1	**8**
Planning	2	0	1	1	1	1	2	0	1	1	**10**
Total	*3*	*1*	*3*	*1*	*1*	*2*	*3*	*0*	*2*	*2*	***18***

TARGET POPULATIONS FOR TEAM-BASED INITIATIVES[1]

TYPE OF TARGET POPULATION	# OF RHAs
Rural Areas (including those with limited access to PHC services)	10
Specific Number of Residents Provided/ Entire Population of Area/ Neighbourhood	10
People with a Specific Condition (e.g.. Diabetes)	9
Population sub-groups (women, aboriginals, seniors, high-risk families)	6
To be determined based on community / individual identified needs	4
High-Risk Neighbourhood	2
People Who Access Physician Services	1

TYPES OF CHRONIC DISEASE MANAGEMENT INITIATIVES[1]

CHRONIC DISEASE MANAGEMENT	# of RHAs
Diabetes	27
Congestive Heart Failure/ Cardiac Rehab / Cardiovascular Disease/ Hyperlipidemia	11
COPD/Asthma	7
Chronic Disease Project/ Framework (generally in place to address many diseases)	12
Case Management Projects for complex care needs (AD; dementia; palliative care)	2
Depression /Mental Illness	3
Increased Focus on health promotion and prevention for diseases in region as part of PHC	4
Not yet determined specifically, but is being planned for	3
Use of IT/ Electronic Records / Software to create CDM profiles or improve CDM generally	3
Renal insufficiency/ dialysis	1
Long-term and Home Care	2
Cancer	1

REASONS FOR INTERSECTORAL COLLABORATION[1]

TYPE OF REASON	# OF RHAs
Increases collaborations and team efforts and improve care provided & increase focus on wellness vs. illness	22
Focuses on the broader determinants of health	7
Educates the public and promotes responsibility for health	3
Builds public engagement and community capacity	2
Consistent with PHC Renewal Principles	2

TYPE OF INFORMATION TECHNOLOGY INITIATIVE[1]

INFORMATION TECHNOLOGY	# of RHAs
EHR in specific locations or as pilots or in the regional generally	13
Participation in provincial initiatives for EHR	12
Using software for PHC in specific locations, other than EHR, e.g. for tracking services, surveillance, administrative purposes, etc.	5
Are interested, but at level of hope or investigation only	5
IT project specific to one program only (e.g. diabetes) for certain sites.	3

TYPE OF ACCESS INITIATIVE[1]

ACCESS 24/7	# of RHAs
Through telehealth provincial	14
Providers (physicians or nurses) on call	5
PHC Clinics provide services after hours (still may not be 24 hrs)	7
Remuneration method encourages extended hours	1
Satellite Services enhance access	1

ALTERNATIVE REMUNERATION FOR TEAM-BASED INITIATIVES[1]

TYPE OF ALTERNATIVE REMUNERATION	# OF RHAs
Provincial Model (i.e. being negotiated with Province's Medical Association)	9
Alternate payment plan (varies from block to sessional to contract to FFS payments depending on site and initiative; unspecified)	9
Salaried	7
Mixed Payment Model (contract; salary; FFS; all vary by physicians)	4
Capitation (based on a complexity analysis of rostered population)	2
Fee for Service	2

CHANGE MANAGEMENT ISSUES

	# OF RESPONSES		
ISSUE	TOTAL	CHALLENGES	STRATEGIES
Building capacity	38	11	27
Building relationships	22	5	17
Communication	10	1	9
Being realistic	8	1	7
Community education	7	3	4
Funding	4	3	1
Leadership	4	1	3
Provider issues	27	24	3
Community issues	3	3	
Resistance to change	19	19	
Information technology	3		3

[1] RHAs responses may have fit into more than one category, therefore numbers will not add up to the total # of RHAs participating in each specific initiative.

IV. Ontario

Distinct from other Canadian provinces that regionalized, Ontario has no regional health authorities to implement primary health care. Nevertheless, because we thought it was important to include Ontario in the national picture, we surveyed the District Health Councils (DHCs). DHCs have responsibility for planning and advising about the health and health services of specific regions, but no authority for delivery of services. Therefore the questions we posed to them were in the passive voice: Instead of asking what initiatives *they* had implemented, for example, we asked *what initiatives were being implemented* in their region.

Six of 18 Ontario DHCs responded to the survey. Four reported that PHC initiatives were being undertaken (67%) and the others reported that initiatives were being planned in their districts. Family Health Networks/ Groups, consisting of family physician practice(s) and nurse practitioners, were the most common type of multidisciplinary teams being undertaken (50%). This trend is related to the Ontario government's support for the creation of Family Health Networks/ Groups. It also provides funding for existing Community Health Centres (CHC) and Primary Care Networks. Another two DHCs reported the expansion of local CHCs. CHCs encompassed a wider range of providers, such as dieticians, social workers, community developers and health promotion workers – more similar to the PHC teams seen in other provinces.

Five of the six DHCs reported that changes to their district's physician remuneration structure were being planned or undertaken. Most new models use a combination of capitation and either fee-for-service with incentives or salary (67%), with one DHC referring to a range of alternate funding options for physicians in the district.

When asked about the barriers to PHC reform, Ontario DHCs indicated concerns relating to turf protection; inadequate government support; need for changed remuneration models; lack of sufficient funding to support initiatives; physician dominance of PHC model; a lack of exemplars; legal contracts and liability issues; and the need for an accountability framework. Of this list, professional protectionism and lack of support from government were the two points most frequently mentioned.

In contrast, several factors were identified as supporting PHC renewal in the DHCs. Government investments or funding, local champions, an accountability/ evaluation framework, evidence-based direction, an inclusive process with GPs, choice and flexibility of PHC models, changes to physician remuneration structure, and a focus on health outcomes (not only on health service activity) were all viewed by the respondents as facilitators to reform. For the most part, factors identified were similar to those voiced by the RHAs.