

*Primary Health Care, Nova Scotia Department of Health and Department of  
Family Medicine, Dalhousie University*

**Primary Care Research and Evaluation Meeting**  
*October 21 and 22, 2008 Meeting Report*

December 2008

Prepared by: Research Power Inc.



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# Introduction

## BACKGROUND

Primary Health Care, Nova Scotia Department of Health and the Department of Family Medicine at Dalhousie University have been supporting primary care research and evaluation over the last number of years. An Evaluation System/Framework for Primary Health Care and an Evaluation Reference Manual were developed to support District Health Authorities (DHAs) and other stakeholders in conducting primary care research and evaluation. The Department of Family Medicine at Dalhousie University is also engaged in several research activities related to primary care (e.g., measuring quality indicators, development and testing of a survey related to patient/client experiences with primary care programs and services, clinical research, etc.). Both Primary Health Care, at the Department of Health, and the Department of Family Medicine are interested in building on the work done to date by connecting all those working in this area around the province. A meeting was convened to facilitate sharing and to discuss moving forward to support primary care research & evaluation.

## PURPOSE OF THE MEETING

On October 21 and 22, 2008, a meeting was held to bring together key stakeholders from across the province to share experiences and learnings related to primary care research and evaluation and to discuss the development of a “system” for supporting primary care research and evaluation. More specifically, the objectives of the session were to:

- Provide an overview of the scope of the current meeting (i.e., a focus on primary care within primary health care) while recognizing the broader context of Primary Health Care (PHC) and importance of linking to this work.
- Showcase current initiatives related to primary care research and evaluation from across the province
- Discuss successes, challenges/gaps and opportunities related to primary care research and evaluation.
- Explore opportunities to develop a coordinated and “systems” approach to support primary care research and evaluation in Nova Scotia.

This report presents an overview of the presentations, results from the small group action planning, and participant evaluation. This report is structured to reflect the two substantive components of the meeting: the presentations made to share research and evaluation activities currently underway in the province and the working sessions to create action steps for the future.

# Overview of the Meeting

## WELCOME

The meeting began with a welcome from Lynn Hedley, Manager of Development, Primary Health Care, Nova Scotia Department of Health and Preston Smith, Head, Department of Family Medicine, Dalhousie University. It was noted that funding for the meeting was provided by Primary Health Care, Nova Scotia Department of Health who collaboratively planned the meeting with the Department of Family Medicine at Dalhousie University. Ms. Hedley noted that this meeting is an opportunity to make connections between DHAs, the Department of Health and Academia. Ms. Hedley emphasized the importance of keeping the clients at the centre of our work while striving to improve health outcomes for Nova Scotia.

Dr. Smith noted that the work of the Department of Family Medicine encompasses clinical work, administration, medical education, and research. Recent work has included visits to DHAs to discuss medical education and specifically how to work effectively with communities (distributed medical education). The importance of data and information for planning primary care, and linking primary health care and research were highlighted.

After the welcome and opening remarks, meeting participants introduced themselves and their interest in primary care research and evaluation. A list of meeting participants is provided in Appendix 1.

## CONTEXT

Fred Burge, Director of Research and Professor in the Department of Family Medicine at Dalhousie University and Stephanie Heath, the meeting facilitator, presented a brief background on primary care research and evaluation to help provide context for meeting participants. The planning committee who assisted with the development of the meeting process and agenda were introduced and acknowledged:

- Eunice Abaga, Primary Health Care, Nova Scotia Department of Health
- Fred Burge, Department of Family Medicine, Dalhousie University
- Judy Chisholm, Primary Health Care, Nova Scotia Department of Health

- Rosanne d'Eon, South West Health
- Bev Lawson, Department of Family Medicine, Dalhousie University
- Stacey Lewis, Tui'kn Partnership

It was noted that primary care is nested within primary health care (PHC) and an overview of each was provided. Primary health care (PHC) is broad and encompasses population health approaches whereas primary care is one aspect of PHC that is focused on health service delivery including health promotion and disease prevention, acute episodic care, continuing care of chronic conditions, education and advocacy. It was noted that the focus of the current meeting was on primary care in order to focus the discussions and ensure the scope was manageable. However, the broader context of primary health care and linkages between PHC and primary care are recognized. The importance of building on existing capacity was highlighted which includes the provincial Primary Health Care Evaluation Framework/System report and the Primary Health Care Evaluation Reference Manual (both produced by Primary Health Care, Nova Scotia Department of Health in collaboration with key stakeholders across the province).

In addition there are many research and evaluation initiatives underway within District Health Authorities, provincially (e.g., the Nova Scotia Health Policy Research Centre, PHIM, etc.), through university research groups, within local communities (e.g., Aboriginal PHC initiatives such as the Tui'kn partnership) and nationally (e.g., Canadian Institutes for Health Information [CIHI], CIHR and CHSRF). It was noted that the intent of the current meeting is to build on this work to discuss strategies for linking and coordinating, and building a system for primary care research and evaluation.

A review of the agenda was provided and it was noted that there would be: presentations showcasing current initiatives; small group work to identify other primary care research and evaluation work in the province; small group work to identify challenges and opportunities for primary care research and evaluation; presentations on potential opportunities through the Nova Scotia Health Research Foundation (NSHRF) and Primary Healthcare Information Management (PHIM); and small group work to identify supports/strategies for moving forward.

## PRESENTATIONS

### ◆ Showcasing Current Initiatives

The evening session on October 21<sup>st</sup> and the first part of the agenda on October 22<sup>nd</sup> provided the opportunity for participants to learn about examples of primary care research and evaluation currently underway throughout the province (six initiatives were presented). Two other presentations were also provided (during the afternoon of the second day) to highlight opportunities and support for primary care research and evaluation through the Nova Scotia Health Research Foundation (NSHRF) and the Primary Healthcare Information Management Program (PHIM). Table one provides an outline of the presentations followed by a summary of the presentations (the handouts from the slides are provided in Appendix 2).

**Table 1: Presentations**

Subject	Presenter
The ANCHOR Project	<ul style="list-style-type: none"> <li>Ms. Claudine Szpifogel, Project Manager of the ANCHOR project and Principal, Research Power Incorporated</li> </ul>
Population Surveys in Primary Care	<ul style="list-style-type: none"> <li>Dr. Fred Burge, Director of Research and Professor, Department of Family Medicine, Dalhousie University</li> </ul>
A Community Registry/Health Information Systems	<ul style="list-style-type: none"> <li>Ms. Stacey Lewis, Manager, Tui'kn Partnership</li> </ul>
Evaluation of Advanced Access and a Mobile Breast Screening Unit	<ul style="list-style-type: none"> <li>Ms. Elaine Rankin, Director of Population Health and Primary Care, Cape Breton District Health Authority</li> </ul>
Measuring Team Effectiveness	<ul style="list-style-type: none"> <li>Ms. Ismay Bligh, Primary Care Facilitator, Annapolis Valley Health (AVH); Mr. Brad Osmond, Community Planning, AVH; Ms. Stephanie Heath, Principal, Research Power Incorporated</li> </ul>
Measuring Quality Indicators in Primary Health Care Teams	<ul style="list-style-type: none"> <li>Ms. Bev Lawson, Research Associate and Lecturer, Department of Family Medicine, Dalhousie University</li> </ul>
The Nova Scotia Health Research Foundation (NSHRF)	<ul style="list-style-type: none"> <li>Meredith Campbell Manager of the Capacity Program and Jennifer McNutt, Manager of the Health Research &amp; Matching Grants Program, NSHRF</li> </ul>

Subject	Presenter
Primary Healthcare Information Management Program (PHIM)	<ul style="list-style-type: none"> <li>Pam Biggs, Application Business Analyst, PHIM Program</li> </ul>

### Presentation 1: The ANCHOR Project

Ms. Szpilfogel provided an overview of the ANCHOR project (A Novel Approach to Cardiovascular Health by Optimizing Risk Management). The project is a three year collaborative research initiative with the goal to improve cardiovascular disease (CVD) risk in a primary care adult population. The one year intervention consists of a health risk assessment (HRA), review of the HRA results, establishment of risk factors, risk stratification, and behavioural intervention by a team of inter-professional providers. The research methodology was briefly reviewed and consists of a classic standard experimental design and a pre-intervention and post-intervention longitudinal study with a comparative group to evaluate participants' achievement of CVD risk reduction. A subcomponent of the main research is a minimal intervention study which will evaluate the efficacy of different levels of interventions to maintain or further enhance the improvement in health outcomes produced by the original ANCHOR behavioural intervention. An economic evaluation is also being conducted to assess the incremental cost per coronary event avoided, coronary death avoided and Quality Adjusted Life Years gained.

The research and evaluation design also consists of a logic model linking activities to outputs and outcomes, and an evaluation matrix where indicators were mapped to the outputs and outcomes. Both quantitative and qualitative methods are being used and include the HRA and ANCHOR database were quantitative measures such as behaviour change variables, risk scores, demographics, etc. are being gathered; focus groups and interviews with key stakeholders and participants to assess process measures such as challenges and facilitators to the initiative and the portability of the model; and a participant survey to assess participant satisfaction and lifestyle changes. The presentation concluded with some highlights of an interim evaluation conducted in December 2007.

### Presentation 2: Population Survey in Primary Care

Dr. Fred Burge provided a presentation on a survey that has been developed and implemented in three districts of the province related to patient reported outcomes of quality primary care. The original survey was adapted from an existing United Kingdom instrument and the Nova Scotia version, called the Primary Care Practice Survey (PCPS), piloted tested in 2003 with further testing and revisions in 2004. The following areas of interest are tapped by the survey: access (and use of services), communication,

continuity, enablement, prevention, patient provider relationship, and overall patient satisfaction.

The various administrations of the survey (in the three DHAs) were reviewed. In three cases the survey was administered via telephone to a random sample of community members. In the fourth administration, the survey was mailed to a random sample of clients of a practice. Some of the challenges and opportunities with the methods were highlighted. Highlights of the results from the various administrations were presented including practice implications. Dr. Burge noted how the survey has helped to connect research and practice, specifically, the work has helped to:

- Measure and compare public perception of primary care in different regions among different groups of people
- Develop a measure for the practice level
- Have a “tool” to measure “change” as it occurs with new initiatives

The presentation concluded with an overview of the resources required to administer the survey including: the survey development research/evaluation team, clinical providers with content/context knowledge, administrative/decision makers, and the contract telephone survey company.

### *Presentation 3: A Community Registry/Health Information Systems*

Ms. Lewis provided a presentation of the work of the Tui’kn Partnership during the Primary Health Care Transition Fund as well as continued work of the partnership in evaluation and the development of health information systems. It was noted that the Tui’kn Partnership consists of five First Nations Bands in Cape Breton who are working collectively to help each other to achieve better health (“mawi apoqmaltutinej klaman kis aji welo’ti’tisnuk”). The goals of the Tui’kn Partnership (originally called the Tui’kn Initiative) were reviewed and they are to: create multidisciplinary PHC teams, create mechanisms for collaborative health planning, and build capacity for local control of health information. Through the Tui’kn Partnership work is underway to sustain gains made through the Tui’kn Initiative (e.g., telehealth, maternal child health project, preparing for the implementation of Panorama, feasibility study on the provision of midwifery, and others).

The Tui’kn Partnership is also doing work to measure the impact of primary care change in their communities including access, quality and health outcomes. A list of indicators has been developed and priorities are being established based on feasibility, validity and relevance with the aim of developing a common set of indicators that can be tracked by all five communities. The Partnership is working to create/secure health information tools and skills to help measure the indicators and document primary care needs by: using databases such as the electronic patient record (EPR); creating a client registry; creating the Unama’ki Health Information System; and developing local health information

analysis skills. Each of these was described and it was noted that the communities are just beginning to use the health information tools. The health information system (HIS) will be used to develop a chronic disease surveillance system and both the HIS and EPR will help to evaluate the impact of PHC changes (e.g., complication rates, readmission rates, ER use, etc.).

Future work will include developing a web-based query and reporting tools, linking the community registry with provincial health program data, linking the HIS with non-insured health benefits, further improving the accuracy of the registry and developing processes for routinely updating it, and enhancing local capacity for data collection, management, analysis and reporting. The presentation concluded with a summary of the limitations of EPRs and the HIS.

#### Presentation 4: Evaluation of Advanced Access and a Mobile Breast Screening Unit

Ms. Rankin provided an overview of an evaluation of advanced access and a cancer screening project underway in Cape Breton. The national and local contexts related to PHC were reviewed and the rationale for the advanced access provided (i.e., patients were unable to access primary care services and visiting the emergency room [ER] for minor complaints). The project objectives were described: increased awareness of advanced access among GPs; increased number of practices using advanced access principles; reduction in non-urgent ER visits; increased satisfaction by all; and the development of local and provincial champions for advanced access. The principles, advantages and disadvantages of advanced access were reviewed along with the implementation plan. Highlights of the results were provided, illustrating the potential for advanced access models to improve patient access and care. Other impacts such as effects on staff and positive system level changes were also highlighted.

An overview of a team-based cancer screening project and its evaluation was also provided. The objectives of the initiative include: increased emphasis on health promotion, disease prevention and chronic disease care (10 World Cancer Prevention Recommendations), improved coordination and integration with other health services, and to facilitate greater use of multi-disciplinary teams. The model and evaluation framework for the project were both reviewed. The presentation concluded with highlights of other research and evaluation initiatives underway within Cape Breton District Health Authority.

#### Presentation 5: Measuring Team Effectiveness

Ms. Bligh, Mr. Osmond and Ms. Heath presented on an evaluation of four interdisciplinary teams in Annapolis Valley Health. The team survey in the Provincial PHC Evaluation Framework was adapted and implemented in three Community Health Centres and one collaborative practice. The survey was administered online, however shortly after the survey link was distributed, the DHA could no longer use the online survey tool due to concerns from the Department of Health with confidentiality and use

of the data (as the web-based tool is American based). Therefore the survey was also administered through the mail. Team sizes ranged from six to 22 members and the survey consists of both closed and open ended questions. The key domains assessed by the survey are demographics, team functioning (e.g., decision making, vision and leadership, role clarity, etc.), general work satisfaction (e.g., patient/client care, patient/client relationship, safety, etc.), collaboration and continuity of care, and professional development and skills.

Highlights of the findings were presented from the four teams and revealed variability in satisfaction with team functioning, consistency in general work satisfaction, variability in satisfaction with collaboration and continuity of care, and a range of professional development opportunities. The challenges and benefits of the survey were also highlighted. The presentation concluded with a discussion of next steps which include a presentation of the findings to the teams, a reflective session or focus group with the teams to further explore and understand the findings, continuing to prioritizing evaluation needs, and securing financial resources to support on-going evaluation.

#### *Presentation 6: Measuring Quality Indicators in Primary Health Care Teams*

The presentation, by Ms. Bev Lawson, began with a definition of quality indicators (QI), also known as quality of care indicators, performance indicators, and performance measures: *a standardized measure that has been created using evidence-based or agreed upon information to assess or describe the functioning of a health care structure, process or outcome*. It was noted that the focus of the current presentation is on clinical or technical effectiveness. Uses of QIs include strategic planning and priority setting, to support quality improvement, reporting of health information to the public and as an evaluation tool following program implementation.

An overview of an assessment of clinical quality of PHC in a collaborative practice in Capital Health was provided. It was noted that approximately 50% of QIs require data from patient charts or electronic records. In the current assessment, a chart audit tool was developed (based on the NS PHC Evaluation framework QIs and national CIHI QIs). The purpose of the review was to provide a baseline of clinical quality that will be used to assess changes over time with the implementation of enhanced service models. The methods were reviewed including sampling procedures and sample size. It was highlighted that in determining sample size there is a trade-off between precision in the final estimates (narrow confidence intervals) and the cost/work load to retrieve and manually audit charts. An overview of the chart audit tool was provided including examples of the quality indicators. Highlights of the results were provided including where indicators revealed good quality care as well as areas where there was room for improvement. The presentation concluded with an overview of the resources that were required to conduct the chart audit (e.g., people, ways to identify subgroups, space, and financial resources).

### **Presentation Questions & Comments from Participants**

Question/Comment: There is a national survey that is looking at patient experiences with primary health care. What is the link of the provincial community survey (i.e., the survey reviewed by Dr. Burge) to this work?

Response: In developing the national survey, stakeholders such as Dr. Burge were consulted and therefore some of the items on the provincial community survey are also on the national survey. The current status and plan for the national survey is not known. However, there may be opportunity to further inform this survey work and access provincial level data (whether the data can be pulled at the district level needs to be explored).

Response: There are also opportunities to use the Canadian Community Health Survey, which has some primary care questions. This data can be accessed at the district level if the sample is large enough and DHAs can have input into questions by October 31, 2008 (by contacting the Department of Health).

Question/Comment: The clinical outcome data and stages of change data being gathered in the ANCHOR project is interesting.

Response: The evaluation and research re: the stages of change data is assessing if clients move along the continuum of behaviour change. The Team collaborative days being done in districts with support through PHC, Department of Health will be looking at knowledge and skills development re: behaviour change (Michael Vallis).

Question/Comment: There is a need to incorporate evaluation into the day to day work of Teams so it is part of the way of working and not intimidating.

Response: Evaluation is part of the plan, study, do, act cycle which many individuals and providers are familiar with (part of quality initiatives).

Question/Comment: How can we ensure effective knowledge exchange so that the evaluation findings and research get to the end users to help them better manage patients and improve practice?

Response: More effective knowledge exchange is required and there are examples of effective dissemination of information that we can learn from (e.g., the Australian PHC Information and Research System which is web based, systems in Manitoba and Calgary). There is also the need for effective social marketing – using the right communication channels, effectively connecting, etc.

Question/Comment: There is a need to ensure effective ways to collect information on race, ethnicity, language. Although there are challenges with asking such questions (e.g., self identification bias, confidentiality, etc.), there are best practices related to how to ask these questions.

Question/Comment: In advanced access models, how does it work for scheduling appointments for preventative health and chronic care (e.g., seniors may forget to call for a follow up re: hypertension or diabetes).

Response: Some times can be saved for booked appointments and there is the need to educate the patient population about the approach. In addition, with electronic systems there is the ability to create registries and implement recall approaches.

Question/Comment: Do you envision a world where there will be baseline QIs across the province?

Response: Having a core set of QIs would be ideal and the project based work underway is helping to test the feasibility of the indicators. In addition, there is a research project underway within the Department of Family Medicine looking at the feasibility of QIs and EMRs to obtain data. CIHI is also continuing work on QIs including creating a subset of the original list of indicators and working with vendors to ensure a minimum standard of functionality to report on QIs.

## ◆ **The Nova Scotia Health Research Foundation and Primary Healthcare Information Management**

### Presentation 7: The Nova Scotia Health Research Foundation (NSHRF)

The presentation began with background information about the NSHRF which became operational in 2000 with the mission *to help improve the health of Nova Scotians through the development and support of a vibrant and sustainable health research community in Nova Scotia to the extent possible with efficient use of available funds*. The categories of research supported through the NSHRF include medical, health outcomes, health services and health policy research. Several of the initiatives of the NSHRF were reviewed including the Researcher Directory, the Capacity Program, and the Health Research Program.

The NSHRF created the Researcher Directory, a web-based and fully searchable database that is a tool for networking and finding experts in certain fields. The Capacity Program is designed to create, strengthen and maintain the health research community in Nova Scotia, build and maintain the tools and skills to support the health research infrastructure (including human resources) and contribute to building a health system that integrates and applies health research. It consists of competitive capacity grants (this includes the community research alliance grant, the development/innovative grant, the team development grant and the NSHRF sponsored workshop grant), research capacity awards (research skills award, proposal development award, and special consideration award), and support to the health research community (health research grants and student research awards). Several of the awards and grants were noted as potential opportunities to help support primary care research and evaluation including the Community Research Alliance Grant, the NSHRF Sponsored Workshop Grant, the Special Consideration Award, and the Collaborative Health Research Project Grant.

The presentation concluded with an overview of the Health Policy Research Centre (project phases and status, members of the steering committee, the working groups, pillars, potential benefits for Nova Scotia and the next steps) as well as other potential opportunities for primary care research and evaluation (e.g., CIHR and CHSRF).

### Presentation 8: Primary Healthcare Information Management (PHIM)

PHIM is Nova Scotia's EMR program that was launched in 2005 and consists of the Nightingale web-based EMR hosted by the province. It was noted that there has been 32% adoption to date with 59 clinics, 210 physicians and 19 nurse practitioners implementing the system. A suite of supports and services are available to promote successful EMR adoptions including the hosted Nightingale EMR, funding for software, licensing, training, a service desk, champion and peer network programs, a user group, ongoing standards development and alignment with the Department of Health's evolving health system improvements. There is the intention to develop a provincial decision support system with the potential to evaluate what is working and areas that require more attention. In terms of data access, the data governance policy for PHIM limits the access

to the systems to the clinics, and physicians determine who has access to patient data. Further, clinics currently have limited reporting abilities enabling them to run against their own clinic's data. Reportable clinical data and reportable administrative data that clinics can access were reviewed. The presentation concluded with a review of decision support priorities (evaluation of NS Hearing and Speech; provincial priorities including chronic disease management, wait times, underserved populations, other provincial priorities; and in the longer term exploring the fit with CIHI PHC indicators).

#### **Presentation Questions & Comments from Participants**

Question/Comment: What about other providers using the electronic system and the ability to link between providers?

Response: This is being built into the system and the potential is there for other providers to document care and connect systems.

Question/Comment: What will be done to support physicians who are using other systems (e.g. translating data from other systems such as practimax). To date, the rumor is that there will not be support for this translation which in effect penalizes family physicians who implemented electronic systems prior to PHIM (who selected Nightingale as the vendor). For this reason a single vendor approach is not ideal and not supported by all.

Question/Comment: It is important to remember that the EMR is a tool for caring for patients versus providing data. There is the potential to create more work for providers in completing numerous fields. In addition, it is important not to lose the narrative and the stories.

Question/Comment: Functionality that is required is a "comma delimited file" exportable feature.

## **WORKING SESSION: ACTION PLANNING**

After the showcasing presentations, meeting participants worked in small groups to identify current initiatives related to primary care research and evaluation underway within the province. The results of this brainstorming is presented in the table below including the name of the initiative and contact information (if available). Following the brainstorming of current initiatives related to primary care research and evaluation, participants worked with a facilitator to identify challenges and opportunities related to primary care research and evaluation. The small groups were asked to identify the top three challenges and opportunities, which the facilitator shared with the larger group during a report back session. The worksheets from the facilitators were reviewed, with key themes identified and the information synthesized below.

## ◆ Current Initiatives Related to Primary Care Research and Evaluation

**Table 2: Initiatives Related to Primary Care Research and Evaluation**

Initiative	Contact
Community Health Board Survey in January 2009	AVH, Bard Osmond
Pre Diabetes Screening	AVH, Susan Miles
Diabetes Care Project – pulled all pts from DCPNS, recalled Family Doctors to follow up with patients	AVH, Susan Miles & Bev Harris
Health Promoting Schools (overweight/physical activity/self-esteem, CPHI funding, CIHR – economic analysis)	AVH, Ismay Bligh
YHC – impact assessment tool in development	AVH, Ismay Bligh
AHTF – Mental Health Addictions, Path Less Travelled, Abor Health Awareness Project – Policy Framework	SSH, Krista Knickle
Want to do baseline measures with a new practice.	SSH, Heather Hopkins
Effectiveness of GP/NP collaborative practice (2003), logic model & indicators (complete) Want to implement a team and client survey and do a chart review, submitted an expression of interest but there are no resources.	SSH, Krista Knickle and Heather Hopkins
Pictou Landing First Nations, PCHA	PCHA, Duane MacInnis
Community survey (from the provincial framework)	PCHA, Jennifer McCarron
Logic Model and evaluation framework for the West Side Team that includes four data collection methods – the practice survey, team survey, chart audit and client satisfaction survey	PCHA, Jennifer McCarron
Family Help Program, MOM Program	IWK, Cindy Brannen
Child Safety Link – Car Seat Safety; Children’s Injury Risk Due to Toppling Furniture: Parental Knowledge, Attitudes and Risk Reduction Behaviour	IWK Health Centre, Sandra Newton
Extra Support for Parents	IWK Health Centre
Spiritual Health – pre-adolescent spirituality (identifying and planning for spiritual needs for ill children); pregnancy and religious diversity; assessing the demographics and associated spiritual/religious needs of families cared for by the IWK Health Centre	IWK Health Centre, Glen Breen
Read to Me! Program; Managing our Mood; Family Help	IWK Health Centre, Patrick McGrath
Children’s Neurosciences, Surgical and Rehabilitation Care - Child Life involvement in pain management (Linda Skinner); Pediatric Rehab (Paula Hutchinson); IWK Autism Team (Susan Bryson)	IWK Health Centre
Youth Justice Services	IWK Health Centre, Ruth Carter
NS Youth	IWK Health Centre, Noni McDonald

Initiative	Contact
Bullying	IWK Health Centre, John LeBlanc
The Duffus Health Centre Project – Collaborative Team, APP, EMR, practice survey, audits	Capital Health, Shannon Ryan and Lynn Edwards
Nurse Practitioner evaluation, Hantsport	Capital Health, Lynn Edwards and Shannon Ryan
Chart audit in other practices	Capital Health, Lynn Edwards and Shannon Ryan
Family Practice Nurse Initiative Evaluation – Practice Survey, Chart Audit Tracking Forms, Client & Team Survey	Capital Health, Shannon Ryan
prideHealth Evaluation	Capital Health, Shannon Ryan
Community Health Team Initiative	Capital Health, Shannon Ryan
Survey for “street” involved providers (Community involvement)	Capital Health, Lynn Edwards
Health needs of African N.S., Preston – Cherry Brook, HAAC	Capital Health, Sharon Davis Murdoch
Provincial programs fit in with PHC, integration – coordination	DoH, Sharon Davis Murdoch
Team Program	GASHA, Lee Ann Murphy
AHTF – MOU – FN & GASHA	GASHA, Peggy Mahou
Social Inclusion & Diversity Screening Project	GASHA, Connie Venedam-Marchand
Pre-diabetes Project	GASHA, Connie Venedam-Marchand
Lindsay Women’s Health Centre	GASHA, Connie Venedam-Marchand
Men’s Health Centre	GASHA, Connie Venedam-Marchand
Well Women Initiative	GASHA, Connie Venedam-Marchand
VON Chronic Disease Screening Project	GASHA, Dawn MacIsaac
Meditech Profiles, Medical student, Evaluation for mammography team approach	CBDHA, Lorianne MacLean
Nurse Practitioner Consumer Survey – satisfaction (small), Plan to expand; Evaluation – mental health/addictions – Clare, Joint District 2 & 3 with mental health & discharge planning – aboriginal	South West Health, Tracey Gerber
Health Status Profile	CHA, Robin Latta
Student teams working together, Interdisciplinary, DHA into PHC, Develop opportunities, Students want this/medicine	Dalhousie University, Anne Godden-Webster
➤ Rural Model of Care – Long & Brier Island (NP – Paramedics – GP)	Dalhousie University, Ruth Martin-Misener (Nursing)

Initiative	Contact
<ul style="list-style-type: none"> <li>➤ NP/GP in LTC Northwood, year 2</li> <li>➤ Practice Pattern Survey of PHC NPs in N.S, National plus N.S</li> <li>➤ Prescribing patterns of NP (PHC) in N.S.</li> <li>➤ CHSRF REISS – How PHC &amp; PHS collaborate to enhance PHC, 3 more years</li> <li>➤ CIHR – NPs in LTC across Canada</li> <li>➤ Lit Review – CDN literature to advanced clinical practice nursing (NP etc)</li> </ul>	
<ul style="list-style-type: none"> <li>➤ CIHR Delphi – core indicators (PHC)</li> <li>➤ Clinic quality indicators – within office practice choose 6</li> <li>➤ National Public Health Agency CDN</li> <li>➤ Family practice – network of networks</li> <li>➤ How EMR assist with CDM 2<sup>nd</sup> wave</li> <li>➤ Vendor database Nightingale</li> <li>➤ DU – 90 – Drug utilization – 90% of drugs Rx – internal quality improvement using Practimax – how use data within practice</li> <li>➤ Tutor – National training program for interdisciplinary PHC researchers – 5 persons, grad students – added program (1 yr)</li> <li>➤ National – attributes of PHC</li> </ul>	Dalhousie University, Fred Burge (Family Medicine)
Senior citizen's oral health	Dalhousie University, Mary MacNally (Dentistry)
Maritime Group of Physicians – do research	Dalhousie University, Fred Burge & Wayne Putnam (Family Medicine)
Post doc fellowship – Interdisciplinary context of PHC models	Charmaine McPherson
Primary Care – Working with First Nations on a Shared Care Project, Logic Model & Quality Indicator Development, Need evaluation plan sensitive to aboriginal perspective	
Primary Care – Health Status Profile, all/First Nations, Integrate with PC	
Working with Dalhousie to evaluate NDSS case definitions in FN communities	Tui'kn Partnership
A1C Tracking Tool (Diabetes Project), work in progress	Truro, Ryan Sommers
PHIM – Expansion, Prioritize needs	DoH, Pam Biggs
<ul style="list-style-type: none"> <li>➤ Colorectal, pre-screening RCP sickle cell &amp; blood disorders</li> <li>➤ DCPNS – guidelines for cultural competency</li> <li>➤ CDSM – Way to Wellness</li> </ul>	DoH, Eunice Abaga
Researcher Directory	NSHRF
Community Geriatric Navigator	Krista Buchanan

## ◆ Challenges Related to Primary Care Research and Evaluation

The worksheets and/or flip charts from the small group work were reviewed and common themes across groups identified. The findings of the thematic analysis of the work sheets are presented below and the verbatim recordings from each of the small groups are provided in Appendix 3. The top three challenges identified by each group are also presented including a synthesis across groups (in the text box below).

### Resources and Capacity

- A lack of human resources and expertise for primary care research and evaluation; there is a need for mentoring around various elements of primary care research and evaluation (e.g., survey and tool development, methodologies, data analysis and reporting, etc.); there is a need to build in-house capacity; there are no local medical schools and a lack of experienced evaluators locally (geographic barriers); think about what is “good enough for our purposes” so costs are reasonable.
- A lack of time and money to do primary care research and evaluation; it takes time to plan evaluation, select indicators, conduct surveys; often team members are not interested in the process, just the results.
- There is a need to build linkages/partnerships with academic centres (researchers and evaluators) to connect with like minded people, however identifying these academics can be challenging, and primary care and academia are very different worlds – there is the need to build relationships and trust. Linking with academic centres is more challenging in remote, rural areas; there is a need to have researchers at the table at the beginning.
- Decision support is a potential resource; however, these district departments are constructed around acute care rather than primary care.
- There is fear associated with doing evaluation and research – a fear of not doing it right.
- Ensuring tools are applicable, response rates are adequate, data is valid, balance between rigour and practicality, consistency in charting.

### Knowledge Translation and Exchange

- A lack of knowledge translation and exchange; challenges with communication and knowledge sharing provincially, nationally and internationally.
- Ensuring information dissemination to multiple sites; ensuring the results and final products are useful and relevant to inform policy and practice.

- There is a lack of awareness about who is doing what, how we can share, ensuring data gets back to the frontline providers (e.g., there is a need to get better at completing the feedback loop – indicators are measured as part of the quality framework, which then goes to the DHA Boards but it does not always get back to the front line people).

### Access to Data and Linkages

- A lack of access to data (primary and secondary); costs to accessing data can be prohibitive; lack of data infrastructure.
- Accessing and using data from provincial programs – the programs “own” the indicators; there is a need to build awareness about how provincial programs and their databases can support DHAs to do evaluation and research; there is also a need to improve communication between provincial programs and Primary Health Care.
- A lack of data and access to data to measure the indicators in the provincial framework; challenges in obtaining data on vulnerable populations (e.g., privacy issues, a lack of instruments and questions re: identification of race, ethnicity); a lack of baseline data (where are we starting).
- There is a need to link data sets (e.g., data from PHRU, MIS, MSI, Meditech, etc.).
- Challenges in using EMR data due to the fact that family physicians “own” the data (i.e., challenges to secondary use) and concerns with maintaining confidentiality.
- A lack of coordination and connection with several silos working in isolation (e.g., the Department of Health, DHAs, provincial programs, MSI, MIS, PHRU, etc.).

### Leadership and Engagement

- System readiness to support primary care research and evaluation (this links to the fact that there is a lack of funding, time, data infrastructure, etc.).
- A lack of leadership and champions; lack of a provincial perspective and approach; need to identify the supports such as tools, etc.
- Primary care research and evaluation are not priorities; the people who need to participate in evaluation do not necessarily see it as a high priority; how do we make it a priority to the teams?
- A lack of provider engagement (evaluation should be part of their role), particularly physicians in fee for service practices; there is need for dedicated clinician time to plan and implement evaluations.

Complex and Long-term

- There are challenges in identifying what needs to be measured (identifying priorities); there is a need to narrow the scope to a common set of indicators.
- Issues related to ethics, such as ensuring appropriate approval processes in a timely manner.
- Overall policy change may be needed to support more costly research initiatives but at the community level, more “simple” and straight forward evaluation may be adequate.
- Many of the health outcomes that are being measured in primary care are long term; there is pressure to affect change and show results in the short term.

**Top Challenges**

*Resources and Capacity to support primary care research and evaluation including human resources and expertise, financial resources, data infrastructure (e.g., data and access to data, instruments, etc.), linkages and access to academia. Noted by all four groups*

*Knowledge Translation and Exchange including ensuring findings are shared with and relevant to practitioners, building awareness about what is happening in Nova Scotia related to primary care and PHC. Noted by two groups*

*Coordination and linkages to facilitate better integration of data, tools, measurement, researchers and evaluators, etc. across all health sectors (e.g., primary care, PHC, public health, provincial programs, etc.). Noted by two groups*

*Leadership to build system readiness, develop capacity, dedicate resources, ensure primary care research and evaluation is a priority, engage providers, etc. Noted by two groups*

## ◆ Opportunities Related to Primary Care Research and Evaluation

The worksheets and/or flip charts from the small group work relating to the identification of opportunities for primary care research and evaluation were reviewed and common themes across groups identified. The findings of the thematic analysis of the work sheets are presented below and the verbatim recordings from each of the small groups are provided in Appendix 3. The top three opportunities identified by each group are also presented – these are bolded in the list below.

- **Explore the development of a network for primary care research and evaluation (this could be virtual); seek opportunities for multi-site research (not more money but money better spent); facilitate collaboration to support primary care research and evaluation (e.g., universities, between DHAs, Quality Initiatives, etc.).**
- **Explore provincial guidelines for primary care research and evaluation in collaboration with DHAs to help ensure leadership for primary care research and evaluation and that it is part of the strategic direction.**
- **Build consensus on a handful of indicators to be measured across DHAs; this needs to be led by someone (provincially) and supported within districts.**
- **Develop and support a system for mentoring/tutoring to support primary care research and evaluation.**
- **Explore opportunities for DHAs and researchers to inform the work of the Health Transformation office; ensure leaders who actively listen are at the table.**
- **Continue to build awareness and interest in primary care research and evaluation; build on the current momentum; continue to build on the work already done through the development of the PHC Evaluation Framework and the PHC Evaluation Reference Manual (e.g., availability of indicators, available data sources such as through RCP, DCPNS, CCNS, etc.); capture the energy and identify next steps; ensure the work is updated and kept current; data can be used at the CHB and DHA level to focus initiatives.**
- **Include evaluators and researchers as part of the plan from the beginning when implementing enhanced care models.**
- **Use PHIM to support primary care research and evaluation; electronic systems are improving and there is potential for better and more consistent recording of data; better quality of data should be available for review in the future.**
- **Link to and incorporate primary care research and evaluation into the Health Policy Research Centre.**
- **Access opportunities through the NSHRF.**
- **Explore opportunities to access and link to existing databases and systems such as MSI, HIT-NS, EMRs, Meditech, etc.**
- **Engage individuals in district practice, (e.g., family physicians, providers, etc.) who are interested, to foster a supportive culture for primary care research and evaluation; leadership is needed at the provincial level as well as from DHAs.**

- Explore incorporating support for primary care research and evaluation into Alternate Payment Plans (APPs).
- Add evaluation to the regular agenda of the PHC Working Group and to the Nurse Practitioner Working Group.
- Invite Primary Health Care to other tables such as palliative care.
- Approach chart audits through processes such as academic detailing.
- Submit proposals to Primary Health Care, Department of Health to support primary care research and evaluation.
- Explore opportunities to harmonize ethics submission processes.
- Explore opportunities to measure race, ethnicity, language, etc.
- Provincial programs are beginning to collaborate which presents opportunities to support more effective primary care research and evaluation.
- Use the best practices portal through the Public Health Agency of Canada (PHAC) to support primary care research and evaluation.
- Explore the assessment of team variability (e.g., team size, number and type of professionals, etc); look at the differences between teams working in communities; if there were more evaluations from various areas there could be the opportunity to compare at the provincial level.

### ◆ **Moving Forward to Support Primary Care Research and Evaluation**

During the final small group working session participants were asked to move the discussion related to opportunities forward to more concrete suggestions by reflecting on *what needs to be done or put in place to support a systems approach to primary care research and evaluation*. Participant were asked to prioritize their ideas by identifying the two to threes ideas or quick wins that they felt should/could be implemented within the next year. The worksheets where the group discussions were recorded were reviewed for common themes and synthesized. The synthesis of the ideas generated as well as the quick wins or next steps are presented below and the verbatim recordings are presented in Appendix 3. (The “quick wins” identified by the groups are bolded)

- **Create a network for primary care research and evaluation, including a central leadership team to lead its development (identification of a leader to move the process forward, requires mandate and resources, identify the vision, ensure expertise, coordination, strategic direction). The network would facilitate capacity building and could be web based and virtual, and**

**through the network create a database of individual knowledge and skills. Leadership at the provincial and DHA/IWK level is required to support the development of a successful network. The network could help to facilitate connections between universities/colleges/research institutions and DHAs and the IWK Health Centre.**

- **Establish and populate a core set of primary care indicators.**
- **Set up a forum or meeting to resolve outstanding issues such as defining and building understanding about a systems approach, use of EMRs, data sharing, etc.**
- **Develop an inventory of data sources that outlines where districts can access data and processes for coordination of data.**
- Continue to facilitate the implementation of EMRs and explore data to be included (e.g., demographic data) and support practices/PHC Centres learning about their population through the EMR.
- Explore the use of other data, such as MSI, to inform patient care and collaborative practice development (information that is collected and presented to practices could be more useful than trying to get through the privacy issues to make EMRs useful at a practice level; use all of the databases to present a picture of the practice).
- Support the linking of provincial databases.
- Ensure the primary care and PHC community has input into the Health Policy Research Centre.
- Identify research priorities that include issues of relevance to primary care and PHC.
- Explore the impact of demographic information and use a best practices approach to identify race, culture, sexual orientation and language, etc. (use a coordinated, common approach).
- Be careful to choose indicators and initiatives where we are prepared to invest resources.
- Create provincial guidelines for users – ensure that DHAs are engaged in this work as well as the work of the Health Policy Research Centre; all stakeholders need to have input into the research agenda; ensure that there is equity of participation from across the province.
- Engage other partners such as Nova Scotia Health Promotion and Protection.

## CLOSING

Dr. Burge closed the meeting by thanking participants for their thoughtful input throughout the two days. It was noted that a report synthesizing the meeting proceedings would be produced and circulated to all participants for review and feedback. Dr. Burge indicated that while there is no concrete plan in terms of moving forward, it is critical that this group stay connected and it is up to all stakeholders to ensure this happens. Together the group is determining the road forward. Dr. Burge acknowledged Primary Health Care, Department of Health for their support which enabled the meeting and Dr. Smith, who sees the importance of this work and supports the Department of Family Medicine's involvement. Finally, all of the presenters were acknowledged for sharing their experiences in primary care research and evaluation, and providing important insights and context for the meeting.

# Participant Feedback Synthesis

At the end of the workshop, participants were asked to complete a feedback survey. Detailed findings from the survey are available in Appendix 4 and a brief synthesis of the survey results is presented in the table below.

The meeting participants were asked to describe the meeting using a likert scale, with 1 = unsuccessful and 5 = very successful. Overall participants were very satisfied with the meeting with 22 of 24 respondents indicating either 4 or 5 on the scale (mean score 4.4).

**Table 3: Synthesis of Meeting Feedback (n=24)**

Question	Synthesized Response	Participant Quotes
<p><i>Overall, upon review of the meeting purpose, I would describe this meeting as...</i></p>	<ul style="list-style-type: none"> <li>Useful networking source/varied perspectives</li> </ul>	<p><i>Very useful talking to different individuals with different investments in primary care. Understanding the variety of perspectives put a different focus on a very complicated process.</i></p> <p><i>Good networking and learning challenges &amp; opportunities.</i></p> <p><i>...the discussions have provided much food for thought concerning linkages/connections between the university and community and between education and practice.</i></p>
	<ul style="list-style-type: none"> <li>Clarified direction and next steps</li> </ul>	<p><i>Provides a mandate to move forward</i></p> <p><i>Great forum to start talking about where to go next keeping in mind the overall goal of DoH, DHA.</i></p> <p><i>Commitment of group to set direction &amp; participate in system.</i></p>
	<ul style="list-style-type: none"> <li>A Learning Opportunity</li> </ul>	<p><i>I am not feeling alone in my frustration/fear or lack of skill in evaluation. I have learned many resources – human contacts, ideas from presentations.</i></p> <p><i>I learned a lot of primary care research and evaluation</i></p>
<p><i>If the meeting could happen again, what parts would you want to remain the same?</i></p>	<ul style="list-style-type: none"> <li>Group discussion/ chance to brainstorm</li> </ul>	<p><i>Group work – very useful, creates synergy in brainstorming.</i></p> <p><i>Brainstorming with participants &amp; mixing up of groups.</i></p> <p><i>Small and large group work.</i></p> <p><i>Group work. It was nice to have the sessions organized as panel presentation – group – panel. Networking was excellent.</i></p>

	<ul style="list-style-type: none"> <li>• Presentation of current activities/projects</li> </ul>	<p><i>Interactive, presentations of what's happening.</i></p> <p><i>Presentation of research &amp; projects that are happening in NS. Evaluation process &amp; outcomes.</i></p> <p><i>Presentations on what is happening across the province – great to hear a lot of the various P.C. research &amp; evaluation activities.</i></p>
<p><i>What parts would you want to see improved? How would you improve them?</i></p>	<ul style="list-style-type: none"> <li>• More time for discussion</li> </ul>	<p><i>Really need more time for further discussion.</i></p> <p><i>Too much sitting &amp; listening – need to break the presentations up a bit. This is a challenge b/c the info is necessary but maybe there is other ways to share it that involves more movement &amp; interaction.</i></p>
	<ul style="list-style-type: none"> <li>• Varied presentation methods</li> </ul>	<p><i>... Invite others to bring posters – another way to share what is being done.</i></p> <p><i>More presentations about developing or on-going primary care projects that have been developed with research/evaluation components. How were the programs designed? Measures employed? Findings?</i></p> <p><i>More opportunity for [participants] to present their work. Posters? Small groups?</i></p>
<p><i>From your perspective, what is the most important action that can be taken to support the successful development and implementation of a systems approach to Primary Care Research and Evaluation?</i></p>	<ul style="list-style-type: none"> <li>• Develop network</li> </ul>	<p><i>Network with: steering [committee] – website/library of resources – educational events – provincial coordination.</i></p> <p><i>Define system &amp; start the network.</i></p> <p><i>Network! Who is doing what – who can we talk to for help, guidance, advice – build capacity.</i></p>
	<ul style="list-style-type: none"> <li>• Leadership, commitment and dedicated resources</li> </ul>	<p><i>Dedication of human &amp; financial resources at the provincial level to help coordinate &amp; support research &amp; evaluation across the province.</i></p> <p><i>Resource 1.0 FTE support person for the Network. Support (money) should come from DOH and DHAs to ensure ownership</i></p> <p><i>Make PHC a priority – resources, time, money, people</i></p>
	<ul style="list-style-type: none"> <li>• Develop common/consistent indicators</li> </ul>	<p><i>Development of consistent slate of indicators.</i></p> <p><i>Core quality indicators that can be measured easily by DHAs.</i></p> <p><i>... Begin a provincial research project measuring 4-5 indicators...</i></p>

# Appendices

## APPENDIX 1: MEETING PARTICIPANTS

### Participant List – Primary Care Research & Evaluation Meeting – Oct 21 & 22, 2008

<u>Name</u>	<u>Title</u>	<u>Organization</u>	<u>Contact</u>
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## **APPENDIX 2: PRESENTATION SLIDES**

## APPENDIX 3: VERBATIM FEEDBACK FROM THE SMALL GROUP WORK

### *Challenges and Opportunities for Primary Care Research and Evaluation*

#### Challenges

##### Group 1

#### Top 3

1. Not having HR or expertise.
2. Integration of tools, measurement, data and what is going on. Across all health sectors – PHC, primary, public health, provincial programs
3. Not knowing what is happening in N.S. re: PHC, primary care etc.

Challenges
Leadership & champion support
In-house PHC growth & development
Project development support & facilitate for change
Provincial programs – own indicators – challenge across continuum prevention – disease focus
CDSM – trying central approach, data collection
EMR (GP own info) (no secondary use)
Confidentiality
Physician engagement (FFS practices)
Clinician/provider engagement – evaluation as part of their role
Ethics Network – support DHA champions/leads
Know drivers for Quality Improvement
Recruit those with knowledge & skills so all can benefit
Knowledge translation & exchange
Need to know what provincial programs can do for DHAs
Expertise gaps (how to locate mentors)
Lack of enough epidemiologists
Where does staff go for eval? Help – need support mentoring & research methodology network
Decision support – constructed around acute
Indicator - # of times contracted experienced evaluators – less in-house capacity, build critical mass
Geographic barriers – no med school or experienced evaluators locally

Approval of ethics (often multiple)
Tool development and applicability
Provincial programs don't talk to each other or PHC
Question validity of data

## Group 2

### Top 3

1. Resources – people/expertise/money, time, data
2. Priorities – research & eval not viewed as a must, needs to be a priority for those with money, challenge to make it a team priority – take the time to participate
3. Knowledge translation – do not need to re-invent the wheel e.g. QI – what others are doing, feedback loop to practices

### Challenges

Resources- finding the bodies to do it. New teams are emerging with specific roles. It is team-based- need to go back to decision support person. Need to make it a clear priorities and commitments. Finding the time to take out of their day to figure out what indicators they want, find how to tweak the surveys. In practical terms of planning it is a challenge e.g. time issues in conducting the surveys. Currently, there are more meetings than before placing greater demands on a person's time. Need to balance it out. It would help to see the result, but they are not interested in the process. Data is a challenge- obtaining it, knowing where it is, paying for it, getting recent data. It would be nice to use EMR to get the info. The data being entered has to be meaningful. Consistency is important in charting.

Priorities- research and evaluation are not seen as a must. It is a priority to the people who hold the money. The people who need to participate in evaluation do not necessary see it as high priority. How do you make it a priority to the team? If you do not handle it correctly, then they may back off

Knowledge translation- what indicators are out there, who is doing what, where we can be sharing ideas. Completing the feedback loop- we measure >90 indicators as part of quality framework, goes to board, but to go back to frontline people does not always happen. This goes back to the resources of people

## Group 3

### Top 3

1. Don't know where to start – where to get the data, tools, education, fear
2. Lack of access to data
3. Human Resources – money, time & skills (partnerships with academic centres are important and is an issue for areas that aren't associated with an academic center)

Challenges
Linkage with academic center is important – is more challenging for remote rural areas
<ul style="list-style-type: none"> <li>- Ability to connect with like minded persons in academia – have interest in area being studied</li> <li>- Identifying these academics is challenging</li> <li>- PC &amp; Academia can be very different worlds – building trust &amp; open relationships can be difficult.</li> </ul>
Lack of access to data (primary & secondary)
Getting good response rates
Linking data sets – e.g. PHRU, MIS, MSI, Meditech, own data sets
Costs to accessing data are prohibitive
Dedicated clinician time to plan & implement evaluation
What’s good enough for our purposes? Can we build that capacity internally as we go along rather than always using costly means?
Evaluation vs. research – not funding evaluation projects
Overall policy change may need the more costly research but at community level, more simple evaluation might be OK.
Health Outcomes you wish to see from evaluation are long term – down the road
Where are we going from prov. perspective? What are our supports, tools?
Fear associated with doing evaluation & research – afraid of not doing it right.
Challenge of communication & knowledge sharing – provincially, nationally, internationally
Time factor is an issue
Physician Engagement is a challenge
Deciding what you need to measure & how to measure it – CIHI & NS specific indicators (Evaluation Framework)
Finding the data to support indicators – narrowing down to common set of indicators that can be measured.
EMR
Human Resource issues – getting the people to do data collection & analysis
Pulling information out on cultural/vulnerable groups is a challenge – privacy issue

## Group 4

### Top 3

1. System readiness – dedicated time & money, work/life balance, data infrastructure (PHIM, CIHI indicators), leadership
2. Lack of access to academic researchers & evaluators – needed at the table for PDSA cycles – from the outset partnerships – provincial team of experts partner with clinicians “on the ground”

3. Silo's – DoH/districts/prov. programs/practices, MIS/MSI/PHRU

Challenges
Baseline state (where are we starting)
Dedicated time and money
Lack of access to academic researchers/evaluators (partnership need)
# of imposed silos
How to develop final product that is useable/what should we get.
Information dissemination with # of sites
PHIM
Work/life balance
System readiness
Time <ul style="list-style-type: none"> <li>– To reflect</li> <li>– To review</li> <li>– To plan</li> <li>– It takes to research</li> <li>– For national funding means longitudinal investment</li> </ul>
Leadership (chicken & egg – need guidelines)
Pressure to affect change
Having researchers at the table at the beginning
Balancing rigor (qual vs quant)
Knowledge translation
CIHI indicators – apply provincially
Data infrastructure

**Opportunities**

**Group One**

**Top 3**

1. Developing mentor/tutor system
2. Partnering with universities, colleges.
3. Creating PHC Research & Evaluation Network.

Opportunities
Harmonize ethic submission process – refine ethics process
Admin evaluation – policy & decision
Proposals to DoH – require tools to evaluate
Infrastructure PHC \$ some to evaluation
PHCWG – add evaluation to regular agenda, include NP working group

Enabling data to assist PHC to base decisions
PHC Task Force – core data needed for decisions
Invite PHC to table at other tables i.e. Palliative care
Engage GPs in providing them with options for projects – Advanced access, EMR
Prevention facilitators – (Ontario) (academic detailing approach chart audits)
NSHRF
CHB – accessing readiness
Raise importance of race, ethnicity & language, etc. (best practices)
Provincial programs starting to work together
Health Policy Research
PHIM

**Group Two**

**Top 3**

1. Awareness & interest in PC research & evaluation – keep up the momentum, develop relationships with DHA, QI’s available
2. Include evaluator as part of the original plan when implementing enhanced care models.
3. Becoming more electronic – potential for better, more consistent recording of data, future availability to obtain info for evaluation.

Opportunities
There is an awareness and interest now in PC and research/evaluation. Indicators are available, so we do not need to reinvent the wheel. This has been fine tuned inns. Opportunity tot tap into national indicators, which can contribute to consistency of collecting indicators at the provincial level. Use of available data such as RCP, DCPNC, CCS, etc. This helps to show individual areas how they compare at the province level. Data can be used at CHB level and DHA level to focus initiatives. Opportunity to continue the current momentum of collaboration. More opportunity to develop relationships within DHA. Builds capacity to share solutions. Collaborate.
Opportunity to include evaluation as part of the original plan when implementing enhanced care models.
More things available in the electronic world. There is potential for better, more consistent recording of data. Better quality of data should be available for review. EMR can bring level of research at the provincial data (access will be a challenge where the data is not used by the province).
Team variability- size, professional. Look at differences between team of working in the community and not able to compare how things are working. Eg. AVH one team with 6, one with 22- hard to compare the teams. If we had more evaluation in dif areas, then more opportunities to compare at the provincial level.
More roles and new roles emerging

Use of students and academic institutions to help with the evaluation/research components.

### Group Three

#### Top 3

1. Can we get consensus on handful of indicators that we can all effectively measure? Who takes the lead on this – province, need supports within the districts to move this forward.
2. NS Health Policy Research Centre
3. Building on/capturing the energy from work that has already been done – PHCTF (transition funds), Provincial Framework & Reference Manual – what are the next steps?

Opportunities
Can we get consensus on handful of indicators that we can all effectively measure? Who takes the lead – province. Need supports within districts to manage this.
NSHRF – Opportunity for PC Research & Evaluation – provide educational opportunities for practice world as well as academic world
DoH – Client Registry (MSI, HITS – NS) provides opportunity to link with different databases (Share Project)
Best practices portal – PHAC (Public Health Agency of Canada)
Potential opportunity – worth exploring – APP (Alternate Payment Plan) for physicians – more opportunity to do PC Research - ? renegotiate APP – build in deliverables for research
Focus on people in district practice who are interested. Look for that when hiring. Foster research & evaluation culture in DHA’s. Engage physicians in this
EMR & Meditech have some interfaces
NS Health Policy Research Centre – potential
Preliminary work – PHCTF – Provincial Framework & Reference – capturing energy from work already done – what are next steps

### Group Four

#### Top 3

1. Provincial guidelines developed in collaboration with districts to address: leadership (culture), funding, personnel, partners (e.g. evaluation, research, university, national, potential for RFP’s), strategic direction
2. Collaboration – virtual network & multi-site projects
3. Health Transformation (Inform & impact these initiatives) – models of care, rural health, PHC Task Force

Opportunities
Provincial guidelines in evaluation & research) in collaboration with districts
Leadership (provincial but also at DHA level)
Funding
Personnel
Partners (university, national)
Potential RFP
Strategic direction
Opportunities for multi-site research is not more money but money better spent
Network – virtual
Update Framework & Reference Manual (keeping current)
Upstream – reflection & planning
For DHA's & researchers to inform Health Transformation
To put leaders with “ears” (active listening) at Health Transformation table

### **What Needs to be Done or Put in Place to Support a Systems Approach to Primary Care Research and Evaluation**

#### **Group 1**

##### Quick Wins

- Website to connect
- Core indicators
- ◆ Get a network for PC research & evaluation - leader, team, capacity building, marketing, website/listserv/communications
- ◆ Establish & populate core set of Primary Care Indicators
- ◆ Set up forum to resolve issues re EMRs/data sharing/support
- ◆ Be careful to choose indicators & initiatives where we are prepared to invest resources.

#### **Group 2**

##### Quick Wins

- Meeting to understand a systems approach
- Facilitation of connection between universities/college/research institution & DHA/IWK.

- ◆ Network virtual or other; database of individual skills; has to be updated regularly by individuals – how to keep it updated?
- ◆ Leadership; leadership at provincial & DHA/IWK level & small group of common indicators
- ◆ Start with these across the province, impact of demographic (inducer) info; use best practices, race; culture; sexual orientation; language etc., coordinated common approach
- ◆ Research priorities that include issues of relevance to P(H)C
- ◆ EMR – including the demographic info etc. – put these in place for all Nova Scotians
- ◆ Lack of resources connection between DHA/IWK and universities/colleges/research institution
- ◆ Systems approach – what does it mean? Opportunity to discuss this at another meeting to focus on what this looks like; we have matured from the capacity ... of the PHCT funding.
- ◆ HPRC has to have the input of the P(H)C community.
- ◆ PHC centres learning from EMR who their populations are and using other info to get the information of where people are not being served. Linking of information so they know who is in their neighbourhood and what they are sick with
- ◆ Move information on to MSI; EMR is for patient care; improving the practice; linking demographics to MSI; information that is collected and presented to practices could be more useful than trying to get through the privacy issues to make EMR tell them this at a practice level, so use all the databases to present a picture of the practice area to the practice.
- ◆ Resources and pressure on existing human resources the need for skills they don't currently have
- ◆ Have some own (by DHA) an indicator and do the analysis

### **Group 3**

#### Quick Wins:

- Network of leadership group.
- Inventory of data sources.
- ◆ Central depot – districts can access

- ◆ “In house” – vision/big picture, expertise, who does/who can
- ◆ Function:
  - Strategic direction (goals of HTO – infrastructure; research & evaluation) re what (all district reps), training – minimal level of expertise in house – basic 3 day seminar.
  - Coordination/process
  - Expertise.
- ◆ Coordinate data.
  - ? role – choose direction; support initiatives that others have identified as priorities
  - Researcher: program evaluation; program: less fear of researchers.
  - Support knowledge mobilization – tools, research, confidence/risk to do it.
  - Right people in room – serious supported small group – mandate
    - Principles
    - Conceptual framework
    - Citizen engagement & representation
    - Check in re representation

#### **Group 4**

##### Quick Wins:

- Leadership from DoH and DHAs at the table – ensure equity for participation.
- A PHC Network.
- The identification of 5 to 6 indicators.
- ◆ System readiness across the board.
- ◆ Provincial guidelines for users
- ◆ DoH should have a formal process to ensure that DHA & other centers are consulted & that @ the tables @ the Research Policy Center – setting the Research agenda
- ◆ Equity lens/geographical & processes in place so people can engage i.e. travel
- ◆ DoH provide leadership to develop a PHC Network across the province - Research/Eval.
- ◆ Health Policy Research Unit – Hire more PHC Research Expertise.
- ◆ Coordination role for PC community researchers.

- ◆ 5-6 core indicators that we could start with provincially. (start with most feasible one)
- ◆ Provincial databases linking together.
- ◆ Aligning strategic direction of PHC – 4 pillars with new providers. (Does not work with all scenarios)
- ◆ Engage HPP – Key participant.

## APPENDIX 4: PARTICIPANT FEEDBACK SURVEY – VERBATIM FEEDBACK

1. Overall, upon review of the meeting purpose, I would describe this meeting as: (circle one)

Unsuccessful 1	2	3	4	Very Successful 5
0	0	2	10	12
Average: 4.4				

**Please explain your response:**

(n=18)

- ◆ Provides a mandate to move forward.
- ◆ Great leadership from the planning committee and Stephanie – a good mix of people/presentations and small group discussions.
- ◆ Great forum to start talking about where to go next keeping in mind the overall goal of DoH, DHA.
- ◆ Provided context for evaluation & research of PHC & excellent venue to meet & connect with other PHC professionals.
- ◆ Very good forum.
- ◆ Excellent opportunity for a group with common interests to start the task of working together.
- ◆ Great starting point.
- ◆ Very useful talking to different individuals with different investments in primary care. Understanding the variety of perspectives put a different focus on a very complicated process.
- ◆ Commitment of group to set direction & participate in system.
- ◆ Thank you for inviting me to participate in this meeting. As I mentioned, I'm not involved in primary health care research & evaluation but the discussions have provided much food for thought concerning linkages/connections between the university & community, between education and practice. Thank you. (And oh yes, I've appreciated the opportunity to make new contacts – and will be following up with several people.)
- ◆ Good networking and learning challenges & opportunities.
- ◆ 1. I am not feeling alone in my frustration/fear or and lack of skill in evaluation. 2. I have learned many resources – human contacts, ideas from presentations.
- ◆ I learned a lot of primary care research & evaluation.
- ◆ Would like a little informal down time re: networking.

- ◆ Excellent source of networking, learned a lot, enjoyed the participants/organizers/presenters.
- ◆ Good networking opportunity. Learned a lot about primary care projects throughout the project.
- ◆ Organized, good facilitation, effort to get the right people in this room. Need to underscore scope & next time include community.
- ◆ Great sharing. Tighter schedule needed.

**2. If the meeting could happen again, what parts would you want to remain the same? (n=21)**

- ◆ Small and large group work.
- ◆ All.
- ◆ Group work. It was nice to have the sessions organized as panel presentation – group – panel. Networking was excellent.
- ◆ Small group work. Sharing of research & eval project NSHRF PHIM.
- ◆ Interactive, presentations of what's happening.
- ◆ Presentations, posters, networking.
- ◆ Opportunities for group discussion. Central location.
- ◆ Group work – very useful, creates synergy in brainstorming.
- ◆ Small grp interaction.
- ◆ Show case work.
- ◆ DHA overviews of what happening. DoH updates. Great facilitation. Great presenters.
- ◆ 1. Presentation of research & projects that are happening in NS. Evaluation Process & outcomes.
- ◆ The panel presentations.
- ◆ Presentations on what is happening across the province – great to hear a lot of the various P.C. research & evaluation activities.
- ◆ Group discussion. Panels.
- ◆ Brainstorming with participants & mixing up of groups.
- ◆ Hold it centrally – Truro good. Mixing of groups/varied tables with various participants.
- ◆ Presentations about research projects.
- ◆ Organized, good facilitation, effort to get the right people in this room.
- ◆ Examples of current PC initiatives in the province.
- ◆ Presentations were useful for sharing. Working groups were productive.

**3. What parts would you want to see improved? How would you improve them? (n=15)**

- ◆ Fewer presentations.
- ◆ Location – would prefer Halifax. The food could be improved i.e. healthier choices.
- ◆ Really need more time for further discussion.

- ◆ Reduce the presentations to the planned time of 15 minutes. 5 minutes for questions. Invite others to bring posters – another way to share what is being done. Thanks!
- ◆ More opportunity for... to present their work. ?posters ?small groups
- ◆ More presentations about developing or on-going primary care projects that have been developed with research/evaluation components. How were the programs designed? Measures employed? Findings?
- ◆ Too much sitting & listening – need to break the presentations up a bit. This is a challenge b/c the info is necessary but maybe there is other ways to share it that involves more movement & interaction.
- ◆ Include bumps & victories associated with work.
- ◆ More time for questions/discussion following presentations.
- ◆ Should be ½ day am after a full day rather than an evening and then a day.
- ◆ More opportunities for sharing. Change venues.
- ◆ Make it 2 full days.
- ◆ Need to underscore scope & next time include community.
- ◆ Meeting in evening until 9pm was long and tiring. Maybe spread it over two work days or end earlier in the evening. A lot of work going on in PC but is not research/evaluated. What about those? How to include the ideas so they can be researched/eval?
- ◆ 1 day session. 9p.m. was a bit late for travel.

**4. From your perspective, what is the most important action that can be taken to support the successful development and implementation of a systems approach to primary care research and evaluation? (n=22)**

- ◆ **Action:** Making PHC a priority – resources, time, money, people.
- ◆ **Action:** Core quality indicators that can be measured easily by DHAs. Create inventory of initiatives online (use Health Promotion clearinghouse) that other DHAs/province can view and maybe implement.
- ◆ **Action:** Agree with named priorities.
- ◆ **Action:** Development of a primary (care) research network (i.e. website/listserv). Connect to Primary Care Research Unit @ Dal Fam Med.
- ◆ **Action:** Development of consistent slate of indicators.
- ◆ **Action:** Explore evidence based evaluation frameworks used in other PHC settings nationally/internationally. Develop Logic model for provincial strategy to evaluate PHC & then set research priorities within the PHC setting, engage stakeholders (academic, DHAs, GPs, gov't). Invest resources throughout province to facilitate measurement of desired outcomes/target indicators (lead, lag, stretch). Use outcomes to evolve practice. Continue to evaluate & answer research questions re: best practice PHC.
- ◆ **Action:** Commitment.
- ◆ **Action:** Provincial core guidelines in Primary Care.

- ◆ **Action:** PC res & evaluation network with a focus on information sharing, education & a mandate to advise the Province on P.C. research & evaluation infrastructure & direction.
- ◆ **Action:** 1. Framework/Guidelines for districts. 2. Begin a provincial research project measuring 4-5 indicators. 3. DoH as leader!
- ◆ **Action:** Ongoing PHC network meetings re: evaluation.
- ◆ **Action:** Leadership (supported).
- ◆ **Action:** Dedication of human & financial resources at the provincial level to help coordinate & support research & evaluation across the province.
- ◆ **Action:** A steering committee or “community of research/evaluation”.
- ◆ **Action:** Define system & start the network.
- ◆ **Action:** Network with: steering... - website/library of resources – educational events – provincial coordination.
- ◆ **Action:** As presented.
- ◆ **Action:** Network! Who is doing what – who can we talk to for help, guidance, advice – build capacity.
- ◆ **Action:** In the short term – a mechanism for communication/sharing of research. In the long term – electronic information system.
- ◆ **Action:** Ensure there is geographical representation & community input is included in the development of the leadership forum.
- ◆ **Action:** The formation of a well supported (small) leadership group with appropriate representation.
- ◆ **Action:** Resource 1.0 FTE support person for the Network. Support (money) should come from DoH & DHA’s to ensure ownership. Possibly family physician/care teams/community clinics also.

## 5. **Further comments** (n=15)

- ◆ Great learning experience. Look forward to future steps.
- ◆ Double side copies of presentations or send electronically.
- ◆ Truro: good location (central). Have it @ the new Holiday Inn (in Truro) – they have better food.
- ◆ Great starting point.
- ◆ Thank you Stephanie!!
- ◆ Thank you! Great learning. Great connections.
- ◆ Great meeting everyone.
- ◆ Tks Great!
- ◆ Great workshop – well facilitated – interesting topic & engaged participants – very informative & enjoyable!
- ◆ Excellent work!
- ◆ Tks.
- ◆ Thanks!
- ◆ Research & Evaluation needs to keep “the patient” and user of the system at the fore front. Ensure we learn internally & externally from our resources to prevent

redundancy & reinvention. Try to engage community members who are using the system frequently. Focus groups? & have info brought forth.

- ◆ An excellent meeting!