Building Research Capacity within the BC Health Authorities

A report on the evaluation of the Health Authority Capacity Building program
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Executive Summary

Background

In 2003, the BC Ministry of Health Services provided funding to the Michael Smith Foundation for Health Research (MSFHR) to develop a health services and policy research initiative to help inform broad-based health system improvements. A Health Services and Policy Research Network (HSPRSN) Steering Council representative of health authorities, academia and the Ministry of Health Services (MOHS) was created to oversee this initiative and developed four different programs to achieve its objectives. The Health Authority Capacity Building (HACB) program was the largest of these and was directed at expanding the capacity of the six BC health authorities (HAs) to engage in and use health services and policy research.

Program Evaluation

In the fall of 2008, MSFHR’s Analysis and Evaluation Department, in conjunction with HSPRSN staff, HA representatives, and experts in the fields of research capacity building and knowledge exchange, developed an implementation and outcome evaluation of the HACB Program. The evaluation was guided by a research capacity building framework and engaged more than 500 participants, including HA executives and staff, HACB managers, and HSPRSN staff.

The evaluation timeframe included grant activities up to the end of July 2009 and are as reported by HA managers in August 2009. As the HACB funding continued to March 31, 2010 some of the health authority activities may not be fully captured in the report.

This report presents the results of the evaluation and outlines:

- how the funding was used;
- areas where health services and policy research capacity was increased; and
- recommendations for program improvements and further development of health services and policy research capacity.

Evaluation Results

The evaluation found that while each HA developed programs to meet its unique health services and policy research needs, there were more similarities than differences among those initiatives. Most of the funding, which amounted to about $4.8 million dollars over five years, was used by the HAs to hire staff. Four HAs implemented a research facilitator model of capacity building that focused on increasing the skills of staff to conduct and use research; one HA predominantly used the funds to hire highly qualified health services and policy researchers to do research of relevance to the HA; and one HA implemented both types of capacity building models. Across all the HAs, over 100 research capacity building initiatives were implemented, engaging more than 11,000 participants. Factoring in web-based resources and services, the reach of the program extended to more than 200,000 participants.

The evidence for increased research capacity being developed during the period of the HACB program was examined in four areas:

- research production and utilization skills of HA staff;
- linkages and partnerships between health authorities, researchers, and other research-support initiatives;
- use of evidence for policy and program changes within the HA; and
• tangible and intangible organizational supports for research production and use (e.g. financial resources, and research supportive policies and organizational culture).

Increased research skills and partnerships
The evaluation found that self-reported levels of research skills (defined as the ability to conduct research and use research evidence in decision-making) were increased for the majority of HA staff who had participated in capacity building activities as compared to non-participating staff. Further, participating HA staff reported that they felt more prepared to be involved in research and evaluation than non-participants. Research related partnerships and linkages were also created, with more than 50 partnerships established between HAs, academic researchers, and other research initiatives. The majority of these (78%) would not have been possible without the HACB grant. It is believed that the increase in research skills of HA staff and the formation of numerous research partnerships were directly attributable to the HACB grant for most of the HAs.

Use of research evidence
Many health authority staff and executives reported that evidence was being used more frequently to inform decision regarding service delivery. Evaluation survey respondents across all the HAs identified more than 200 examples of the use of research evidence for policy and program improvement. However, within the limitations of the evaluation, it was not possible to directly attribute the use of research evidence to the HACB grant.

Increased research support infrastructure
The evaluation also found that research support infrastructure has increased at most HAs. Significantly, at the end of the HACB grant capacity building staff positions created through HACB funding will be continued at all but one HA. It is anticipated that 15 capacity building positions will exist post HACB grant. In total, capacity building positions increased by 275 percent over the course of the HACB program.

At the beginning of the grant program, there was significant variation among the HAs in their health services and policy research needs and capacities. At the end of the program, there are three HA research support departments that either did not exist before or have been significantly enhanced. In addition, two HAs (FH and VIHA) have established research or research capacity building as a corporate priority, with planning committees established to oversee the development and implementation of a research agenda. Survey respondents from some health authorities believed the HACB program was directly responsible for fostering these tangible supports. They strongly emphasized that having dedicated funding was essential to their ability to focus on developing health services and policy research capacity. Others noted that the global trend toward more research and evidence-informed practice also played a major role.

Although tangible infrastructure changes were readily found at most HAs, findings on the presence of a research supportive organizational culture were mixed. Most HA executives believe their organizations have research supportive cultures. However, the majority of staff see their HA as only “somewhat effective” in developing a research supportive culture.

Research capacity building enablers
HA executives and HACB managers at more than four health authorities identified the following factors as enabling research capacity building work:
• Dedicated external funding
• Dedicated capacity building staff within an integrated research department
• Partnerships and reciprocal knowledge exchange between HAs and academic researchers
• Leaders / research champions at all levels of the organization, in particular at the executive level
• Sustained enthusiasm and increased interest and participation in research by building on and celebrating previous successes
Research capacity building challenges
Common factors identified by HA executives and HACB managers at all six health authorities as imped ing capacity building work include:

- Frequent staff turnover, particularly in leadership positions made it difficult to maintain relationships and communication
- Lack of appropriate skills amongst staff to be able to get more involved in research and evaluation – only so much that workshops and resources can do to get staff prepared
- Competing priorities – care delivery is the primary priority
- Organizational structure in some organizations made it difficult to integrate the capacity building framework

Recommendations for program improvement
The program was viewed as worthwhile and a success by most HA managers with the following program aspects recognized as the most valuable:

- Openness of the grant to respond to the context and needs of each HA
- The creation of a community of practice of research facilitators (MSFHR supported HACB managers to meet throughout the grant period)
- Dedicated external funding

It was suggested the following aspects of the program could be improved:

- Predetermine the length of grant at the start and build in formative reviews at predetermined periods
- Recognize the long time frame required for capacity building work
- Develop evaluation requirements at the beginning of the grant

Future health services and policy research capacity needs
HACB managers and HA managers/executives suggested that much capacity building work is still required within the health authorities. Nine priorities were identified:

- Increasing the perceived value of research
- Determining or setting research priorities
- Supporting staff participation in research
- More networking and research collaboration among the health authorities
- Longer time frame for capacity building
- More funding
- Greater integration with other departments within the HA
- Support for training
- Evaluation support

Conclusion
Based on the findings of this evaluation, it is evident that over the period of the HACB program, health services and policy research capacity was increased at most HAs, and that the HACB grants contributed to some of these increases. It is also evident that the environment for research has changed at most BC health authorities, and in many cases the HACB grant was a catalyst for that change.

The work to address health services and policy research capacity in HAs is not yet complete. The HAs noted that continued external funding is required to enable ongoing skills development for staff and to promote a research supportive culture. The majority of respondents in this evaluation believe MSFHR should continue to facilitate capacity building work as it is best positioned to support the networking, collaboration, and integration required for optimizing the production and utilization of health services and policy research.
The report contains many suggestions for ways MSFHR can best support further efforts in the area of research capacity building. These include:

- funds for capacity building
- advocacy for a health services research strategy
- support and promotion of linkages and partnerships
- focus on knowledge translation and exchange
- strengthen program evaluation within the province
- offer a variety of other funding mechanisms

Many of these suggestions are in keeping with MSFHR’s new proposed strategic direction and should be explored with the HAs and other Foundation stakeholders.
About this Report

This report presents the key findings and recommendations of an evaluation of the Health Authority Capacity Building (HACB) program of the Health Services and Policy Research Support Network (HSPPRSN). A list of terms, definitions, and acronyms used in the report can be found in Appendix A.

To keep this report to a manageable size, additional information/data is provided in the Appendices. The report is divided into five sections:

Section 1. Background
• provides an overview of the HACB program and a brief description of the evaluation framework and methodology

Section 2. Capacity building activities implemented
• presents a summary the capacity building activities implemented

Section 3. Has research capacity been increased?
• reviews the impact of the capacity building work

Section 4. Lessons learned from capacity building
• focuses on what was learned about building research capacity in large health service organizations

Section 5. Future research capacity building needs
• contains recommendations for future health services and policy research capacity building programs

Section 1. Background

The Health Authority Capacity Building Program

In March 2003, the BC Ministry of Health Services (MOHS) provided funding to the Michael Smith Foundation for Health Research (MSFHR) to implement a health services and policy research initiative to inform the development, implementation, and assessment of health system redesign. The Health Services and Policy Research Support Network (HSPPRSN) comprised of health service researchers and representatives from the health authorities (HAs) and the MOHS was established to provide direction and oversight for this initiative.

The HSPPRSN established three goals for the initiative:

1. To increase capacity for producing and using health services and policy research.
2. To identify and support high priority health services and policy research projects and knowledge translation initiatives.
3. To support alignment between health service and policy researchers and decision-makers in health service organizations.

To achieve these goals, HSPPRSN established four programs:

1. The Health Authority Capacity Building Program (HABC) – facilitate increased use and participation in health services and policy research within the province’s health authorities.
2. The Investigative Team Program – support integrated teams (researchers and decision-makers) in a program of research in a HSPRSN priority area.
3. Research Operating Grants – to provide funds for researchers and decision-makers to work together on a research project in a priority area.
4. Partnership Funds – enable researchers and/or decision-makers to leverage national research funding in priority areas.

The Health Authority Capacity Building Program (HACB), the largest of HSPRSN programs, was tasked with developing a “basic platform” of skilled staff and resources to help the province’s six health authorities (HAs) increase their capacity for conducting and using health services and policy research.

The program was launched in 2004, when MSFHR received proposals from each HA outlining its vision for health services and policy research and how it would use funding to achieve that vision. These underwent formative review by an external expert panel that provided recommendations to improve proposals, which HAs were required to address.

Four health authorities were awarded $350,000 in program funding for a three-year period beginning January 2005. The two remaining health authorities received additional funds on the recommendation of the review panel and with the approval of the HSPRSN. Through a series of extensions, three additional funding periods were provided. The extensions were unanticipated at the beginning of the program and were implemented to accommodate the MSFHR’s funding and review cycle. At the conclusion of the program on March 31, 2010, the HAs will have received five years of support totalling almost $4.8 million (Table 1).

### About the HACB Program Evaluation

This evaluation of the HACB program and its achievements was produced for the HSPRSN Steering Council to inform future programming decisions. A mixed method, multi-informant implementation and outcome evaluation was used, developed by the Analysis and Evaluation Department of the MSFHR. The evaluation design was reviewed by HSPRSN staff, health authority representatives, and other experts and corresponds to the recommendations of Dobbins et al. (2009) for studying evidence-informed decision-making. The evaluation methods and sample sizes are presented in Table 2. Evaluation tools are available in Appendices G, H, and I.
The tools described in Table 2 were adapted for use by each health authority as appropriate for their unique circumstances (primarily by adjusting the wording of survey and interview questions). PHSA is a research intensive health authority, with a number of dedicated research centres and extensive research activity. The Research Capacity Building Survey was not implemented at PHSA because it would have been very difficult for respondents to distinguish and attribute capacity building activities supported by the HACB award given the broad range and magnitude of applied health research activities and support already in existence within the health authority.

The evaluation was designed to answer the following questions:

**HACB Program implementation**
1. What capacity building work took place?
2. How many people were reached and what were their characteristics?
3. How many and what types of partnerships were established?

**Capacity building outcomes**
4. Were the program objectives achieved?
5. What impact did this have on the health authorities?
6. Were there any unintentional impacts?
7. Would the objectives have been accomplished without HACB funding?

**Capacity building program and process**
8. What were the enablers and challenges for the program?
9. Was the program worthwhile? How could it have been improved?

**Measuring Research Capacity: The Research Capacity Building Framework**

To determine whether research capacity was increased through the HACB Program, a literature review was conducted of research capacity building models and ten models were reviewed in depth to develop a conceptualization of research capacity (Cathexis 2008). Based on this review, and drawing from Cooke (2005), nine components of capacity were identified to use as a tool to categorize and describe capacity building activities.

The nine components identified for the HACB program evaluation cover both the capacity to produce and use research, and include:

- Developing skills
- Creating or enhancing infrastructure and resources
- Facilitating a research mindset among those close-to-practice
- Creating or enhancing linkages, partnerships, and collaborations
- Engaging in knowledge translation and exchange
- Enhancing leadership
- Creating or enhancing research culture
- Promoting and engaging in research activity
- Ensuring sustainability

Detailed definitions for each of these components are provided in Appendix A. To guide the HACB evaluation, a research capacity building (RCB) framework, based on these components, was developed (Figure 1). The framework is a modified program logic model and breaks out capacity building activity components (second column from the left), outcomes (third column) and indicators (far right column).

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1 Although included as an activity component due to its importance for building capacity this category was not used when categorizing the activities implemented by the health authorities.
The nine activity components developed for the framework were grouped into four broad outcome areas: enhanced research skills; increased collaboration and partnerships; enhanced knowledge translation and exchange, and value of research through organizational supports such as infrastructure and resources. The data collection tools for the evaluation of program outcomes (surveys, interviews, and HACB manager report) were developed from the indicators.

Evaluation limitations

The evaluation timeframe included the grant activities up to the end of July 2009; however, the HACB program and capacity building activities within health authorities continued past this date. This report only includes those capacity building initiatives conducted within the evaluation timeframe and reported in the HACB manager’s reports. There are additional limitations to the evaluation to note:

- Although completed by over 500 respondents, the survey size represents a very small proportion of total HA staff. This limits how much the findings can be generalized to accurately represent the situation for any particular HA.

- Two of the data sources (interviews and surveys) depend on retrospective perceptions. Through triangulation and reliance on multiple respondent groups, the evaluation attempted to compensate for the limitations of retrospective data. In some health authorities, however, there was turnover in capacity building-related positions, which may also hinder retrospective perceptions.

- There is a lack of a comparator. As a result, it was not possible to determine the relative value of the HACB program approach to research capacity building or to determine the relative success of any specific capacity building activity. Future research and evaluations should attempt to parse out the effectiveness of the different approaches in order to understand which combination of programs works best in which contexts.
Figure 1 The HACB research capacity building framework

HACB Program Goal

Provide financial support to each BC Health Authority to enable them to develop or build upon a basic platform of research skills and resources in order to increase capacity for engaging in and using research leading to a system that is more strategic and forward looking in addressing health services and policy research issues.

Capacity Building Components

- Skill Development
- Close to Practice
- Linkages, partnerships, and collaborations
- Knowledge Translation and Exchange

Capacity Building Outcomes

- Enhanced skills of staff to undertake, understand, and apply research and evaluation
- Collaboration and partnerships with others have increased
- Knowledge translation and exchange has been enhanced

Health Authority values the importance of research and evaluation

Indicators

- Increased participation in research activities within HA
- Increased research skills and understanding in staff
- Increased submission of fundable grants; increased success rates of funding
- Increased internal interactions among research producers and users
- Increased external networking and collaborations
- Greater use of research in decisions regarding policy, management or practice
- Increased dissemination through presentations and publications
- Wider involvement in research activity and decision-making by staff, researchers and external partners

- Increased awareness of the value of research (culture)
- Establishment of research priorities
- Invested annual funding and committed resource allocation
- Infrastructure developed and enhanced
- Development or enhancement of research policies
- Increased leadership
- Enhancement of HR policies and practices to support positions that include involvement in research activity
Section 2. Capacity building activities implemented

The context for capacity building

Capacity building is context dependent. The capacity building activities implemented by each HA were influenced by the overall provincial health service delivery environment as well as by more localized health service requirements and policy research needs.

Since 2001, health services in BC have been delivered by five regional health authorities and a sixth provincial health authorities. The five regional HAs are: Vancouver Coastal Health (VCH), Vancouver Island Health Authority (VIHA), Fraser Health (FH), Interior Health (IH), and Northern Health (NH). The sixth is the Provincial Health Services Authority (PHSA), which is responsible for specialized provincial health services and includes the following agencies: BC Cancer Agency, BC Centre for Disease Control, BC Children’s Hospital and Sunny Hill Health Centre for Children, BC Mental Health & Addiction Services, BC Provincial Renal Agency, BC Transplant, BC Women’s Hospital & Health Centre, and Cardiac Services BC. As Figure 1 shows, the HAs differ in their geographic size, funding levels, and population coverage.

Figure 2 Profile and geographical coverage for BC health authorities as of November 2008²

² All funding figures reflect the BC government funding for the 2007/2008 year and do not include capital funding allocations, payments from the Medical Services Plan, or additional non-governmental funding received. The PHSA figure was provided by Dr. Stuart MacLeod, VP Academic Liaison and Research Coordination, while all other budget figures are available from the Government of BC, Ministry of Health Services at: www.health.gov.bc.ca

The PHSA population was determined from the total BC population as reported by the Statistics Canada estimation of July 1, 2008. Up to date figures are available at www.bcstats.gov.bc.ca/DATA/pop/pop/estspop.asp#totpop

All other figures are as reported by the respective Health Authorities on their websites, accessed November 25, 2008, and available from: www.fraserhealth.ca/AboutUs/Pages/default.aspx; www.interiorhealth.ca/information.aspx?id=566; www.northernhealth.ca/About/Quick_Facts/default.asp; www.viha.ca/about_viha/; www.vch.ca/about/numbers.htm
Section 2. Capacity building activities implemented

Capacity building by health authority

In 2004, at the time the HACB awards were made, there was significant variation among the HAs in their health services and policy research needs and capacities, ranging from those with minimal infrastructure and staff for such activity (NH and IH) to those with some established, albeit small, research supports (VIHA and FH), to those with dedicated academic research institutes (VCH and PHSA).

Below is a summary of the pre-grant capacity and needs within each HA. A brief description is provided of the level of research underway within the HA before the HACB program, the capacity building needs that were identified by HAs, and the programs developed within HAs to meet these needs. This information was taken from the original HA grant proposals and from the HACB managers in their end-of-grant reports.

As the grant progressed over four years, health authorities’ capacity building needs changed, and the activities evolved to meet new or redefined needs, to capitalize on accomplishments, and to expand or refine services. As they learned from implementation, some health authorities significantly re-strategized their capacity building; some expanded their efforts in the areas of greatest impact and others narrowed their focus to areas of greatest need.

To understand the types and purpose of activities undertaken by the health authorities and how they evolved over time, each health authority was asked to provide a list of the initiatives undertaken throughout the grant period and to indicate which of the capacity building components was addressed by each one. In their August 2009 reports, the HACB managers listed the capacity building initiatives, defined as “a single event or activity, or series of activities or events that had the same purpose.” To assist with the analysis, HAs were asked to group “like” activities. For example, skills building workshops were to be considered one type of initiative even if each workshop focused on a different set of skills. The final set of initiatives used for analysis was kept as close as possible to those reported by the HACB managers, with slight modifications for consistency. For example, if one health authority reported ‘website’ and ‘online tools’ as separate initiatives, but others reported them as a single ‘online resources’ initiative, the former were grouped together as a single initiative to reflect the majority. A list of all HA initiatives, as reported by the HAs, is provided in Appendix B.

For each initiative, the health authorities indicated which of the capacity building components the initiative intended to address (could address more than one). Detailed definitions of each component were provided for guidance (see Appendix A). Health authorities were asked to consider eight of the nine components of the framework: the ninth component, sustainability, emerged as a component that relied on the other eight components: it was success in these other components and commitment from the health authority to maintain efforts that supported sustainability. It was also clear that there were no capacity building initiatives that specifically addressed sustainability.

Along with the summary of capacity within each HA presented below, a figure is provided that illustrates how capacity building initiatives evolved over the course of the grant. The unique needs and strategies of each health authority are reflected in the shift of the dashed line (initiatives implemented at the start of the grant) to the solid line (initiatives currently being implemented) in each figure (Figure 3 through Figure 8). The farther to the right the line is, the more initiatives there were that addressed some aspect of that particular component. It is important to note that these figures are not intended to reflect any progress toward achieving particular impacts under the components, nor are they meant to reflect the intensity of work for each initiative. They show the proportion of initiatives with influence on each component. They are intended to illustrate the adaptable and constantly changing nature of capacity building work and how this generally reflects each health authorities’ unique context and approach.

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3 For a list of all initiatives implemented across the health authorities, see Appendix B.
4 Examples of what should be defined as an ‘initiative’ were provided to the HAs in the HACB Manager Report Template’ included in Appendix B.
Northern Health

Northern Health delivers healthcare across a vast geographic area to a population which is largely rural, and often remote. At the time of the proposal, NH had little capacity to support research or knowledge dissemination and utilization. Its research support staff consisted of a manager, who also held other portfolios, and a single research/information officer supporting the population health program area. A temporarily funded, shared position provided a research liaison officer between NH and the University of Northern BC (UNBC).\(^5\) Academic and health services researchers did exist in the north, (UNBC was continuing to expand, a BC Rural and Remote Health Research Institute was funded by a five-year grant from the Ministry of Health Services and a Northern Medical Program was being developed); however, the absence of staff within the HA to coordinate and support partnerships with academics resulted in little opportunity for HA staff to become involved in research. The HA also identified needs in the areas of communicating and applying research findings to management and clinical practice.

NH used its HACB funds to create and staff a research and evaluation department, with one manager and three regional research facilitators housed at each of NH’s local health service delivery areas. The work of the research facilitators was to train and support HA staff to conduct and use research and to facilitate linkages and exchanges between academic researchers and the HA. Table 3 shows the major activities implemented. As stated in the HACB manager report, “the proposed strategy invested greatly in ‘people-capacity’ within Northern Health.”

Initially, most of NH’s initiatives addressed all of the capacity building components (Figure 3 – dashed line). Throughout the program, NH maintained initiatives that addressed all components (Figure 3 – solid line) with slight variations. This may have reflected NH’s initial context, where there was little to no capacity to support research.

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\(^5\) This position was funded through the MSFHR institutional grants program.
**Interior Health**

Interior Health is the second largest HA by geographical area and also faces challenges in delivering health services across rural and remote locations. Prior to the HACB Program, IH had limited capacity for research and knowledge translation activities. There was one new position (Director of Information Support and Research) responsible for identifying research opportunities, seeking collaborations with academic institutions and undertaking specific health service research studies. There was also one researcher within the population and public health portfolio. Interior Health was conducting some research (clinical trial studies) at specific acute care sites.

Although IH noted staff interest in research, there was little support for anything beyond what could be undertaken by the newly appointed director. In addition, there was no research review or ethics approval system for research outside of the hospitals. IH identified challenges in establishing partnerships with academic institutions and research centres (the launch of the satellite campus of UBC Okanagan and Thompson Rivers University coincided with the start-up of the HACB grant) and limited ability to use research findings in decision-making.

IH used the HACB grant to fund research facilitators and establish a research support department. The department focused on expanding staff skills through training, mentoring, infrastructure support, developing networking opportunities, and promoting knowledge translation. Table 4 lists key initiatives implemented by IH. The facilitators provided staff services such as:

- identifying sources of high quality, relevant research findings and best practices;
- assisting with synthesis, analysis and interpretation of data, and research findings;
- developing of letters of intent, grants, research proposals, and ethics applications;
- stimulating uptake, utilization, and dissemination of research findings;
- providing training and coaching in research skills;
- supporting the application of research skills to practice and policy making;
- establishing partnerships between IH staff and researchers at academic institutions; and
- working with other HAs and research networks in British Columbia, including collaborating with UBC Okanagan to establish a health researcher/facilitator position there.

Initially, IH initiatives focused on the capacity building components related to knowledge translation and exchange and facilitating close-to-practice mindsets, which reflects their approach to capacity building using research facilitators that focus on staff skills and opportunities (Figure 4 – dashed line). They also had many initiatives addressing the enhancement of partnerships. Over the course of the grant, IH largely maintained this approach to capacity building (Figure 4 – solid line).

<table>
<thead>
<tr>
<th>Table 4 Key Initiatives Implemented by Interior Health</th>
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<tbody>
<tr>
<td>Research Skills Workshop Series</td>
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<tr>
<td>Research Brown Bag Lunch Seminars</td>
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<tr>
<td>Literature summaries and syntheses</td>
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<tr>
<td>Annual Interior Health Research Conference</td>
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<tr>
<td>Researcher-Decision Maker Meet n’ Greets</td>
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<tr>
<td>Research project support (grant proposal development, facilitation of partnerships, ethics applications)</td>
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<tr>
<td>Development and maintenance of IH Research Website</td>
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<table>
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<tr>
<th>Figure 4 Change in capacity building components addressed by Interior Health initiatives over the course of the HACB grant</th>
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<tr>
<td>Creating or enhancing linkages, partnerships, collaborations</td>
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<tr>
<td>Engaging in knowledge translation and exchange</td>
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<tr>
<td>Enhancing leadership in research</td>
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<tr>
<td>Facilitating close-to-practice mindsets</td>
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<tr>
<td>Creating or enhancing research culture</td>
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<tr>
<td>Creating or enhancing infrastructure or resources</td>
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<tr>
<td>Promoting and engaging in research activity</td>
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<tr>
<td>Developing Skills</td>
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</tbody>
</table>

More initiatives addressing the component
Vancouver Island Health Authority

Vancouver Island Health Authority was more involved in research than NH or IH prior to obtaining its HACB grant. Clinical research was conducted in the capital region before VIHA was formed in 2001. In 2002, VIHA began to increase capacity by providing administrative services to VIHA-affiliated researchers. When the Island Medical Program was established in 2004, VIHA evolved further as an academic health centre.

At the time of VIHA’s HACB proposal in 2004, research was underway in surgery, endocrinology, palliative care, population health, child health, and patient safety. There were research collaborations with the Centre on Aging and Centre for Addictions Research at the University of Victoria and with a Victoria Palliative Research Network -a partnership of BC Cancer Agency, VIHA, Victoria Hospice, and the University of Victoria. Many of these projects were funded by the Canadian Institutes of Health Research (CIHR).

With an active research portfolio, VIHA identified a weakness in its lack of infrastructure support for researchers, particularly in grant writing, project coordination, and research design. There was also a need for expertise in biostatistics and health policy research. VIHA developed a similar model to NH and IH and focused on building capacity by funding an “internal network of community-based knowledge brokers.” These individuals performed functions similar to the research facilitators at NH and IH. Table 5 shows the key capacity building initiatives implemented by VIHA.

Figure 5 shows how initiatives at VIHA evolved. Over the course of the grant, the initiatives shifted to more organizational-related components than individual-related components. By the end of the grant (solid line), more initiatives were addressing infrastructure, including leadership and culture, as well as promoting research activity. Although it appears few initiatives addressed skill development compared to other components, this only reflects diversity in the number of activities, and doesn’t consider the volume of work. Although VIHA may have had fewer initiatives focused on skills development, this area could still have accounted for a substantial amount of its HACB work.

<table>
<thead>
<tr>
<th>Table 5 Key initiatives implemented by Vancouver Island Health Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research Advisory Committee</td>
</tr>
<tr>
<td>Capacity planning activities including a capacity Building Needs Assessment, an environmental scan of research capacity building activities within BC and other health service organizations across Canada, and the development of a capacity building framework.</td>
</tr>
<tr>
<td>COACH-NCR (Uvic Centre on Aging and VIHA’s Continuing Health Services created a network for collaborative research)</td>
</tr>
<tr>
<td>Research Newsletter</td>
</tr>
<tr>
<td>Research Rounds</td>
</tr>
<tr>
<td>Research Use Week</td>
</tr>
<tr>
<td>Purchase of SPSS</td>
</tr>
</tbody>
</table>
Fraser Health

Fraser Health’s interest in research capacity building began prior to the HACB grant. At the time of the grant, FH’s research activity included more than 70 pharmaceutical trials, vaccine delivery research projects, elder care research, and cardiac surgical care research. In addition, FH had a Vice President of Research and had created two research appointments (a joint full-time appointment with SFU and FH focused on modelling acute care and critical care capacity, and an emergency room physician leading a women’s health-related program of research). FH also had affiliation agreements and joint appointments with UBC (medical school), SFU, and Kwantlen Polytechnic University (nursing education).

The primary focus of FH’s capacity-building work was to facilitate development of core skills in research and knowledge creation to support management and staff in undertaking and applying research to improve health service delivery in the HA. To this end, FH used HACB funds to staff a variety of research facilitator-type positions within its existing research and development department, including an epidemiologist and grant facilitator. At the end of the HACB grant, FH had redefined its capacity building goal and added additional expertise to support the HA in becoming “an academic healthcare organization that improves health outcomes and health services sustainability through teaching, education and research”.

Table 6 lists key capacity building initiatives undertaken by FH. Developing infrastructure was an important to FH as shown by unique initiatives including a grant competition for new researchers (the grants themselves were not funded with HACB funds), development of research teams, and development of standard operating procedures. FH was also successful in signing a Memorandum of Understanding (MOU) with CIHR to allow Fraser Health to administratively and financially manage research awards.

Looking at the capacity building components addressed by FH initiatives, Figure 6 shows that more initiatives focused on knowledge translation and exchange and promoting research activity, which is consistent with FH’s initial capacity building objectives. The figure also shows that FH largely maintained the focus of its initiatives over the course of the grant related to the components and actually expanded its efforts in many areas (similar shape and shift in the dashed and solid lines).
Vancouver Coastal Health

Unlike the HAs presented thus far VCH was already a research-intensive organization prior to the HACB program. The HA includes several academic research centres and teaching hospitals, as well as two major research institutions, Vancouver Coastal Health Research Institute and the Providence Health Care Research Institute. In 2005/06, the institutes received approximately $58 and $19 million respectively in peer-reviewed grants. Within these institutes, the Centre for Clinical Epidemiology and Evaluation and the Centre for Health Evaluation and Outcomes Science are key health service and policy research units.

Despite the volume of research, VCH identified a need to strengthen linkages between researchers and decision-makers to support evidence-based decision making. The organizational structure of VCH provided few opportunities for researchers to connect with those responsible for guiding improvements to health practice, administration or policy.

VCH was conscious of the time-limitations of the HACB grant and this was reflected in the activities outlined in their HACB proposal. The capacity building focus for VCH was on activities “that would act as catalysts whose impacts did not depend on the presence of an ongoing program or department”. Accordingly, the initial work focused on brokering partnerships, grant writing support for knowledge translation opportunities, and presenting seminars for researchers on strategies for effective knowledge translation. To manage this capacity building work, a director was hired for the Health Services and Policy Research Collaboratory.

After eighteen months, VCH identified a new focus for its RCB efforts. Phase II of its capacity building work, from January 2007 to the end of the grant, supported training in program evaluation and provision of evaluation services. Table 7 lists the initiatives implemented by VCH in both Phases I and II. The significant change in focus between the two phases is evident in Figure 7, which shows the changes in capacity building components addressed by initiatives from the start to end of the grant. In Phase II (solid line), the initiatives heavily focused on the research culture – through facilitating close-to practice mindsets, developing skills and engaging in research activity (specifically evaluation activity). This is aligned with the goals of VCH’s program evaluation course, which was the key initiative of Phase II. Although Figure 7 does not show a remarkable shift in focus on developing skills, this is primarily due to Phase II focusing volume of effort within one initiative (the course) as opposed to a number of different initiatives addressing this component.

![Figure 7 Changes in capacity building components addressed by VCH initiatives over the course of the grant](image-url)
Provincial Health Services Authority (PHSA)

Provincial Health Services Authority is also a research-intensive organization. In 2003/04, the activities of over 500 investigators affiliated with PHSA and its agency-related research institutes and centres brought in over $100 million in research funding. Medical facilities within PHSA also attract considerable industry sponsorship for clinical trials research.

Despite this high level of research production, prior to the HACB grant, PHSA’s Five-Year Strategic Plan (developed in 2005) identified the need to build research capacity and strategies to enable translation of knowledge into better practice. Although there was substantial capacity for conducting research within PHSA, like VCH, there were few opportunities to develop research supports across agencies and effectively use research and evaluation knowledge to support decision-making and practice change. PHSA also recognized that increased capacity in database analysis and clinical epidemiology was needed if programs were to support the kinds of changes in health policy required for system improvement.

Unlike the other health authorities, PHSA used its HACB grant funds to hire highly qualified health researchers to conduct their own research and research of relevance to the health authority. This included health economists, epidemiologists and a systems analyst. Additionally, PHSA developed online educational resources in these areas for staff across the organization. PHSA capacity building initiatives are listed in Table 8.

Because of the variety and uniqueness of PHSA’s activities, the capacity building components addressed in Figure 8 may not fully reflect PHSA’s strategy for the HACB funds, particularly because of their existing extensive research activity and the challenge of attributing any initiatives’ impact solely to the HACB funding. It is clear from the figure, however, that the development of skills was addressed through ongoing work to produce the online educational resources. This together with the continued work of the funded researchers along with funding seminars and meetings of a variety of research stakeholders strengthened most capacity building components.

Table 8 Key initiatives implemented by the Provincial Health Services Authority

<table>
<thead>
<tr>
<th>Initiatives</th>
<th>At the start of the grant Jan 1, ’05 to Jul 31, ’06</th>
<th>Currently Aug 1, 08 to Jul 31, 09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Directed learning modules on health services research</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workshops, seminars, and training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy rounds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Development of evaluation framework (imPROVE)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 8 Changes in capacity building components addressed by PHSA initiatives over the course of the grant

Creating or enhancing linkages, partnerships, collaborations
Engaging in knowledge translation and exchange
Enhancing leadership in research
Facilitating close-to practice mindsets
Creating or enhancing research culture
Creating or enhancing infrastructure or resources
Promoting and engaging in research activity
Developing Skills

More initiatives addressing the component
Capacity building across the health authorities

As outlined in the preceding section, despite differences in size, needs, and initial health services and policy research capacity, HAs all implemented very similar RCB initiatives. Across all of the HAs, two basic models of health services and policy research capacity building were implemented: a research facilitator model, and a qualified health researcher model.

The research facilitator model focuses on training and supporting others to do and use research. The qualified health researcher model is less about building the capacity of others and more about increasing evidence-informed decision-making through the conduct and appreciation of research. In this model, a highly qualified health researcher conducts his or her own research or research of relevance to the HA.

In four of the HAs (FH, IH, NH, VIHA), the research facilitator model was used; in two health authorities (VCH and PHSA), both models were used to varying degrees. VCH moved more toward the research facilitator model in its second phase. PHSA primarily used the qualified health researcher model with some capacity building resources developed for staff. While Figures 3 to 8 show that both models can incorporate all of the capacity building components, there are significant differences between the two models.

As shown in Figure 9, all HAs spent almost all of their funds on HACB staff; however, there were differences in the number of FTEs employed among the HAs. For example, both PHSA and NH supported five positions, but for PHSA this represented a total of about 1.7 FTEs, while for NH this represented about 4.5 FTEs. To some extent, this reflects the difference in compensation for research facilitators versus highly qualified health researchers.

Not surprisingly, all HAs implemented more capacity building initiatives by the end of their HACB grant than at the beginning, as would be expected in any program planning cycle. This holds true even when considering that some of the initiatives were developed to be time-limited. It should be noted that the number of initiatives undertaken within each health authority indicates the diversity of activities implemented but does not reveal the volume of work associated with those initiatives.

Across all the HAs, a total of 11,077 participants were reported as participating in or accessing capacity building events and services related to the HACB program. Including online resources such as websites, databases and educational tools, the reach estimate grows to more than 205,000 users. On average, according to HACB survey respondents, each HA staff member was involved in two RCB activities.

Staff within the health authorities were the primary target of the HACB initiatives, as seen in Figure 10. Single initiatives could target more than one group shown in the figure, but almost all involved health authority staff. Because of variation in how the target population were reported by the health authorities, ‘general staff’ includes any staff not specifically defined as a decision maker or clinician/practitioner. Clinicians, practitioners, and health professionals are one group as there was some overlap in these categories. The 19 percent ‘Other’ group shown includes for example, students, patients, the government, and the MSFHR-funded Health of Population Networks.

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6 FTEs are approximate, as some positions changed FTE during the grant period.
Section 2. Capacity building activities implemented

Summary of capacity building

Despite initial differences in HA capacity building needs, there were more similarities than differences among activities implemented by the HAs. Four health authorities predominantly implemented a research facilitator model of capacity building, one HA primarily implemented a qualified health researcher model, and one health authority sequentially implemented each. Regardless of which model was implemented, all HAs used most of their HACB funds for personnel. With the exception of PHSA, most of the positions were research facilitator-type positions.

The focus of work varied among the HAs and was not related to the number of initiatives that each implemented. NH implemented activities addressing all eight capacity building components identified for this review, and showed little change in focus from the beginning of the grant to the end. In contrast to that, VHC deliberately changed the focus of its activities after the first funding period. Other HAs also made changes, but these reflect a difference of emphasis rather than the kind of shift seen in VCH.

The capacity building initiatives reached a substantial number of HA staff, with more than 11,000 participants reported by the HAs as attending capacity building activities and events. Including web-based resources, the reach of the HACB program extends to over 200,000 participants. Clearly, many initiatives were undertaken across the province in the five years of the HACB program and the funded initiatives had a sizable reach.

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**Figure 10 Target populations of capacity building initiatives**

% of initiatives targeting each group, all HAs

<table>
<thead>
<tr>
<th>Health Authority Staff</th>
<th>Clinicians, practitioners, or health professionals</th>
<th>General staff</th>
<th>Decision makers</th>
<th>Academic researchers and partners</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Authority Staff</td>
<td>97%</td>
<td>50%</td>
<td>69%</td>
<td>44%</td>
<td>19%</td>
</tr>
<tr>
<td>Clinicians, practitioners, or health professionals</td>
<td>97%</td>
<td>50%</td>
<td>69%</td>
<td>44%</td>
<td>19%</td>
</tr>
<tr>
<td>General staff</td>
<td>50%</td>
<td>69%</td>
<td>62%</td>
<td>44%</td>
<td>19%</td>
</tr>
<tr>
<td>Decision makers</td>
<td>69%</td>
<td>62%</td>
<td></td>
<td>44%</td>
<td>19%</td>
</tr>
<tr>
<td>Academic researchers and partners</td>
<td>44%</td>
<td>44%</td>
<td>44%</td>
<td>44%</td>
<td>44%</td>
</tr>
<tr>
<td>Other</td>
<td>19%</td>
<td>19%</td>
<td>19%</td>
<td>19%</td>
<td>19%</td>
</tr>
<tr>
<td>Other Health Authorities</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
</tr>
</tbody>
</table>
Section 3. Has research capacity been increased?

The evidence for whether the HACB program resulted in increased HA research capacity was gathered from the four outcome areas of the research capacity building framework developed for this evaluation. These areas include: research skills, partnerships and collaborations, knowledge translation and exchange, and the value placed on research as evidenced by organizational supports.

Research skills

One way to increase health services and policy research capacity is by increasing the ability of individuals to conduct and use research. All six health authorities implemented capacity building initiatives aimed at improving research (or evaluation) skills of individual staff. The HACB managers reported that they believed the skill building was the most successful of all capacity building activities implemented. A common initiative was skill-building workshops offered on a variety of topics such as: literature searching, program evaluation, statistical analysis, and critical appraisal of evidence. Other popular initiatives included one-on-one clinics and consultations and development of training materials through toolkits, websites, and guidelines. These initiatives were primarily implemented by FH, IH, NH, and VIHA. VCH developed a program evaluation course for staff, and PHSA created online educational modules on topics in health economics.

Participants in the capacity building activities across the health authorities were surveyed about whether their research skills improved as a result of their participation. Figure 11 shows that 74% of respondents feel their research skills were increased; the majority also reported feeling that they have become more involved in the production and use of research. The proportion of respondents who have become more involved in using research evidence is higher than those who have become more involved in doing research, and within some HAs this difference was quite significant (e.g. NH 73% more involved in using research, 52% more involved in conducting research). From the survey demographics, about 32% of survey respondents did not have experience conducting or using research prior to the HACB grant. Considering the varying levels of experience of being involved in research, all respondents were asked how prepared they are to be involved in undertaking research, conducting an evaluation, or using research evidence in decisions or practice (Figure 12). The majority of respondents either agreed or strongly agreed that they were well prepared to be involved in each of these areas, most strongly in using research evidence (90%). These data show that participants reported that they believed their skills have been increased and that they were more prepared to be involved in research.

Figure 11 Changes in skill and research involvement as reported by survey respondents

<table>
<thead>
<tr>
<th>% of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>As a result of participating in or accessing capacity building services...</td>
</tr>
<tr>
<td>Do you feel that your research skills have improved? n=451</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>Have you become more involved in research activities at your HA? n=389</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Yes, much more</td>
</tr>
<tr>
<td>Do you feel you have become more involved in using research evidence in your decisions or practice? n=389</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Yes, much more</td>
</tr>
</tbody>
</table>

7 PHSA is not included as it was not possible to identify those staff that used the online module.
To determine if the reported level of preparedness can be attributed at least in part to the capacity building activities, the responses of participants in the capacity building activities were compared to additional responses collected from non-participants. The comparison in Figure 12 shows significant difference in the responses between participants and non-participants. In all three areas, those that had participated in or had accessed the capacity building activities felt significantly more prepared than the non-participants. This suggests that the HACB activities contributed to increased preparedness of staff to be involved in research. The difference ranged from about 19% to 51% in the HAs. It should be noted that the number of non-participants that responded was lower than participants (average of 43 versus 342, respectively).

The proportion of respondents who were prepared to use research evidence was much higher than those prepared to conduct research or an evaluation. This could be a reflection that many of the activities implemented by the HAs focused on the knowledge and skill required for research use (such as knowledge translation and exchange activities, decision-making and leadership support, and promotion of research awareness and importance) than to the direct conduct of research.

VCH focused its second phase of activities on training staff in conducting program evaluations. As they did not specifically address enhancing research skills, VCH respondents were only asked whether they were well prepared to conduct an evaluation. Ninety-seven percent perceived (i.e., agreed or strongly agreed) that they were well prepared.

When asked which capacity building activities made the most significant contribution to capacity building within the HAs, the HACB managers reported individual skills building work was the most successful. This information is presented in Appendix C.

HACB managers and the interviewed executives in five HAs\(^8\) were asked whether the capacity building initiatives supported by the HACB program had increased research production and utilization skills within their HA. While the executives noted that skill building was the focus of many capacity building activities, most were not able to comment on whether there was an increase in these skills among staff. However most HA executives did note that the amount of training in their HA had significantly increased as a result of the HACB grant.

**Main Findings: Were Skills Increased?**

- HA staff who attended capacity building activities reported being more prepared to participate in research and evaluation than staff who did not attend capacity building events or activities.
- HACB program participants reported that they felt their research skills improved and ability to use research evidence in decisions increased as a result of the capacity building work in their HA.

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\(^8\) Excluding PHSA.
Section 3. Has research capacity been increased?

- HACB managers believe skills building to be the most successful of all capacity building activities implemented.
- HA executives believe more training on research and evidence use was made available to HA employees by the HACB grant.

Conclusion

Based on survey results from five HAs, those individuals who participated in HACB skill building initiatives reported that they believed their research skills and ability to do research and evaluation had been improved.

Collaborations and partnerships

Another way to increase health services and policy research capacity is by increasing linkages and partnerships among researchers, others interested in research, and other research supportive initiatives (Dobbins, et al. 2009). This was the second outcome area examined to determine whether linkages and partnerships were increased through the capacity building work.

To determine whether linkages and partnerships were increased through the HACB program, HACB managers were asked to list all partners engaged during the capacity building grant and to indicate the nature of engagement along a collaboration continuum ranging from:

- sharing information or networking (e.g. FH promoting its research week event to other HAs);
- coordinating activities (sharing information and harmonizing activities, e.g. FH and VCH employing the same evaluation educator);
- cooperating on joint initiatives (sharing information, harmonizing activities and sharing resources, e.g. NH and UNBC developing a joint ethics review board); and
- collaborating in common initiatives such that each partner enhances the other’s capacity, (e.g. VIHA and UVIC implementing a research help desk where university students gain experience doing research and the HA gains research staff).

Figure 13 shows where the nature of partnerships was focused along the continuum, primarily on networking to share information. HACB managers listed over 50 different partners. On average, each HA had 16 partners. Most partners were involved in a single activity with the HA, while about 20% of partners were involved in multiple activities. Information on partnerships and partner involvement is provided in Table 9.

The majority of partners were academic institutions, suggesting that creating linkages between researchers and the HA was a major focus of the work undertaken in this area (Figure 14). The second most frequent partner was with networks, primarily MSFHR’s Health of Population Networks. The majority of partners (78%) were located within BC.

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10 A full list of partners is provided in Appendix E.

11 The MSFHR funds 8 population of health networks within BC whose role is to support research within a particular content area. As of 2009, the networks were as follows: BC Child and Youth Health Research Network, BC Environmental and Occupational Health Research Network, BC Mental Health and Addictions Research Network, BC Network for Aging Research, BC Rural and Remote Health Research Network, Disabilities Health Research Network, Network Environments for Aboriginal Research BC, and Women’s Health Research Network.
Section 3. Has research capacity been increased?

...we are not trying to replicate the research expertise and the work that is led by these institutions, but rather to build the relationships and synergies necessary to take full advantage of each others’ expertise.

- NH on building partnerships

The HACB managers reported that 78% of partnerships were formed during the grant period, and about half would not have been possible without the HACB grant. HACB managers also reported that half the partnerships will continue beyond the grant period.

When asked whether they had increased interactions with others in the HA or with partners outside the HA for research purposes as a result of the HACB program, 78% of survey respondents said yes. Participants in HA capacity building activities were more likely than non-participants to have made research connections within the HA. Participants were much more likely to have made connections with others outside of the health authority for research purposes than non-participants.

As a result of HACB initiatives, one Interior Health executive reported several successful grants involving partnerships between IH staff and academic researchers at a variety of institutions, including:

- University of Alberta (CIHR Partnership for Health Systems Improvement grant);
- Thompson River University;
- Selkirk University;
- University of British Columbia Okanagan; and
- Centre for Operational Excellence at UBC.

Fraser Health was also successful in developing academic partnerships to further their research endeavours, including the development of research collaboration agreements with nine universities.

VIHA developed partnerships that resulted in a shared research ethics subcommittee with the University of Victoria as well as a research help desk course that matches students from the University of Victoria with HA staff to undertake research relevant to VIHA.

Northern Health worked with UNBC on joint grant applications. The two organizations also collaborated on a research course in the school of nursing that involved students conducting research and presenting evidence on clinical questions of direct relevance to NH.
Main Findings: Have Linkages and Partnerships Increased?

- 50 different research partners were listed across all HAs
- 78 percent of research partnerships were developed during the grant period
- Half the research partnerships will continue beyond the grant period
- 50 different research partnership activities were reported
- The majority of health authority capacity building participants reported they had connected with others within and outside of the HA to conduct or apply research

Conclusions:

At the outset of the grant many HAs reported their inability to connect with outside academic researchers hampered their ability to engage in health services and policy research. This evaluation found that the HACB program facilitated linkages, partnerships, and collaborations related to research across all the HAs and that half of these partnerships will continue beyond the grant period. This finding suggests the HACB program was effective at increasing capacity in this area of health services and policy research.

Knowledge translation and exchange: increased use of research evidence

In the area of knowledge translation and exchange (KTE), the use of research evidence emerged as the primary area addressed by the capacity building work, and so was primarily examined through this evaluation. Within the research utilization literature three types of use have been identified: instrumental, conceptual, and symbolic (Amara 2004).

Instrumental use refers to using research studies in specific and direct ways. Conceptual use involves using research to increase understanding of a topic without necessarily leading to direct action, and symbolic use means using research to justify decisions that have already been made. This evaluation concerned only the instrumental use of research and was examined by asking HACB managers and HA executives and staff for examples of research used for policy, practice or management decisions.

Across all the HAs, executives said they had seen an increase in decisions made on the basis of evidence. As reported by one IH executive: “At the senior executive level, the sophistication of the information and evidence that we get from various programs and people has changed.” He went on to report that the ability to evaluate programs in a more structured and formal way has also significantly improved.

The routine use of evidence was also reported by executives at FH:

“When a new practice or policy is looking to be introduced, revised, or changed, there’s more reliance on ensuring that the appropriate background research, literature review, best practice information is routinely gathered.”

“If we are looking at making decisions related to program delivery in a community, we will now conduct research into the characteristics of that community.”

The use of evidence for decision-making was also confirmed by other HACB survey respondents. When asked whether research evidence had led to notable changes in a program, service or practice within their HA, a majority of respondents (70% across the HAs that implemented the survey) confirmed this was the case, and over half could provide an example and 25% offered more than one example. In total, 219 examples were provided. The full list of examples is included in Appendix D. The list reveals research-
influenced changes across a wide range of areas including smoking cessation programs, telephone follow-up for patients with congestive heart failure, falls prevention, and best practices in sepsis treatment.

HACB survey respondents were asked if they used more research evidence in their decisions and practice since the program, and 67% confirmed this. Survey findings also show that the proportion of HACB respondents who report using more research evidence is higher than those who report doing more research. Within some HAs this difference was quite significant, possibly reflecting a greater need for research utilization than research production among HA staff (for example, in Northern Health, 52% of respondents reported being more involved in research while 73% reported being more involved in using research evidence).

While the data from HA executives and staff provide many examples of research utilization for program and policy decisions, they do not speak directly to the effect of the HACB grant. To determine whether the HACB grant had an effect on research use, comparisons were made between capacity building participants and non-participants on how well prepared they were to conduct or use research. As seen in Figure 12 (page 17) participants were more prepared than the non-participants to conduct research and use research evidence in decision-making. It is important to note, however, that 13 percent of all HACB survey respondents were identified as non-participants and this relatively small number limits the generalizability of the survey findings.

Several of the HACB managers and executives also commented that there is a movement toward greater research utilization, or evidence-informed practice and decision-making, as part of a larger trend within government, funders, and all types of health service organizations.

**Main Findings:**

- HA executives report greater evidence-informed decision making following HACB program
- HA staff report research evidence is being used in a variety of ways to improve services and programs within the HAs
- 219 examples of evidence use were provided by and HA executives and staff, and HACB managers
- HA staff report they are more involved in using evidence in decisions and practice

**Conclusions:**

Research is being used and evidence-informed decisions are being made within the HAs, and while the HACB activities support this trend, there are limitations to determining their direct influence.

**Research infrastructure and culture**

The last area of capacity examined in this evaluation involves organizational supports for research. All models of capacity building for research and evaluation recognize that the type and level of organizational support influences the extent of research production and use (Belkhodja 2007, Cathexis 2008, Stetler 2009). This includes both tangible support such as infrastructure for research support departments, staff, and funding, and intangible support such as organizational values or culture.

The research capacity framework developed for this evaluation identifies several research supportive infrastructure components, including capacity building staff, capacity building initiatives, leadership, research priorities and policies, and research supportive human resource policies. This section examines whether the research infrastructure within the HAs changed during the grant period (i.e., whether a “platform” of organizational support for research was created or enhanced, as described in the funding proposal guidelines) and looks at perceptions of the research culture within the HAs.
Section 3. Has research capacity been increased?

Infrastructure Changes

Providing the HAs with dedicated funding for capacity building enabled them to increase the number of staff and consultant positions supporting capacity building work (Figure 15, also see Figure 9). In total, the equivalent of 24.1 FTE staff was created during the grant period. Of the staff positions reported to be supporting the capacity building work during the grant, four (representing 3.5 FTE) existed prior to the HACB grant period. It is anticipated that 15 (representing 12.3 FTE) capacity building positions will exist continue after the HACB grant, as reported by the HACB managers. In total, capacity building staff positions will have increased by 275% over the course of the HACB program and the FTEs will have increased 251%.

At the time of this report, only IH was not able to confirm commitment to ongoing funding for any HACB grant funded positions.

Province-wide, the following staff will be retained post-HACB grant:

- Two HABC grant positions at FH will continue with FH funding
- The director position supporting capacity building work at VCH that was created through HACB funding, has been assumed by VCH\textsuperscript{13} with the position given a new title of Director of Innovation in Health Technology
- NH will fund the salary of the manager and two research facilitators involved in capacity building work originally funded through the HACB program
- Positions within PHSA will continue with PHSA funding
- VIHA has also made several HACB supported staff permanent

Not only will there be more capacity building staff post-grant, but the staff members appear to be well integrated into the organizational structures and operations. Integration has been found to be a key feature of sustainable evidence-informed practice (Stetler et al, 2009). NH, for example, deliberately established an integration mechanism through formal reporting relationships. Recall that NH hired a number of research facilitators and placed them within each of its three health service delivery areas (HSDAs). Matrix reporting relationships were used so that each facilitator reported to the manager of the research and evaluation department and to the chief operating officer of their HSDA. Facilitators were also included on the HSDA leadership teams. The HACB manager believes that strong inter-departmental connections were formed because of the decision to locate the research facilitators in each HSDA.

In other HAs, such as IH and PHSA, the integration of research capacity building staff was achieved through project-based work. At VIHA, staff had developed strong ties with other departments that do research on a regular basis, such as public and population health observatory,

\textsuperscript{13} This is particularly significant as this health authority set out to use the HACB funds in a way that would not require on-going support on the part of the health authority but after only 1.5 years of funding, the HA chose to take over the salary of the grant funded position.
Section 3. Has research capacity been increased?

palliative care, the pain clinic, perinatal care, mental health, and continuing health services (care for the elderly). This is also how integration was pursued at FH, although at least one HA education committee was formed with staff from research administration and development.

At VCH, capacity building work was similarly integrated through project-based relationships. The Director of the Collaboratory/Director of Innovation in Health Technology was also deliberately located in the corporate offices rather than within VCH’s research institutes.

In addition to the increased number of capacity building staff among the HAs following the HACB program, at the end of the program there was 25% more capacity building initiatives underway than there was at the start. Although the number of initiatives that will continue without HACB funding will be far fewer than the number implemented during the program, the HACB program certainly created a legacy in this area.

At the start of the HACB program, there was significant variation among the HAs in their health services and policy research needs and capacities. The HACB grant program has contributed to the development or enhancement of research support departments at NH, IH, VIHA, and FH. There will also be more infrastructure and support for research priority setting. NH, for example, established a Regional Research Review Committee during the grant. Similarly, IH has more research supportive policies including a research strategy, research priority setting processes, policies around ethics and Human Resources, and provincial practice education guidelines.

The research infrastructure has also been increased at VIHA. There is now a strategic plan for research, research priorities in health services research and clinical trials, and research policies on the conduct of research with Aboriginal and First Nations people. In addition, the research portfolio is now positioned within one of the six major portfolios through which all of VIHAs clinical care and quality support services are provided (Research, Quality and Safety). VIHA is also developing a strategic plan to guide its development as an academic research organization.

Infrastructure improvements were also noted at FH through the development of research priorities and processes to ensure that research priorities are aligned with corporate priorities. FH undertook a significant strategic planning process and is now implementing plans for the development of a research institute focused on health system improvement and sustainability. The Research Administration and Development (RAD) goals through 2009 to 2014 are to build research, evaluation, knowledge synthesis and exchange capacity, and to develop a sustainable funding strategy. The MOU with CIHR has allowed internal FH researchers to compete for CIHR research funding.

PHSA noted the creation of two leadership and priority setting mechanisms, a research committee of the PHSA board and an inter-agency research committee.

In summary, across all the HAs there are many examples of increased infrastructure for research as a legacy of the HACB grant program.

Research Supportive Culture

Intangible support through the values or culture of an organization can also promote research (Dobbins et al. 2009; Stetler, et al, 2009). As culture may be perceived differently by different members of an organization, it needs to be examined from multiple perspectives. The current evaluation looked at the perceptions of HA executives and staff, and HACB managers.

Almost all HA executives and HACB managers believe that research has gained increased importance within the health authorities in recent years. VIHA, for example, has seen a major shift in the importance placed on research, as illustrated in the excerpt below from the HACB manager’s report:

“…we were often told that having an office to support researchers in their endeavors was a life line.”

- VIHA on researchers’ perspectives of infrastructure
Section 3. Has research capacity been increased?

“….research principles and practices have become increasingly a part of VIHAs strategic efforts at the highest level.”

“The new focus on evaluable strategic priorities has emerged only because a sophisticated understanding of research, including translational research and evaluation, has now permeated to the very highest levels of the organization. This process is the result of a variety of capacity-building efforts which have made program focus and evaluation highly normative in health authority strategic planning.”

VCH also noted an increased demand for evidence: “…new programs are required to use evidence and existing programs are required to use evidence to determine level of ongoing support.”

HACB survey respondents were asked to rate the effectiveness of their HA at providing 12 components of a research supportive culture. For most of the components, respondents were unable to rate their HA’s effectiveness on that dimension.14 The majority of respondents either skipped the question or reported ‘I don’t know’ as to the effectiveness. The challenge in measuring changes to supportive research culture is reflected in these results.

There were only four items had a sufficient number of responses to be reliably reported. These included providing training, supporting staff to participate in research, promoting evidence-informed practice, and promoting networking opportunities. However, as shown in Table 10, overall, the majority of respondents judged the HA to be “somewhat effective” in these four areas.

When asked whether or not there had been a change in any of these components in the past four years (the period of the HACB grant program), the respondents for these four components were unable to confirm this, despite the fact that more than half of the respondents (~55%) had been with their HA for at least four years.

Main Findings:

- At five of the six HAs, ongoing funding for research capacity building staff has been assumed by the HA. As a result, there will be more capacity building staff in the HAs post-grant than before the grant.
- Several HAs will continue to fund some of the capacity building initiatives that were originally funded through the grant.
- There are now more research priority setting mechanisms in the HAs than there were prior to the HACB program.
- While most HA executives and HACB managers report that research is now more important and that their respective HAs are research supportive organizations, the majority of HA staff responding to the HACB survey perceive the HAs as only somewhat effective in providing research support.

Conclusions:

Taken together, these findings indicate that the HACB grant has resulted in an increase in research infrastructure at most of the HAs (i.e., more staff, more initiatives, more HA money dedicated to supporting research capacity building than before the grant, and more emphasis on research priority setting).

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14 The twelve items are included in Appendix F.
Overall conclusions on the increase in capacity

Has research capacity increased within the health authorities?

Looking at the overall results from the HACB survey and other data related to research capacity, it appears that many aspects of health services and policy research capacity have been increased at the HAs. There have been increases in research supportive infrastructure, improved research skills, increased participation in research activities, increases in research-related partnerships and collaboration, and many examples of evidence-informed decision making and changes to practice, policy, and management.

It is evident that some of these increases in capacity can be directly attributed to the HACB grant program. At NH and IH, the grant enabled the establishment of research support departments where none existed before. In five HAs, staff hired through the HACB grant will have their salaries taken over by the HAs post grant. In several HAs the program created capacity building initiatives which also will continue beyond the grant period. A majority of participants in the capacity building activities in five of the HAs reported they have increased research skills as a result of their participation and in every HA there were increases in partnerships and collaborations.

While the HACB grant is responsible for many or even most of these increases, it cannot take responsibility for all the changes reported by evaluation participants. In particular, the interviews with HA executives revealed that many had difficulty distinguishing HACB activities from other research capacity building activities within their HAs, and therefore could not directly attribute changes to the HACB grant. This was expected, given the complexity of most HAs, and the general trend within health care toward more evidence-informed practices and management. In fact, many respondents mentioned that the changes they had seen over the past few years reflect the direction in which the health care system is already moving (e.g., increased focus on KTE, and research funders like CIHR and MSFHR requiring the joint participation of academics and practitioners for grant-funded research). Recognition of the effectiveness of the HACB grant for building capacity was least evident at PHSA because of the nature and size of the HACB grant relative to

<table>
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<tr>
<th>Table 10 Participant perspective on the effectiveness of the HAs in key capacity building areas, as reported by survey respondents</th>
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<tr>
<td>How effective do you think your Health Authority is currently in this area? Results are shown for the four (out of 12) areas where the proportion of valid responses was 75% or greater. A valid response meant that an answer other than 'I don't know' was chosen.</td>
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<tr>
<td>% of responses for: Effective</td>
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<tr>
<td>Overall</td>
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<td>---------------------------------------------------------------</td>
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<td>Providing training, education, and skill development opportunities in research</td>
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<td>Supports staff, managers, physicians, and other individuals to participate in research</td>
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<td>Promoting and encouraging research activity and evidence-informed practice</td>
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<td>Promoting research-related networking opportunities within the HA</td>
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Note: the survey was not conducted at PHSA
the scope of ongoing research activities at PHSA. PHSA noted an overall increase in the volume of health services research activity, but said the HACB grant had little direct impact.

In view of all the findings from this evaluation, we can conclude that the HACB program did have some success in meeting the objective of helping HAs to establish a "platform" for increasing their health services and policy research capacity. Across the HAs, that platform has enabled the development of research skills, the formation of research partnerships and collaborations, and the implementation of capacity building initiatives with ongoing funding from several HAs.

"It has put research on the map."

- VIHA on the capacity building work
Section 4. Lessons learned from capacity building

Much has been learned about building health services research capacity during the five years the HACB program was offered. This section of the report looks at the enablers for research capacity building as well as the common challenges. It also looks at the HACB program overall and its effectiveness as a mechanism for facilitating capacity building.

Enabling capacity building

HACB managers and HA executives were asked to describe factors that enabled the capacity building work. Of these, several were common across more than four of the health authorities:

1. Funding
   External funding from MSFHR was integral to the development of research and research services within many of the health authorities. Without this funding, some of the health authorities would not have been able to venture into this area. In addition, the dedication of funds specifically for research capacity building from the HACB grant as well from the health authorities themselves ensured that health authorities could build and sustain activities over a period of several years, which is essential for effective capacity building.

2. Research department
   Dedicated capacity building staff within an integrated research department was an important success factor. Those health authorities with a department including research in its portfolio prior to the HACB grant reported that this pre-existing structure made the initiation of capacity building efforts easier. Health authorities that used the HACB grant to establish this structure indicated that having a dedicated department and staff provided objectivity, credibility, and expertise for their research support services.

3. Partnerships
   Building quality research relationships, particularly with academic institutions, was reported by most of the health authorities as an enabler to their capacity building work. Reciprocal knowledge exchange with academic researchers expanded health authority research capability.

4. Leadership
   Every health authority expressed the need for strong leadership and champions of research at the executive level. The benefits of this commitment include raising the profile of research within the organization, improving research use in decision making, establishing research priorities, encouragement and support to front line staff to get involved in research, leveraging of academic partnerships, and finally, recognition and celebration of capacity building achievements. It was also noted that champions from all levels of the organization, staff and managers as well as executives, elevated these benefits.

5. Building on previous success
   Although success may be defined differently within each health authority, most of them reported the ability to sustain enthusiasm and increase interest and participation in research grows as research activities are initiated and celebrated. One health authority referred to the ‘buzz’ in the health authority that grew from the staff sharing positive and successful experiences with the capacity building efforts.

There were other enablers that varied in importance for health authorities depending on their unique context. For example, Northern Health pointed to technology capability as an indispensable enabler for working across a large geographical area. Fraser Health highlighted the MOU with CIHR and the facilitator positions.
(epidemiologist and grant facilitator) as key for FH researchers to apply successfully for external research funding.

Many of the enablers were built into the HACB program. The program provided separate and dedicated funding to all HAs and required that each HA develop partnerships with academic institutions, other research supportive initiatives, and with each other. Other enablers can easily be incorporated into future program guidelines to optimize the success of initiatives.

**Challenges to capacity building**

HACB managers and HA executives were asked about the challenges faced in building capacity. Many of the enablers are reflected in the challenges. While funding dedicated to capacity building was essential for success, one of the greatest challenges across health authorities was securing funding within health authority budgets to sustain the work. Several challenges that differ from the reciprocal of enablers and that were common across the six health authorities include:

1. **Staff**
   Two types of staff challenges were identified: frequent staff turnover and the skill set of the staff in general. Turnover in leadership positions, in particular, made it difficult to maintain relationships and communications. Many staff lacked the appropriate skills and training to get more involved in research and evaluation and to use research evidence in their decisions or practice. While research training was a main focus of the capacity building work in many health authorities, it is a continuing challenge. Health authorities also noted that there is only so much that skill workshops and resources can do to get staff prepared to do research.

2. **Competing priorities**
   For staff, as well as the health authorities, care delivery is the primary priority. For the staff, this means workload demands restrict opportunities for research. It also was challenging for the HACB managers to raise the profile of research and to ensure its inclusion in the HA priority setting processes given that research is but one of many factors that influence resource allocation decisions.

3. **Organizational structure**
   Some health authorities faced challenges in appropriately integrating the capacity building work into the organizational structure, particularly in the areas of decision-making support, research planning, and evaluation and quality improvement.

There were other challenges that were of varying degrees of importance to health authorities depending on their unique context. For example, Northern Health and VIHA faced challenges in filling capacity building positions, each for different reasons. PHSA reported challenges in sharing data across its organizations to support collaborative inter- and trans-agency health services research.

Challenges were also reported by health authorities that could not be considered within the RCB framework. These correspond to aspects of the external environment that impede research such as geography and population characteristics, political influences, and sharing among organizations.

While it should be possible to design future programs to incorporate some of the enablers and to address the challenges, some may be beyond the scope of any individual intervention. For example, creating a research supportive culture may be asking too much of a single intervention;
however, given its importance it should be recognized and addressed within research capacity building initiatives.

Lessons on the HACB program

The HACB evaluation also collected data on how various aspects of the HACB program and its administration facilitated or hindered capacity building. The components of the program that were evaluated by the different respondents (HACB managers, HA managers and executives and HSPRSN staff) included the amount of funding, the formative review used to assess proposals, the nature of a non-prescriptive grant, and program extensions.

Most respondents were satisfied with the amount of funding; with only one commenting that the size of the grant was inadequate. HSPRSN staff suggested that improvements were needed in determining the size of the grants across health authorities. Few comments were offered on the formative review process with only one HA mentioning that more could have been done in the formative review process to help the HA focus its activities. The program permitted each HA to use its funds in the most appropriate way for its particular context and needs. HSPRSN staff believed that provision for HA-specific proposals was “absolutely critical” given the unique needs and characteristics of each health authority. The HAs offered differing opinions as to the value of this non-prescriptive programming. The openness was seen by some as a strength, but by others as a weakness as revealed in the two comments below.

“The HACB program goals were established broadly to acknowledge the uniqueness of each health authority’s situation. The grant did not require a focus on capacity development simply for the ‘doing’ of research. Because it was broad enough to encompass research development, research use and evaluation, it has been successful and embraced by our staff.”

“In retrospect, it was probably a mistake to apply it evenly to all six health authorities. Vancouver Coastal Health Authority and PHSA are unlike the other four health authorities, and they might have benefited from a differentiated approach that emphasized knowledge transfer to partner organizations.”

While the health authorities appreciated the long time period over which funding was provided (when the program ends, it will have provided just over five years of funding), the multiple extension periods were problematic as they were not known in advance. This made planning less than optimal, as illustrated by the quote below:

“The succession of brief funding extensions reduced staffing stability and limited our ability to take on large projects. Had I known that this funding had a reasonable chance of being extended as long as it has, I would have approached the programming differently.”

Comments by HACB managers on suggested areas of improvement for MSFHR included:

- Fostering a sense of mutual engagement (one HA felt MSFHR was reactive rather than proactive and another said that MSFHR did not provide a sense of mutual engagement with common goals);
- Improving evaluation planning and reporting (the evaluation was not developed until the last year of the funding and HACB managers had to compile and submit the end of grant report over a short time period during the summer months); and
- Improving funding extension planning.

Most HACB managers reported that the program was worthwhile.

“Of all the programs that HSPRSN offered, this was the one that was the most on the ground and practical and I think it was the one that had the greatest chance of success in bridging that academia service gap.”

The following aspects of the program appeared to work best for most HAs:

- Openness of the grant to respond to the context and needs of each HA
- The creation of a community of practice of research facilitators (MSFHR supported HACB managers to meet throughout the grant period)
- Dedicated external funding
The following aspects of the program could be improved:

- Predetermine the length of grant at the start and build in formative reviews at predetermined periods
- Recognize the long time frame required for capacity building work
- Develop evaluation requirements at the beginning of the grant

“The grant program recognized that capacity to do and to use research is needed in health authorities, not just in academic institutions; if all of the research took place in, and was driven by, academia, there cannot be effective integration of research into practice. HSPRSN was innovative in its commitment to direct health services research funding to health authorities.”
Section 5. Future research capacity building needs

Additional needs for capacity building beyond the HACB program were articulated through the interviews and by the HACB managers. Suggestions on future roles for MSFHR were also provided.

HACB managers and HA managers/executives commented on capacity building work that is still required. A list of themes extracted from the data is presented below.

1. Increasing the perceived value of research
   Despite the finding that most HA executives believe their organizations are becoming more supportive of research, all recognized that more work is required to promote the importance of research for HA programming and decision making.

2. Determining or setting research priorities
   While several HAs had implemented processes to develop research priorities, this was not done uniformly across the HAs. In addition, it was recognized that more progress can be made if provincial priorities are established and tailored to the specific context of each HA.

3. Supporting staff participation in research
   A number of recommendations focus on how research can more easily be supported within the HAs. These include seed grants for beginning researchers or granting programs dedicated to HA staff unable to compete successfully against academic researchers in traditional research funding competitions. Support is also required in building research and research release time into job descriptions and human resource policies.

4. Need for more networking and research collaboration among the HAs
   Although many of the HAs worked together during the grant period and some of this work was facilitated by periodic meetings sponsored by the MSFHR, the HAs saw the value of further collaboration and networking to enable joint development of services and materials.

5. Longer time frame for capacity building
   The HAs were unanimous in calling for a longer time frame than the initial three years of funding to facilitate this type of work.

6. More funding
   Given the current climate of reduced HA spending and budget alignment, a call for continued external, dedicated capacity building funding was made.

7. Greater integration with other departments within the HAs
   Among HAs, there were organizational differences as to where research support departments were situated and how integrated they were with core planning and service delivery. For HAs where the departments were perceived to be outside of the main decision-making bodies, it was recognized that better integration would facilitate the “institutionalization” of research and evidence-based decision-making.

8. Support for training
   While the extent of HA capacity building work was substantial, it reached only a fraction of the total number of HA staff. Several HAs reported that their training workshops often had long waiting lists and could not accommodate the demands for these services.

9. Evaluation support
   A number of HAs included developing capacity for evaluation as part of their capacity building work. Similar to the need for additional training capacity, in
some HAs the needs for evaluation could not be met by existing capacity building departments or services.

These themes span the range of capacity building elements found in the research capacity building framework and include infrastructure elements (organizational culture, integration, priority setting, and funding), individual level elements (individual skills in research and evaluation), and partnerships (relationships among HAs). These needs also reflect the challenges in capacity building work reported by HACB managers and executives.

The HACB survey respondents were also asked if there was “anything further that the HA could do”. Table 11 presents the top four responses across HAs. The responses identify two issues: allowing more dedicated time for conducting and/or applying research, and increasing skills (through funding to attend courses, directly providing training, and mentoring). These needs reflect the challenges mentioned by HACB managers and HA executives and managers. These needs should be considered in future program development.

### Future role for MSFHR in capacity building

Health authority managers and executives and HACB managers were asked about the role that MSFHR could play in continuing to support health services and policy research.

1. **Continued funding for capacity building**

   The evaluation has shown that further development of health services and policy research capacity is needed and that it requires a long term funding commitment. It also indicated that securing health authority funds for this activity is a challenge. Several comments from the interviews and HACB manager reports pointed to the ability for MSFHR to support unique programs such as this that are not supported through other funding agencies.

2. **Health services research strategy**

   MSFHR could play an advocacy role to the government to develop a provincial health services research strategy. This would also allow MSFHR to act as a neutral party and work closely with health authorities to assist in determining and supporting their unique roles and resource requirements. Closer links with the Ministry of Health Services could also allow targeting of capacity building to meet Ministry strategies and needs.

3. **Support and promote linkages and partnerships**

   MSFHR is well positioned to coordinate or facilitate more networking and collaborations among health authorities, as well as between health authorities and academic institutions. There is also an opportunity for MSFHR to broker research opportunities with similar health service delivery organizations across the country.
4. Focus on knowledge translation and exchange

MSFHR provides considerable support for primary research, but could increase emphasis on KTE to ensure research is effectively shared and used. This role for MSFHR underlies many of the other suggestions on this list.

5. Strengthen program evaluation within the province

Health authorities reported difficulty in moving individual evaluation skills to a more advanced level. MSFHR could play a role in strengthening the level of expertise available across health authorities and in government and in promoting the significance of evaluation in building research capacity and improving evidence-based decisions and practice.

6. Other funding mechanisms

A variety of other funding mechanisms could be taken to enhance research capacity building, for example:

- Seed grants to health authorities to conduct research and promote participation of new, non-academic researchers
- Platforms in applied health research such as health economics, policy research, and health services evaluation
- Fund flexible career development research positions within the health authorities
- Inventory and disseminate research opportunities available to health authorities

Many of the above suggestions are in keeping with the new strategic directions MSFHR has proposed. Within all these suggestions, continued work with the HAs was paramount.

Conclusion/Final Comments

This evaluation has shown that the HACB grant program did increase some aspects of health services and policy research capacity at most of British Columbia’s health authorities. New infrastructure has been established, more staff are now dedicated to research capacity building, more initiatives are available for staff, and partnerships have been created between HAs and academic institutions and among the HAs themselves.

The HACB program has certainly addressed two objectives of the HSPRSN health services and policy initiative: increasing capacity for producing and using health services and policy research and supporting the alignment between health service and policy researchers and decision-makers in health service organizations. The health services and policy research landscape has changed at most of the HAs. The HACB grant had a role in contributing to this changed landscape, but the HAs were also influenced by a more general trend of increased attention to evidence-informed decision making.

Although the HACB grant appears to have been a significant catalyst for change at many of the HAs, the work is not yet complete. The HAs believe that continued external funding is required to enable ongoing skills development for staff and the promotion of a research supportive culture.

There is perceived value in MSFHR continuing to facilitate research capacity building work and being a catalyst to link those involved in this work across the province. Almost every HA noted, with appreciation, the valuable opportunities provided by the funding.

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This report has provided many suggestions for how health services and policy research capacity building can be continued and improved. However, working in partnership with the HAs, researchers, and the Ministry of Health Services was one of the most frequently mentioned recommendations made by respondents to the HACB evaluation survey.

I think it [HACB program] was a very strategic move on somebody's part ... I think it's been a very big part of our shift and I think it was pretty essential for us as an organization ... thank you to Michael Smith for this, and I strongly encourage them to continue to do this good work.

- Executive perspective from NH
References


Appendices

For all appendices, please see accompanying document.