



CITIZEN BRIEF



ENHANCING ACCESS TO PATIENT-CENTRED PRIMARY CARE IN ONTARIO

action
best available evidence



15 OCTOBER 2016



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The McMaster Health Forum

For concerned citizens and influential thinkers and doers, the McMaster Health Forum strives to be a leading hub for improving health outcomes through collective problem solving. Operating at regional/provincial levels and at national levels, the Forum harnesses information, convenes stakeholders and prepares action-oriented leaders to meet pressing health issues creatively. The Forum acts as an agent of change by empowering stakeholders to set agendas, take well-considered actions and communicate the rationale for actions effectively.

About citizen panels

A citizen panel is an innovative way to seek public input on high-priority issues. Each panel brings together 10-16 citizens from all walks of life. Panel members share their ideas and experiences on an issue, and learn from research evidence and from the views of others. The discussions of a citizen panel can reveal new understandings about an issue and spark insights about how it should be addressed.

About this brief

This brief was produced by the McMaster Health Forum to serve as the basis for discussions by the citizen panel on enhancing access to patient-centred primary care in Ontario. The brief includes information on this topic, including what is known about:

- the underlying problem;
- three possible elements of an approach to address the problem; and
- key implementation considerations.

This brief does not contain recommendations, which would have required the authors to make judgments based on their personal values and preferences.

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Key Messages

What's the problem?

Several factors contribute to the challenges of enhancing access to patient-centred primary care. These factors broadly relate to:

- primary care not always providing access to services that address what make us sick;
- the number of people living with one or more chronic diseases continues to grow, which places strain on primary care;
- Ontarians having unequal access to primary care and many lacking timely access;
- the patient not always being put at the centre of care;
- difficulty in connecting patients to what they need due to a lack of coordination;
- past reforms having tried, with some success, to address these challenges; and
- additional system features making it difficult to provide patient-centred primary care.

What do we know about elements of a comprehensive approach for addressing the problem?

- **Element 1:** Ensure Ontarians receive access to the care they need, when they need it
 - This could include providing flexible appointment scheduling, using team-based care differently to provide better access to care for all Ontarians (e.g., in northern and rural areas), expanding the mechanisms through which primary-care clinicians and patients, families and caregivers can interact, and providing access to culturally and linguistically appropriate care.
- **Element 2:** Put the patient at the centre of care
 - This could include creating personalized care plans for patients and their families, supporting self-management, supporting shared decision-making between care providers and patients, using technology to engage patients in their care (e.g., patient portals and personal health records), engaging care coordinators for the sickest patients, and ensuring effective communication and coordination between care providers (e.g., after discharge from hospital).
- **Element 3:** Make the system accountable to meeting patient expectations
 - This could include engaging citizens and stakeholders in identifying what should be measured to determine if the system is meeting patient expectations, using an evaluation plan to find out if changes to the system have an impact, what additional changes might be needed, and reporting publicly on the performance of the system.

What implementation considerations need to be kept in mind?

- Barriers to implementing these elements might include: 1) complexity of and high costs associated with enhancing the use of information-sharing technology (e.g., electronic health records that patients can access); 2) lack of interest in or supports for some citizens, providers and organizations to engage in new ways of receiving/providing primary care; and 3) difficulty balancing patient expectations against what is feasible given existing resources.
- Windows of opportunity for implementing these elements might include: 1) drawing on momentum created by newly introduced legislation to strengthen patient-centred care in Ontario; and 2) using primary-care reform to meet larger health-system goals.

Box 1: What is patient-centred primary care?

Patient-centred care has been defined as “providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.”⁽⁴⁾ The overall goal of patient-centred primary care is to be able to provide access to comprehensive, coordinated and continuing care to the population it serves.⁽⁶⁾ There are 10 pillars that have been used to define a vision of patient-centred care, which we summarize in Table 1.

Several systematic reviews (and some key studies) have found that models that incorporate many or all of these pillars of patient-centred care have many benefits, including:

- increased access to specialists;
- improved patient and clinician experience;
- better use of information-sharing technology (e.g., email and electronic health records) to deliver care;
- improved coordination of care;
- enhanced delivery of preventive services; and
- reduced hospitalizations and emergency department visits.^(1;8;9;9-13)

Table 1. Pillars of patient-centred primary care (table adapted from www.patientsmedicalhome.ca)(22)

Pillar	Description
1 - Provide patient-centred care	<ul style="list-style-type: none"> Care that is focused on the individual patient and tailored to their specific needs.
2 - Provide access to a most responsible care provider	<ul style="list-style-type: none"> This is the 'point person' for each patient's primary care and could be a physician or nurse practitioner who takes responsibility for delivering patient-centred care over time.
3 - Deliver care using teams	<ul style="list-style-type: none"> Patient-centred primary care may provide many services to keep patients healthy and help when they're sick, with these services being provided by teams or networks of providers. Team members typically include family physicians, nurse practitioners, registered nurses, pharmacists, other professionals (e.g., dietitians and social workers), and staff (e.g., medical assistants).
4 - Ensure timely access to care	<ul style="list-style-type: none"> Patient-centred primary care would provide ready access to care when patients have health concerns (this could include 24/7 access, including weekends, much like some 'medical home' models in the United States). This typically means interacting with a care provider or one of their team members when care is needed (and this could be done over the phone, by email, online or in-person depending on the nature of the health concern).
5 - Provide comprehensive and coordinated care	<ul style="list-style-type: none"> Patients receive access to a broad range of care and services, which include home and community care (e.g., home care, therapy for mental health and addictions, and travel to medical appointments), as well as preventive services (e.g., screening and counselling for risky behaviours). These services are also seamlessly linked across providers, teams and settings.
6 - Ensure continuity of care	<ul style="list-style-type: none"> Patient-centred care ensures patients have a continuous relationship with a provider or team of providers that endures over time.
7 - Use electronic medical records to support patients	<ul style="list-style-type: none"> Patient-centred care uses electronic medical records to coordinate care across providers and settings, and to give patients access to their health information. Electronic medical records are also essential for supporting the delivery of evidence-based care and preventive services (e.g., through reminders and prompts for clinicians).
8 - Support education, training and research	<ul style="list-style-type: none"> Patient-centred primary-care models provide ideal sites for training physicians and other healthcare professionals such as nurse practitioners, and for conducting research that informs ongoing efforts to strengthen primary care.
9 - Evaluate and support ongoing improvement	<ul style="list-style-type: none"> As part of continuous quality improvement, primary care 'homes' carry out iterative and ongoing evaluation, and continuous improvement of the effectiveness of services provided, and progress towards achieving goals relevant to patients, providers, organizations and systems.
10 - Ensure strong internal and external supports	<ul style="list-style-type: none"> Primary care 'homes' need to draw on strong internal (i.e., governance and management structures) and external supports (i.e., engaging citizens and relevant stakeholders) to continue to improve care for their patients and contribute to achieving system-level goals. An important part of this pillar is ensuring that patients are engaged in care redesign and quality-improvement activities.

Questions for the citizen panel

>> We want to hear your views about a problem, three elements of an approach to addressing it, and how we can address barriers to moving forward.

This brief was prepared to stimulate the discussion during the citizen panel. The views and experiences of citizens can make a significant contribution to finding the best ways to meet their needs. More specifically, the panel will provide an opportunity to explore the questions outlined in Box 2. Although we will be looking for common ground during the discussions, the goal of the panel is not to reach consensus, but to gather a range of perspectives on this topic.



Box 2: Questions to consider for your deliberations

Question related to the problem

- What challenges have you and your family faced in accessing primary care when you need it?
- What challenges have you experienced related to accessing patient-centred primary care for:
 - those who are healthy but may need some care to prevent diseases;
 - those with some ongoing care needs;
 - the sickest Ontarians; and
 - groups that are often marginalized or lack access to needed care (e.g., those from underserved and/or rural areas, people living in poverty, those with mental health and addictions and/or those from ethnocultural groups that may face cultural or linguistic barriers to accessing care)?

Questions related to the elements of an approach to address the problem (please also see more specific questions provided as part of each element)

General questions

- What has made primary care work well for you, your family and/or caregivers in the past?
- What should patient-centred primary care look like in your community?
 - What should it look like for: 1) healthy patients; 2) those with some ongoing care needs; 3) the sickest Ontarians; and 4) groups that are often marginalized or lack access to needed care?

Key questions related to your preferences for accessing care

- Do you have a preference for whether a family physician or another type of primary-care provider (e.g., nurse practitioner) is most responsible for your primary care over time?
- How can technology be used to enhance your access to and experience with primary care?
- What do you expect in terms of receiving timely access to care from your most responsible care provider?
- If your most responsible care provider is not available when you need them, would you prefer to:
 - wait until you can see them;
 - interact with them using technology (e.g., email); or
 - interact with another provider who you may not know (e.g., another family physician or a nurse practitioner working in the same team)?
- What do you want and expect from primary care to ensure all of your care (e.g., home care, acute care) is seamlessly coordinated?
- Would you be comfortable with receiving care from teams of providers with expertise in common conditions (e.g., low-back pain, depression and end-of-life care) who can collaborate with your most responsible care provider?

Box 3: Glossary

Primary care

"Level of a health service system that provides entry into the system for all new needs and problems, provides person-focused (not disease-oriented) care over time, provides care for all but very uncommon or unusual conditions, and co-ordinates or integrates care provided elsewhere by others."(3)

Patient-centred care

"Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions."(4)

Chronic disease

A health problem requiring ongoing management over a period of years or decades (e.g., asthma, cancer, depression, diabetes and heart disease).(14)

Home and community care

Services to help people receiving "care at home, rather than in a hospital or long-term care facility, and to live as independently as possible in the community. Home and community care is delivered by regulated health care professionals (e.g., nurses), non-regulated workers, volunteers, friends and family caregivers."(16)

Self-management

"An individual's ability to manage the symptoms, treatment, physical, psychosocial, and lifestyle changes inherent in living with a chronic condition."(17) It empowers patients and prepares them to manage their health and healthcare.(18;19)

Electronic health record

"A complete health record under the custodianship of a health care provider(s) that holds all relevant health information about a person over their lifetime. This is often described as a person-centric health record, which can be used by many approved health care providers or health care organizations."(21)

Box 4: The Health System in Ontario

Key features of the health system

- Medical care provided in and with hospitals and by physicians is fully paid for as part of Ontario's publicly funded health system.
- Care and support provided by other healthcare providers such as nurses, physiotherapists, occupational therapists and dietitians are typically not paid for by the health system unless provided in a hospital or long-term care setting, or in the community through Family Health Teams, Community Health Centres, and community and other designated clinics.
- Other healthcare and community services such as prescription drug coverage, community support services and long-term care homes may be partly paid for by the health system, but any remaining costs need to be paid by patients or their private insurance plans.
- Fourteen geographically defined Local Health Integration Networks (LHINs) have responsibility for the planning and funding of healthcare in their regions, and for ensuring that the different parts of the health system in their regions work together.
- The most recent estimates of the health workforce in Ontario indicate that for every 100,000 Ontarians there are 100 family physicians, 102 specialists, 699 registered nurses (including 14 nurse practitioners), 83 pharmacists, 48 physiotherapists and 38 occupational therapists.(7)
- 94% of Ontarians report having a primary-care provider,(15) and 25% of the population receive team-based care (Family Health Teams, community health centres, nurse-practitioner-led clinics and Aboriginal health access centres).(5)

Features most relevant to home and community care

- Fourteen Community Care Access Centres (CCACs) – one for each LHIN – have responsibility for connecting people with the care they need at home and in their community (although these have been proposed to be eliminated in the most recent proposal for strengthening patient-centred care in Ontario).
- 644 not-for-profit community support-service (CSS) agencies provide assistance to more than 800,000 community-dwelling Ontarians (including older adults, and people with a physical disability and/or mental health issue, and addictions). The assistance can include personal support (e.g., for household tasks, transportation, meals-on-wheels, supportive housing and adult day programs).(20)
- 75 community health centres (CHCs) serve approximately 500,000 people in Ontario with 250,000 of these accessing primary, home and community care services.

Features for specific populations (high-needs users of the health system)

- 82 Health Links (of an anticipated total of 100) support the delivery of integrated care for those with complex needs (typically those living with multiple chronic diseases).



There is “convincing evidence that strong primary care is associated with lower costs and improved quality of care”(1;2)

The context: Why is enhancing access to patient-centred primary care a priority?

>> Primary care is a foundation of the health system and is central to achieving high-quality clinical care and an improved patient experience

In December 2015, the Government of Ontario published a proposal for how to achieve its commitment to transforming the health system into one that puts the needs of patients at its centre.(23) Building on this, the province recently introduced Bill 41, which is called the *Patients First Act*. The key components of this proposed legislation and how each could help patients (as identified in the summary of the legislation) are outlined in Table 2.

As can be seen, enhancing access to patient-centred care is central to the legislation. However, to support its implementation there is a need to identify patient expectations for patient-centred primary care in Ontario. This is important for ensuring that the changes made contribute to enhancing patient experience, improving the health of Ontarians and reducing costs.

Table 2: Summary of key components of the proposed Patients First Act and how it could help patients (content adapted from the Patients First summary)(24)

Component	How it could help patients*
Effective integration of services and greater equity across sub-regions	<ul style="list-style-type: none"> • Care delivered based on community needs • Enhanced appropriate care options to ensure that community needs are met • More funding directed to patient care • Easier transitions between acute, primary, home and community and long-term care • Increased effective, evidence-based care across the province • Stronger provincial planning, supported by robust data management and performance measurement
Timely access to, and better integration of, primary care	<ul style="list-style-type: none"> • Improved access to a primary care provider when needed, including on evenings and weekends • Better communication between patients, families and health care providers • Easier access for patients to a range of health care services • Reduced emergency department use and hospital readmissions through greater care coordination and collaboration between providers • Higher patient satisfaction
More consistent and accessible home and community care	<ul style="list-style-type: none"> • Clear standards for home and community care • Improved integration of home and community care with primary care and other community services • Greater consistency and transparency in home and community care delivery across the province • A better patient and caregiver experience
Strong links to population and public health	<ul style="list-style-type: none"> • Better reflection of population needs in health service planning and delivery • Health planning and service delivery to be better informed by public health expertise • Stronger linkages between disease prevention, health promotion and care

*The content in this column is verbatim from the Patients First summary document.(24)

What has been done in Ontario to enhance access to patient-centred primary care?

Ontario has implemented several models of team-based care that draw on many of the pillars of a patient-centred model of primary care. These include:

- Family Health Teams (team-based primary-care model consisting of physicians, nurse practitioners and other clinicians working in collaboration with extended hours of care provided);
- Nurse Practitioner-led Clinics; (a primary-care model where nurse practitioners assess, diagnose, treat and monitor a wide range of health problems);
- Community Health Centres (serving primarily hard-to-reach communities and disadvantaged populations that may have difficulty accessing healthcare services and which have salaried physicians); and
- Aboriginal Health Access centres (these provide a combination of traditional healing, primary care, cultural programs, health-promotion programs, community-development initiatives, and social-support services to First Nations, Métis and Inuit communities).(25)

However, as outlined in the next section about the problem, these models have not been rolled out in a way that achieves coverage for all Ontarians in need of team-based care, particularly for those with complex health needs.

To provide patient-centred care for those with complex health needs, the province began the implementation of approximately 100 Health Links. As part of this initiative, family physicians, hospitals, long-term care homes and community organizations work as a team to provide more coordinated care for those with the most complex health needs. This includes providing patients with:

- an individualized care plan;
- providers responsible for ensuring the plan is followed;
- supports for taking the correct medications; and
- a most responsible care provider who knows the patient and their situation.(26)

Currently 82 of approximately 100 Health Links have been implemented in Ontario and the models continues to evolve. Given this, citizen perspectives about how best to provide patient-centred primary care to those with the most complex health needs is also needed to inform the continued implementation of the Health Links.



Only 1 in 4 Ontarians have access to a team of primary-care providers. Those who are sicker, live in urban areas and new immigrants are less likely to receive care from a primary-care team (5)

The problem: Why is enhancing access to patient-centred primary care in Ontario necessary but challenging?

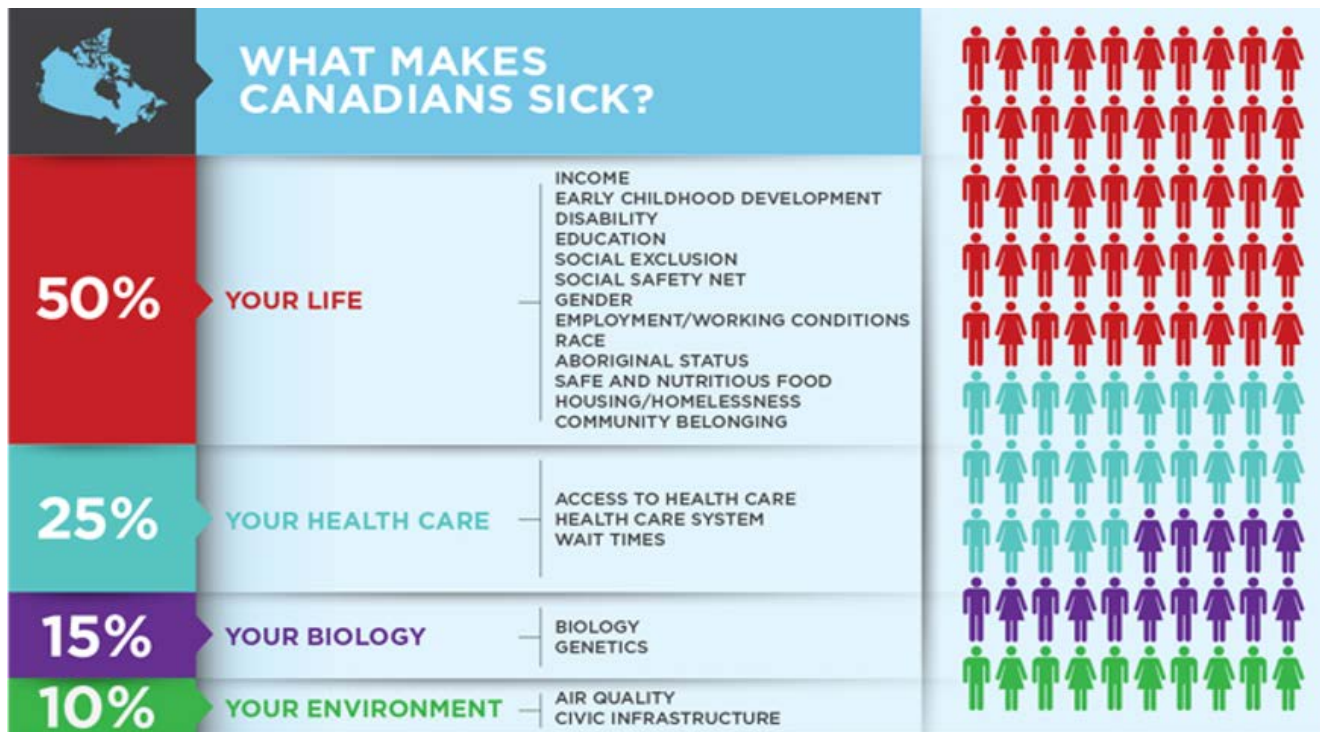
Several factors contribute to the challenges of enhancing access to patient-centred primary care. These factors broadly relate to:

- primary care not always addressing what makes us sick;
- the number of people living with one or more chronic diseases continuing to grow, which places strain on primary care;
- Ontarians having unequal access to primary care and many lacking timely access when they are sick;
- the patient not always being put at the centre of care;
- difficulty in connecting patients to what they need due to a lack of coordination;
- past reforms having tried, with some success, to address these challenges; and
- additional system features making it difficult to provide patient-centred primary care.

Primary care does not always provide access to services that address what make us sick

As displayed in Figure 1 from the Canadian Medical Association, there are many factors that contribute to what makes us sick. Healthcare contributes to addressing about 25% of what makes you sick.(27) But the health system, particularly primary care, can do more than just provide access to healthcare as it can connect people to needed home and community supports to keep them healthy and help address the many other factors that affect our health. However, as noted on the next page, the burden of chronic disease continues to grow, pointing to a need to focus on keeping people healthier.

Figure 1: What makes Canadians sick? (Figure from the Canadian Medical Association)(27)



The number of people living with one or more chronic diseases continues to grow, which places strain on primary care

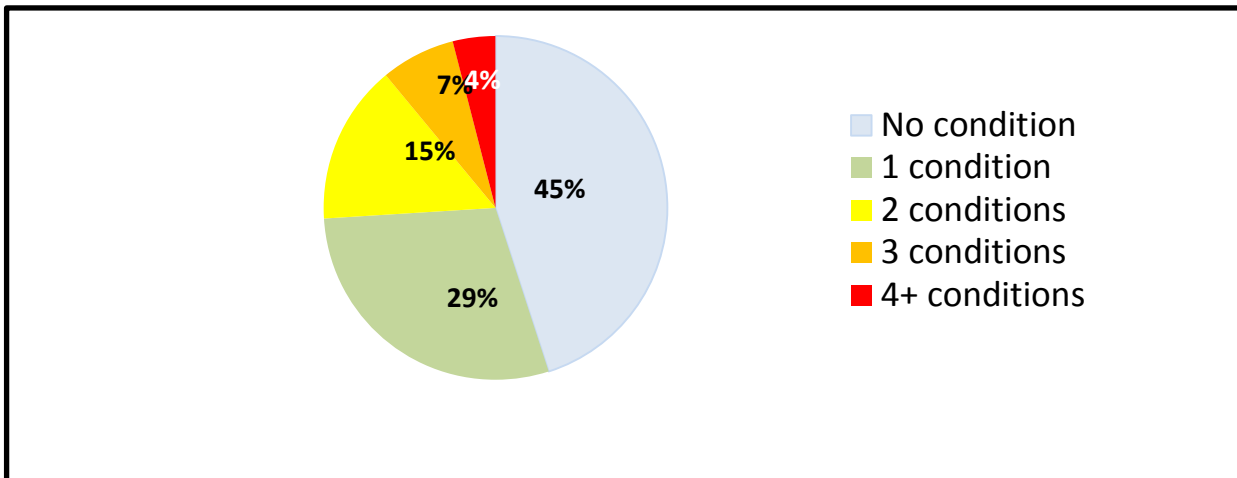
Many people are living with chronic diseases (see Figure 1), and data indicates that approximately:

- 38% of Canadians over the age of 20 have at least one chronic disease;(28)
- 21% of Canadians are living with a major chronic disease (cancer, diabetes, cardiovascular disease, chronic respiratory diseases);(28)
- 15% of Canadians are living with two or more chronic diseases;(28)
- 80% of Ontarians over the age of 45 (roughly 3.7 million people) are living with a chronic disease;(29) and
- 70% of those considered the sickest Canadians have two or more chronic diseases.(29)

Also, the number of people living with chronic disease is increasing by 14% per year in Canada.(30) In Ontario the population is projected to increase to 16.9 million by 2031 with those 65 and over making up 25% of the population. The combination of population growth and aging is expected to increase the burden of chronic disease in the province.(31)

This burden of chronic disease is also more concentrated in some groups. For example, 75% of Ontarians over the age of 65 report having one or more chronic disease.(32) In addition, chronic disease affects the most vulnerable in our society,(29;33;34) with the poorest Canadians being almost three times as likely as the highest-income Canadians to have multiple chronic diseases.(34)

Figure 1: Canadians with chronic health conditions



Ontarians have unequal access to primary care and many lack timely access when they are sick

Ninety-four percent of Ontarians report that they have a primary-care provider.(15) This puts Ontario slightly above the national average and in the middle when compared to similar countries.(15;35) However, access to primary care is not equal for all Ontarians. For example, those often not served well by the health system are those who are often marginalized, including Indigenous peoples, cultural groups (particularly recent immigrants and refugees), people living with mental health issues and addictions, and Francophones.(23)

Access also varies depending on where you live. At the low end, 87% of those living in the North West LHIN (a large region of the province that includes many First Nations communities with the major city being Thunder Bay) reported having a primary-care provider, as compared to 97% in the South East LHIN (which is northeast of Toronto).(15)

Some findings indicate that primary care is not available when Ontarians need it, but these findings depend on what patients deem to be ‘timely access.’ For example, recent estimates indicate that 40% of Ontarians report receiving a same- or next-day appointment when they are sick. This finding is similar to the national average of 38%, but it is the lowest in a recent comparison of 13 countries.(35) Similarly, 56% report difficulty accessing care after hours,(35) which is likely because after-hours care is not provided in many primary-care models. This percentage is substantially higher than most of the other 13 countries surveyed (e.g., only 29% reported difficulty in the United Kingdom).(35)

However, while another study found similar results for access to same- or next-day care, it also found that a large majority found it easy to get an appointment, and that they were seen as quickly as they wanted.(36) This points to a need for a flexible approach to providing and measuring timely access, which needs to be based on patient preferences. Indeed, a study with a sample of Ontario patients found that patients thought that timely access could range from one day to one week (but participants agreed that waiting longer than one week was unacceptable).(37) Also, study participants indicated that they expected physicians to be responsive within 30 minutes of arriving for their appointment.(37)

The patient is not always put at the centre of care

A recent analysis of the performance of Ontario's health system found that 86% of adults indicated they were always or often involved in decisions about their healthcare.⁽¹⁵⁾ This level of involvement is average, and only marginally lower than the best-performing countries, such as the United Kingdom (87%) and New Zealand (88%).⁽¹⁵⁾

Even though patients report relatively high levels of involvement in their care, there are several ways in which the patient is not put at the centre of care. For example:

- health professionals don't always work together to get people the care they need,⁽³⁸⁾ despite this being important for improving patients' outcomes;⁽³⁹⁻⁴³⁾ and
- a lack of electronic health records (i.e., a system enabling healthcare providers to access health information about individual patients) means that all the information about a patient is typically not in one place.

This often leads to patients having to 'tell their story' many times to different providers, instead of the providers coordinating and sharing information to make care as seamless as possible.

Also, patients, families and caregivers often lack the supports they need to empower them to take responsibility for their health and managing their care, and are not always engaged in policy development about the health system. Without such supports and engagement opportunities, care may not be patient-centred and policy developed to address health system issues may not be based on citizens' values and preferences.

It is difficult to connect patients to what they need due to a lack of coordination

Lack of coordination makes it difficult to provide patient-centred care. For example, the sickest Ontarians, such as those with multiple chronic health conditions and/or developmental disabilities, pose a significant and growing challenge for providing care that is coordinated and patient-centred. These sickest patients and their caregivers can be left to navigate the system, where they have to see a family physician, set and attend appointments with several specialists in different settings, manage many medications, organize home-based care and identify additional supports such as transportation that they may need. Indeed, situations such as this have been found to increase the risk of medical error and poor care coordination,⁽⁴⁴⁾ as well as patients having to retell their medical history.



Past reforms have tried, with some success, to address these challenges

The component of the health system in Ontario that incorporates most of the pillars of patient-centred care outlined in Table 1 are the 184 Family Health Teams,(45) as well as other team-based models of care (e.g., community health centres, Nurse Practitioner-Led Clinics and Aboriginal Health Access Centres). In general, Family Health Teams include “a team of physicians, nurse practitioners, registered nurses, social workers, dietitians, and other professionals who work together to provide primary health care for their community.”(46) Family Health Teams, as well as the other team-based models, serve a roster of patients and ensure they receive comprehensive, coordinated and continuous care when needed.

Evaluations of Family Health Teams indicate that they seem to address some of the access issues noted earlier, with approximately 79% of patients being able to get same-day appointments.(47) Family Health Teams have also achieved high satisfaction among patients and physicians.(43;45)

A recent evaluation of Family Health Teams, however, reveals that these benefits are not reaching all Ontarians or those most in need, indicating that they:

- only reach 25% of the population (this includes those receiving team-based care through other settings such as community and Aboriginal health centres, and nurse practitioner-led clinics);
- typically reach healthier patients instead of those with complex health needs who often need interprofessional care the most;
- have patients with higher incomes;
- have low numbers of recent immigrants enrolled; and
- are more often located in non-major urban areas or rural areas as compared to major urban areas.(5)

The same report also revealed that while Family Health Teams perform well on some indicators such as cancer screening and diabetes care:

- their patients use emergency departments more than patients in other models of care; and
- there are few differences in hospital admissions/readmissions and in specialist visits.(5)

Additional system features making it difficult to provide patient-centred primary care

Fixing these issues is not easy and requires taking on many system-level challenges. A big part of the challenge for enhancing access to patient-centred primary care is that resources need to be deployed and the system needs to be designed in a way that is flexible enough to address the needs of the healthiest to the sickest patients.

There are several examples of additional system features that contribute to this challenge. First, enhancing access to patient-centred primary care requires that patients have timely access to their preferred provider, and that visits are valuable and not subject to severe time constraints. However, patients often only have 15 minutes with their doctor, which limits the attention that can be paid to patients, particularly to those with complex needs. Also, the goal of ensuring patient attachment to a primary-care practice has resulted in some practices having rosters that are too big to serve in a timely way. As a result, the ability of providers to meaningfully engage patients in decision-making about their care is often limited.⁽⁴⁸⁾ It also makes it difficult to provide the supports needed to help patients self-manage some parts of their care.⁽⁴⁸⁾

Second, most physicians feel that they are not well prepared to manage the care of patients with complex needs, including being able to coordinate care and communication with other providers.⁽⁴⁹⁾ This is likely the result of a lack of training, support and/or coaching for physicians and their teams for working in a patient-centred model that manages the needs of all their patients, from the healthiest to the most complex.

Lastly, most doctors are not paid in a way that supports providing care to the healthiest (e.g., to support efforts to keep them healthy) or address the needs of those with complex conditions. For example:

- most doctors are paid for each service provided separately (this is called a ‘fee-for-service’ model), which is not always conducive to supporting preventive, integrated care for patients with complex needs,⁽⁵⁰⁾ or alternative ways of accessing care (e.g., through email); and
- most capitation contracts (i.e., providing a fixed amount to provide care for a patient each year) are only adjusted for age and sex and do not take into account medical complexity or other factors that could make patients sicker.



We have selected three elements of an approach to address the problem for which we are seeking public input.

Elements of an approach to address the problem

>> To promote discussion about the pros and cons of potential solutions, we have selected three elements of an approach for building a primary-care 'home' for every Ontarian

Many approaches could be selected as a starting point for discussion. In collaboration with our steering committee for this project and through consultation with key informants, we have identified three elements of a potentially comprehensive approach for which we are seeking public input. These elements would:

- Ensure all Ontarians receive the care they need when they need it;
- Put the patient at the centre of care; and
- Make the system accountable to meeting patient expectations.

Together, these elements emphasize the 10 pillars of patient-centred care models that were identified earlier in Table 1. These approach elements should not be considered separately. Instead, each should be considered as contributing to a comprehensive approach to addressing the problem. New approach elements could also emerge during the discussions.

As you review the elements, please keep in mind the general questions that we posed at the start of the brief, as well as the more specific questions that we have included in each element below. The broad questions for you to consider include:

- What has made primary care work well for you, your family and/or caregivers in the past?
- What should patient-centred primary care look like in your community?
 - What should it look like for: 1) healthy patients; 2) those with some ongoing care needs; 3) the sickest Ontarians; and 4) groups that are often marginalized or lack access to needed care?

Element 1 – Ensure all Ontarians receive the care they need, when they need it

Overview

The first element aims to address the pillars of patient-centred primary care of providing timely access to care, providing access to a most responsible care provider, and delivering care using teams of providers. Several of the activities listed below could also apply to achieving the goals outlined in the other approach elements.

This could include:

- providing flexible appointment scheduling (i.e., access to same- or next-day appointments for those with urgent needs, and appointments within a reasonable period of time for those with less urgent needs);
- using a team-based approach to care, where patients see their most responsible care provider (e.g., their family physician) whenever possible, with follow-up where necessary when this is not possible in more urgent cases;
- expanding the mechanisms through which primary-care clinicians and patients, families and caregivers can interact (e.g., smart phone apps that support self-management through secure telephone and email consultations); and
- providing access to culturally and linguistically appropriate care.

Evidence to consider

We identified several systematic reviews (i.e., a synthesis of results from all the studies addressing a specific topic) relevant to the three activities listed above that could be included in this element.

Key findings from these reviews include:

- scheduling which shifts away from pre-arranged schedules to an open schedule where patients are offered an appointment on the day they call or at the time of their choosing (usually within 24 hours), has been found to reduce wait times and no-show rates, but effects on patient satisfaction were mixed;(51)
- patients and clinicians report improved healthcare access, greater satisfaction and enhanced quality of healthcare in the Family Health Team model;(43)

- models of care that use a collaborative team-based approach for people with mental health conditions improve mental and physical quality of life and social role functions, when delivered for different disorders and in different settings;(52)
- telemedicine, as compared to usual face-to-face care or just consultation over the telephone, achieves similar health outcomes, and can improve the management of some chronic diseases such as diabetes, but evidence about its costs and acceptability to patients and providers is uncertain;(53)
- increasing numbers of health professionals are using smartphones, with primary-care providers being the largest adopter of using mobile applications, and mobile applications have been found to be useful as they allow physicians' practices to respond quickly to patients through email and text messages, prevent errors, help manage patient data, and support collaborative care with patients;(54) and
- among culturally and linguistically diverse patients, providing culturally appropriate care was found to improve patient compliance to health behaviours and assist in accurately identifying patient needs.(55)

Questions to consider

- Do you have a preference for whether a family physician or another type of primary-care provider (e.g., nurse practitioner) is most responsible for your primary care over time?
- How can technology be used to enhance your access to and experience with primary care?
- What do you expect in terms of receiving timely access to care from your most responsible care provider?
- If your most responsible care provider is not available when you need them, would you prefer to:
 - wait until you can see them;
 - interact with them using technology (e.g., email); or
 - interact with another provider who you may not know (e.g., another family physician or a nurse practitioner working in the same team)?
- If you have adequate access to care, do you think walk-in clinics are needed? Why or why not?

Element 2 – Put the patient at the centre of care

Overview

The second element aims to address the pillars of patient-centred primary care of providing patient-centred care, delivering care using teams of providers, providing comprehensive care, ensuring continuity of care and using electronic medical records.

This could include:

- creating personalized care plans where patients and clinicians collaboratively develop a plan to address the patients' health issues;
- promoting self-management resources;
- supporting shared decision-making with care providers (e.g., through decision aids);
- engaging patients, families and caregivers in care by providing access to personal health records (sometimes called patient portals) that allow for lab-test results review, online medication refills, provision of after-visit summaries, and informational supports that help patients, families and caregivers manage care;
- engaging care coordinators for the sickest patients who assume responsibility for ensuring patients are transitioned across providers, teams and settings; and
- ensuring effective communication between care providers (e.g., after discharge from hospital and urgent care visits).

Evidence to consider

We identified several systematic reviews relevant to the six activities listed above that could be included in this element, which we summarize in Table 3.

Questions to consider

- What would be helpful to support you to take ownership of your health, and understand how to manage your own care?
- What do you want and expect from primary care to ensure all of your care (e.g., home care, acute care) is seamlessly coordinated?
- Would you be comfortable with receiving care from teams of providers with expertise in common conditions (e.g., low-back pain, depression and end-of-life care) who can collaborate with your most responsible care provider?
- What do you want and expect in terms of the use of technology for:
 - providers using your health records across teams and settings; and

- patients, families and caregivers having access to personal health information to help them manage their care?

Table 3: Summary of evidence about element 2

Activity	Key findings
Personalized care plans	<ul style="list-style-type: none"> • Personalized care planning has been found to improve some indicators of physical and psychological health status, as well as patients' ability to manage their condition.(46)
Self-management resources	<ul style="list-style-type: none"> • Approaches to self-management: <ul style="list-style-type: none"> ○ can include interventions "designed to develop the abilities of patients to undertake management of health conditions through education, training and support to develop patient knowledge, skills or psychological and social resources"; ○ can be delivered individually or in groups, face-to-face or remotely and by professionals or peers; and ○ have been found to reduce health service utilization without negatively affecting patient health.(47)
Shared decision-making with care providers	<ul style="list-style-type: none"> • Approaches to supporting shared decision-making have been found to have no effect on patient participation in primary care or on patient- or disease-related outcomes.(48;49) • However, decision aids (materials that help individuals and/or their caregivers make decisions about their healthcare) have been found to be helpful because they: <ul style="list-style-type: none"> ○ increase knowledge about healthcare options;(50-53) ○ encourage consumer involvement;(53) ○ support realistic perception of outcomes and risk;(51;53-56) ○ reduce decision-related conflict;(53) ○ increase patient-practitioner communication;(53) and ○ support professionals to provide information and counselling about available choices.(50)
Providing access to personal health records	<ul style="list-style-type: none"> • Mixed evidence was found related to providing patients with access to personal health records. While one review found no substantial effects,(56) another found they: <ul style="list-style-type: none"> ○ improved patient self-efficacy; ○ improved patient-provider communication; ○ had a modest impact on patient satisfaction; ○ increased the length of time physicians spent documenting patients visits, but decreased the amount of time spent with patients; and ○ did not result in patients feeling stressed or overwhelmed by the information provided.(57)

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	<ul style="list-style-type: none"> • Individuals with some conditions (e.g., diabetes, hypertension, asthma, HIV, fertility management, glaucoma and hyperlipidemia) were found to benefit more from access to personal health records than others.(58)
Engaging care coordinators for the sickest patients	<ul style="list-style-type: none"> • Approaches used to improve coordination of care significantly reduce the number of people with chronic diseases (except for those with mental illness) being admitted to hospital, as well as emergency department visits for older adults.(58) • System navigators are a relatively new approach to link people with complex conditions to the care they need, so there is a lack of evidence to determine if they are helpful for supporting transitions between different settings.(59)
Supporting effective communication between providers and settings	<ul style="list-style-type: none"> • Electronic health records have been found to improve the quality of healthcare by allowing providers to make more efficient use of time and adhere to guidelines, as well as to reduce medication errors and adverse drug events for patients.(57) • Chronic-care models that incorporate clinical information systems (i.e., systems such as electronic health records that organize patient and population data to facilitate more efficient care) as one of several components, have been found to improve the functioning of healthcare practices, as well as health outcomes of patients.(61;62) • Creating tailored discharge plans for patients has been found to reduce how long they stay in hospital and the likelihood that they will be readmitted.(60)

Element 3 – Make the system accountable to meeting patient expectations

Overview

The third element aims to address the pillars of patient-centred primary care of supporting education, training and research, evaluating and supporting ongoing improvement, and ensuring strong internal and external supports.

This could include:

- engaging citizens and stakeholders in identifying what should be measured to determine if the system is meeting patient expectations;
- using an evaluation plan to find out if changes to the system have an impact and what additional changes might be needed; and
- reporting publicly on the performance of the system at the practice/organizational, community, regional and provincial level.

Evidence to consider

We identified several systematic reviews relevant to engaging citizens and stakeholders in identifying what should be measured, and about reporting publicly on the performance of the system. We did not identify any reviews about using an evaluation plan to find out if changes have an impact.

One review indicated that more research is needed to understand the impact of engaging citizens and stakeholders in identifying what should be measured.⁽⁵⁹⁾ However, other reviews found that:

- in well-designed public-engagement processes, participants often report high levels of satisfaction, increased knowledge and ability to build consensus among diverse views;⁽⁶⁰⁾
- there are mixed results about whether public engagement has an impact on decision-making, and patients have reported feeling that the impact of their involvement was small;^(61;62) and
- public-engagement efforts are more successful at the regional and local levels rather than the national level.⁽⁶²⁾

Reviews about reporting publicly on the performance of the system found that:

- public reporting in hospitals, nursing homes and on individual providers has resulted in reductions in mortality and improvements in quality of care;(63)
- individual clinicians and organizations are the most responsive to public reports, and in response were found to make positive changes to their practices;(63;64)
- while public reporting did not generally result in any harm, there was mixed evidence as to whether it can result in health professionals selectively choosing patients or “cherry picking”;(63) and
- public reporting has little impact on patient’s choice of providers, except for some effects among younger, more educated patients.(63;64)

Questions to consider

- What would be meaningful for you to know about how primary care is performing?
- Do you think the performance of primary care should be publicly reported? Why or why not?
- If the performance of primary care were to be publicly reported, would you want to know the results at the level of a primary-care practice/organization, community, region (i.e., the Local Health Integration Networks) or for the entire province (or all of these levels)?
- Should wait times between referral from primary care to seeing a specialist be reported?



Implementation considerations

It is important to consider what barriers we may face if we implement the proposed elements of an approach to address the problem. These barriers may affect different groups (e.g., patients, citizens, healthcare providers), different healthcare organizations or the health system. While some barriers could be overcome, others could be so substantial that they force us to re-evaluate whether we should pursue that option. Some potential barriers to implementing the elements include:

- difficulty in enhancing the use of information-sharing technology needed to support patient-centred care because of high costs for developing and implementing it (e.g., electronic health records that patients can access);
- lack of interest in or supports for some citizens, providers and organizations to engage in new ways of receiving/providing primary care (e.g., not all citizens have access to mobile phones and payment for providers may not support delivering care through mechanisms such as email); and
- difficulty balancing patient expectations against what is feasible given existing resources.



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The implementation of each of the three elements could also be influenced by the ability to take advantage of potential windows of opportunity. A window of opportunity could be, for example, a recent event that was highly publicized in the media, a crisis, a change in public opinion, or an upcoming election. A window of opportunity can facilitate the implementation of an element.

Examples of potential windows of opportunity relate to:

- **Drawing on the momentum of proposed reforms:** There has been increased momentum created by newly introduced legislation to strengthen patient-centred care in Ontario. When combined with the recognition from Health Links and efforts of other jurisdictions to promote patient-centred care, this attention could support changes that enable the system to be more responsive to patient preferences, needs and values.
- **Meeting health-system goals:** Improving access to patient-centred care by incorporating pieces from each of the three elements could help the province address each of the four goals in its action plan for the health system, which are: 1) improving access; 2) connecting services; 3) supporting people and patients; and 4) protecting the universal health system.



Acknowledgments

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Conflict of interest

The authors declare that they have no professional or commercial interests relevant to the citizen brief. The funder played no role in the identification, selection, assessment, synthesis, or presentation of the research evidence profiled in the citizen brief.

Merit review

The citizen brief was reviewed by a small number of citizens, other stakeholders, policymakers and researchers in order to ensure its relevance and rigour.

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References

1. Reid RJ, Johnson EA, Hsu C, Ehrlich K, Coleman K, Trescott C et al. Spreading a medical home redesign: Effects on emergency department use and hospital admissions. *The Annals of Family Medicine* 2013;11(Suppl 1):S19-S26.
2. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Quarterly* 2005;83(3):457-502.
3. Starfield B. *Primary Care: Balancing Health Needs, Services and Technology*. New York, United States: Oxford University Press; 1998.
4. Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, D.C.: National Academy Press; 2001.
5. Glazier RH, Hutchison B, Kopp A. Comparison of Family Health teams to Other Ontario Primary Care Models. Toronto, Canada: Institute for Clinical and Evaluative Science; 2015.
6. The College of Family Physicians of Canada. The Patient's Medical Home. The College of Family Physicians of Canada 2015 October 22; Available from: URL: <http://patientsmedicalhome.ca/>
7. Mattison CA, Lavis JN. Chapter 5: Health human resources. In: Lavis JN, editor. *Ontario's Health System: Key Insights for Citizens, professionals and Policymakers* (in press). 2016.
8. Hoff T, Weller W, DePuccio M. The patient-centered medical home: A review of recent research. *Med Care Res Rev* 2012 December;69(6):619-44.
9. Jackson GL, Powers BJ, Chatterjee R, Prvu Bettger J, Kemper AR, Hasselblad V et al. The patient-centered medical home: A systematic review. *Annals of Internal Medicine* 2013;158(3):169-78.
10. Reid RJ, Fishman PA, Yu O, Ross TR, Tufano JT, Soman MP et al. Patient-centered medical home demonstration: A prospective, quasi-experimental, before and after evaluation. *American Journal of Managed Care* 2009;15(9):e71-e87.
11. Reid RJ, Coleman K, Johnson EA, Fishman PA, Hsu C, Soman MP et al. The Group Health medical home at year two: Cost savings, higher patient satisfaction, and less burnout for providers. *Health Aff (Millwood)* 2010;29(5):835-43.
12. Peikes D, Zutshi A, Genevro JL, Parchman ML, Meyers DS. Early evaluations of the medical home: building on a promising start. *American Journal of Managed Care* 2012;18(2):105-16.
13. Williams JW, Jackson GL, Powers BJ, Chatterjee R, Bettger JP, Kemper AR et al. Closing the quality gap: revisiting the state of the science (vol. 2: the patient-centered medical home). *Evid Rep Technol Assess (Full Rep)* 2012 July;(208.2):1-210.
14. World Health Organization. *Chronic Diseases and Health Promotion*. World Health Organization 2012; Available from: URL: <http://www.who.int/chp/about/en/>

McMaster Health Forum

15. Health Quality Ontario. Measuring Up: A Yearly Report on How Ontario's Health System is Performing. Toronto, Canada: Queen's Printer for Ontario; 2015.
16. Health Canada. Home and Community Care. Health Canada 2014; Available from: URL: <http://www.hc-sc.gc.ca/hcs-sss/home-domicile/commun/index-eng.php>
17. Johnston S, Liddy C, Ives S, Soto E. Literature Review on Chronic Disease Management. Ottawa, Ontario: Élizabeth Bruyère Research Institute; 2008.
18. Lavis JN, Boyko JA. Evidence Brief: Strengthening Chronic Disease Management in Ontario. Hamilton, Ontario: McMaster Health Forum; 2009.
19. Wagner EH, Austin BT, Von KM. Organizing care for patients with chronic illness. *Milbank Quarterly* 1996;74(4):511-44.
20. Sinha SK. Living Longer, Living Well: Report Submitted to the Minister of Health and Long-Term Care and the Minister Responsible for Seniors on recommendations to Inform a Seniors Strategy for Ontario. Toronto, Canada: Ministry of Health and Long-Term Care; 2012.
21. Canada Health Infoway. EMR, EHR, and PHR – Why all the confusion? Canada Health Infoway 2016 February 26; Available from: URL: <http://infowayconnects.infoway-inforoute.ca/2011/04/07/emr-ehr-and-phr-why-all-the-confusion/>
22. Patient's Medical Home. The Patient's Medical Home. The Patient's Medical Home 2015 December 18; Available from: URL: <http://patientsmedicalhome.ca/files/uploads/CFPC-Patients-Medical-Home-EN.pdf>
23. Government of Ontario. Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario. Toronto, Canada: Queen's Printer for Ontario; 2015.
24. Government of Ontario. Patients First: Reporting Back on the Proposal to Strengthen Patient-Centred Health Care in Ontario. Toronto, Canada: Government of Ontario; 2016.
25. Association of Ontario Health Centres. Aboriginal Health Access Centres. Association of Ontario Health Centres 2016 January 19; Available from: URL: <https://www.aohc.org/aboriginal-health-access-centres>
26. Ontario Ministry of Health and Long-Term Care. Transforming Ontario's Health Care System: Community Health Links provide coordinated, efficient and effective care to patients with complex needs. Ontario Ministry of Health and Long-Term Care 2016 September 13; Available from: URL: <http://www.health.gov.on.ca/en/pro/programs/transformation/community.aspx>
27. Canadian Medical Association. What Makes Canadians Sick? Health Care Transformation 2013 June 25; Available from: URL: <http://healthcaretransformation.ca/infographic-social-determinants-of-health/>
28. Government of Canada. Chronic Disease and Injury Indicatory Framework. Government of Canada 2015 December 8; Available from: URL: <http://infobase.phac-aspc.gc.ca/cdiif/>
29. Health Council of Canada. How Do Sicker Canadians with Chronic Disease Rate the Health Care System? Results from the 2011 Commonwealth Fund International Health Policy Survey of Sicker Adults. Toronto, Canada: Health Council of Canada; 2011.

30. Elmslie K. *Against the Growing Burden of Chronic Disease*. Ottawa, Canada: Public Health Agency of Canada; 2016.
31. Cancer Care Ontario, Ontario Agency for Health Protection and Promotion (Public Health Ontario). *Taking Action to Prevent Chronic Disease: Recommendations for a Healthier Ontario*. Toronto, Canada: Queen's Printer for Ontario; 2012.
32. Canadian Institute for Health Information. *Seniors and the Health Care System: What is the Impact of Multiple Chronic Conditions*. Ottawa, Canada: Canadian Institute for Health Information; 2011.
33. Fortin M, Bravo G, Hudon C, Lapointe L, Almirall J, Dubois MF et al. Relationship between multimorbidity and health-related quality of life of patients in primary care. *Quality of Life Research* 2006;15(1):83-91.
34. Health Council of Canada. *Population Patterns of Chronic Health Conditions in Canada - A Data Supplement to Why Healthcare Renewal Matters: Learning from Canadians with Chronic Health Conditions*. Toronto: Health Council of Canada; 2007.
35. The Commonwealth Fund. *Commonwealth Fund International Survey. The Commonwealth Fund 2013*; Available from: URL: <http://www.commonwealthfund.org/topics/international-health-policy>
36. Laberge M, Pang J, Walker K, Wong S, Hogg W, Wodchis WP. *QUALICOPC (Quality and Costs of Primary Care) Canada: A focus on the aspects of primary care most highly rated by current patients of primary care practices*. Ottawa, Canada: Canadian Foundation for Healthcare Improvement; 2014.
37. Wong ST, Watson DE, Young E, Regan S. What do people think is important about primary healthcare? *Healthcare Policy* 2008;3(3):89-104.
38. Pojskic N, MacKeigan L, Boon H, Ellison P, Breslin C. Ontario family physician readiness to collaborate with community pharmacists on drug therapy management. *Research in Social and Administrative Pharmacy* 2011;7(1):39-50.
39. Tan ECK, Stewart K, Elliott RA, George J. Pharmacist services provided in general practice clinics: A systematic review and meta-analysis. *Research in Social and Administrative Pharmacy* 2014;10(4):608-22.
40. Dennis S, May J, Perkins D, Zwar N, Sibbald B, Hasan I. What evidence is there to support skill mix changes between GPs, pharmacists and practice nurses in the care of elderly people living in the community? *Australia and New Zealand Health Policy* 2009;6(1):23.
41. Chisholm-Burns MA, Kim Lee J, Spivey CA, Slack M, Herrier RN, Hall-Lipsy E et al. US Pharmacists' Effect as Team Members on Patient Care: Systematic Review and Meta-Analyses. *Medical Care* 2010;48(10).
42. Kwint HF, Bermingham L, Faber A, Gussekloo J, Bouvy ML. The Relationship between the Extent of Collaboration of General Practitioners and Pharmacists and the Implementation of Recommendations Arising from Medication Review. *Drugs Aging* 2013;30(2):91-102.

43. Gocan S, Laplante MA, Woodend K. Interprofessional collaboration in Ontario's family health teams: A review of the literature. *Journal of Research in Interprofessional Practice and Education* 2014;3(3).
44. Schoen C, Osborn R, How SK, Doty MM, Peugh J. In chronic condition: Experiences of patients with complex health care needs, in eight countries, 2008. *Health Affairs* 2009;28(1):w1-16.
45. Rosser WW, Colwill JM, Kasperski J, Wilson L. Progress of Ontario's family health team model: A patient-centered medical home. *The Annals of Family Medicine* 2011;9(2):165-71.
46. Ontario Ministry of Health and Long-Term Care. Family Health Teams. Ontario Ministry of Health and Long-Term Care 2014 December 31; Available from: URL: <http://www.health.gov.on.ca/en/pro/programs/fht/>
47. The Conference Board of Canada. Final Report: An External Evaluation of the Family Health Team (FHT) Initiative. Ottawa, Canada: The Conference Board of Canada; 2014.
48. Haggerty JL. Ordering the chaos for patients with multimorbidity. *British Medical Journal* 2012;345:e5915.
49. Osborn R, Moulds D, Schneider EC, Doty MM, Squires D, Sarnak DO. Primary care physicians in ten countries report challenges caring for patients with complex health needs. *Health Affairs* 2015;34(12):2104-12.
50. Tinetti ME, Fried TR, Boyd CM. Designing health care for the most common chronic condition - Multimorbidity. *JAMA: The Journal of the American Medical Association* 2012;307(23):2493-4.
51. Rose KD, Ross JS, Horwitz LI. Advanced access scheduling outcomes: A systematic review. *Archives of Internal Medicine* 2011;171(13):1150-9.
52. Woltmann E, Grogan-Kaylor A, Perron B, Georges H, Kilbourne AM, Bauer MS. Comparative Effectiveness of Collaborative Chronic Care Models for Mental Health Conditions Across Primary, Specialty, and Behavioral Health Care Settings: Systematic Review and Meta-Analysis. *AJP* 2012;169(8):790-804.
53. Flodgren G, Rachas A, Farmer AJ, Inzitari M, Shepperd S. Interactive telemedicine: Effects on professional practice and health care outcomes. *Cochrane Database of Systematic Reviews* 2015;(9):Art. No.: CD002098. DOI: 10.1002/14651858.CD002098.pub2.
54. Mosa ASM, Yoo I, Sheets L. A Systematic Review of Healthcare Applications for Smartphones. *BMC Medical Informatics and Decision Making* 2012;12(1):1-31.
55. Horvat L, Horey D, Romios P, Kis-Rigo J. Cultural competence education for health professionals. *Cochrane Database of Systematic Reviews* 2014;(5):CD009405. doi: 10.1002/14651858.CD009405.pub2.
56. Alkureishi MA, Lee WW, Lyons M, Press VG, Imam S, Nkansah-Amankra A et al. Impact of electronic medical record use on the patient-doctor relationship and communication: A systematic review. *Journal of general internal medicine* 2016;31(5):548-60.

57. Jilka RS, Callahan R, Sevdalis N, Mayer KE, Darzi A. ?Nothing About Me Without Me?: An Interpretative Review of Patient Accessible Electronic Health Records. *Journal of Medical Internet Research* 2006;17(6):e161.
58. Price M, Bellwood P, Kitson N, Davies I, Weber J, Lau F. Conditions potentially sensitive to a Personal Health Record (PHR) intervention, a systematic review. *BMC Medical Informatics and Decision Making* 2015;15(1):1-12.
59. Kötter T, SAchaefer FA, Scherer M, Blozik E. Involving patients in quality indicator development: A systematic review. *Patient Preference and Adherence* 2013;7:259-68.
60. Abelson J, Montesanti S, Li K, Gauvin F, Martin E. Effective strategies for interactive public engagement in the development of healthcare policies and programs. Ottawa, Canada: Canadian Health Services Research Foundation; 2010.
61. Legare F, Boivin A, van der Weijden T, Pakenham C, Burgers J, Legare J et al. Patient and Public Involvement in Clinical Practice Guidelines: A Knowledge Synthesis of Existing Programs. *Medical Decision Making* 2011;31(6):E45-E74.
62. Conklin A, Morris Z, Nolte E. What is the evidence base for public involvement in health-care policy? Results of a systematic scoping review. *Health Expectations* 2012;epub.
63. Totten A, Wagner J, Tiwari A, O'Haire C, Griffin J, Walker M. Closing the quality gap series: Public reporting as a quality improvement strategy. Evidence Report No. 208 ed. Rockville (MD): Agency for Healthcare Research and Quality; 2012.
64. Marshall MN, Shekelle PG, Leatherman S, Brook RH. The public release of performance data: What do we expect to gain? A review of the evidence. *JAMA* 2000;283(14):1866-74.

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