McMaster University

McMaster HEALTH FORUM

BUILDING A PRIMARY-CARE 'HOME' FOR EVERY ONTARIAN

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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 building a primary-care 'home' for every Ontarian. This brief includes information on this topic, including what is known about:

- the underlying problem;
- three possible options to address the problem; and
- potential barriers and facilitators to implement these options.

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 building a primary-care 'home' for every Ontarian. These factors broadly relate to:

- Ontarians have unequal access to primary care and many lack timely access when they are sick;
- the patient is not always put at the centre of care;
- a lack of coordination in the health system makes it difficult for patients to be easily connected to what they need;
- past reforms have tried, with some success, to address these challenges; and
- achieving more fulsome success will require taking on system-level challenges that citizens prioritize for us.

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

- **Element 1:** Ensure all Ontarians receive the care they need when they need it
  - This could include providing same-day scheduling to ensure timely access to care, using team-based models differently to provide better access to care for all Ontarians, and using secure email and telephone communication to enhance access to, prepare for, follow-up from, or substitute for in-person visits.
- **Element 2:** Put the patient at the centre of care
  - This could include creating personalized care plans based on patient goals, supporting self-management, supporting shared decision-making between care providers and patients, and using electronic health records to engage patients in managing their care.
- **Element 3:** Ensure the full range of care is seamlessly linked across providers, teams and settings
  - This could include engaging care coordinators for the sickest patients to help with transitions across providers, teams and settings, providing outreach and follow-up for discharges from hospitals and emergency departments, and ensuring effective communication between care providers.

What implementation considerations need to be kept in mind?

- Barriers to implementing these elements might include: 1) hesitancy among policymakers to invest in new ways of doing things during a time of 'no new money'; 2) resistance from citizens, providers and organizations to new ways of 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) harnessing the increased attention being paid to reforming primary care in Ontario; 2) drawing on momentum created by high-profile proposals to reform primary care; and 3) using primary-care reform to meet larger health-system goals.

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 1. Although we will be looking for common ground during these discussions, the goal of the panel is not to reach consensus, but to gather a range of perspectives on this topic.

>> Box 1: Questions for citizens

Questions related to the problem

- What challenges have you faced in accessing primary care when you need it?
- What challenges do you see for providing a primary-care 'home' for:
  - the sickest Ontarians;
  - those with some ongoing care needs; and
  - those with no chronic conditions but who may need some care to prevent diseases

Questions related to the elements of an approach to address the problem

- Element 1: What do you want and expect from a primary-care 'home' to make sure you get the care you need when you need it? What do you expect in terms of:
  - receiving timely access (e.g., should care be available on the same or next day?);
  - receiving timely access if for some reason your most responsible care provider is not available the same or next day;
  - who you see and your relationship with them (e.g., family physician or nurse practitioner?); and
  - how care is provided (e.g., from teams of providers and using email and/or electronic health records)?
- Element 2: What does patient-centred care mean to you? What would be helpful to support you:
  - to take ownership of your health; and
  - to understand how to manage your own care?
- Element 3: What do you want and expect from a primary-care 'home' to ensure all of your care is seamless?

Question related to implementation considerations

- What do you see as the main challenges for achieving these expectations?

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

The context: Why is building a primary-care 'home' for every Ontarian 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

The Government of Ontario has expressed its committment to transforming the health system into one that puts the needs of patients at its centre. To do this, the government's latest action plan focuses on four key goals:

- **improve access** – providing faster access to the right care;
- **connect services** – delivering better coordinated and integrated care in the community and closer to home;
- **inform people and patients** – providing the education, information and transparency they need to make the right decisions about their health; and
- **protect our universal public health system** – making evidence-based decisions on value and quality, to sustain the system for generations to come.(12)

These are important goals, but not simple ones to achieve. A key part of the plan to achieve them is to strengthen primary care. This includes ensuring patients have a family physician or nurse practitioner as their most responsible clinical provider of care, as well as access to teams of providers when needed (see glossary for definitions). Strengthening primary care is important to achieving each of the four goals because it means:

- improving access to primary care as the entry point into the health system;
- connecting people to primary-care providers who can both deliver care and coordinate the care provided by specialists and others;
- informing people and patients in primary-care settings about their care options, which has the benefit of primary-care providers such as family physicians and nurse practitioners building relationships with patients over time, which results in better health outcomes, delivery of preventive care and lower costs;(13;14) and
- protecting universal access to primary care for all Ontarians.

Box 2: 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."(6)

Most responsible care providers in a primary-care 'home'

- **Family physicians**: "The family physician is a skilled clinician. Family physicians demonstrate competence in the patient-centred clinical method; they integrate a sensitive, skillful, and appropriate search for disease. They demonstrate an understanding of patients' experience of illness (particularly their ideas, feelings, and expectations) and of the impact of illness on patients' lives."(7)
- **Nurse practitioners**: "Nurse practitioners assess, diagnose, treat and monitor a wide range of health problems using an evidence based approach to their practice."(9)

Primary-care models that most closely resemble a primary-care 'home'

- **Family Health Teams**: "Primary health care organizations that include a team of family physicians, nurse practitioners, registered nurses, social workers, dietitians, and other professionals who work together to provide primary health care for their community."(10)
- **Nurse practitioner-led clinics**: "Primary health care organizations that provide comprehensive, accessible, person centred and co-ordinated primary-care services to people of all ages."(9)
- **Community health centres (CHC):** Interdisciplinary teams that service hard-to-service communities and populations that may have trouble securing health services. CHCs focus on addressing the underlying conditions that affect people's health, such as those listed in Figure 1. They offer regular and extended hours and physicians are salaried employees.
- **Aboriginal Health Access Centres**: "Aboriginal community-led, primary health care organizations. They 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."(11)

Other primary-care models

- **Family Health Organization/Family Health Network** (groups of physicians paid by capitation with limited extended hours and a telephone consultation service)
- **Family Health Group** (groups of physicians paid fee-for-service with limited extended hours)
- **Comprehensive Care Model** (solo physicians, paid fee-for-service with regular office hours and one extended session per month)

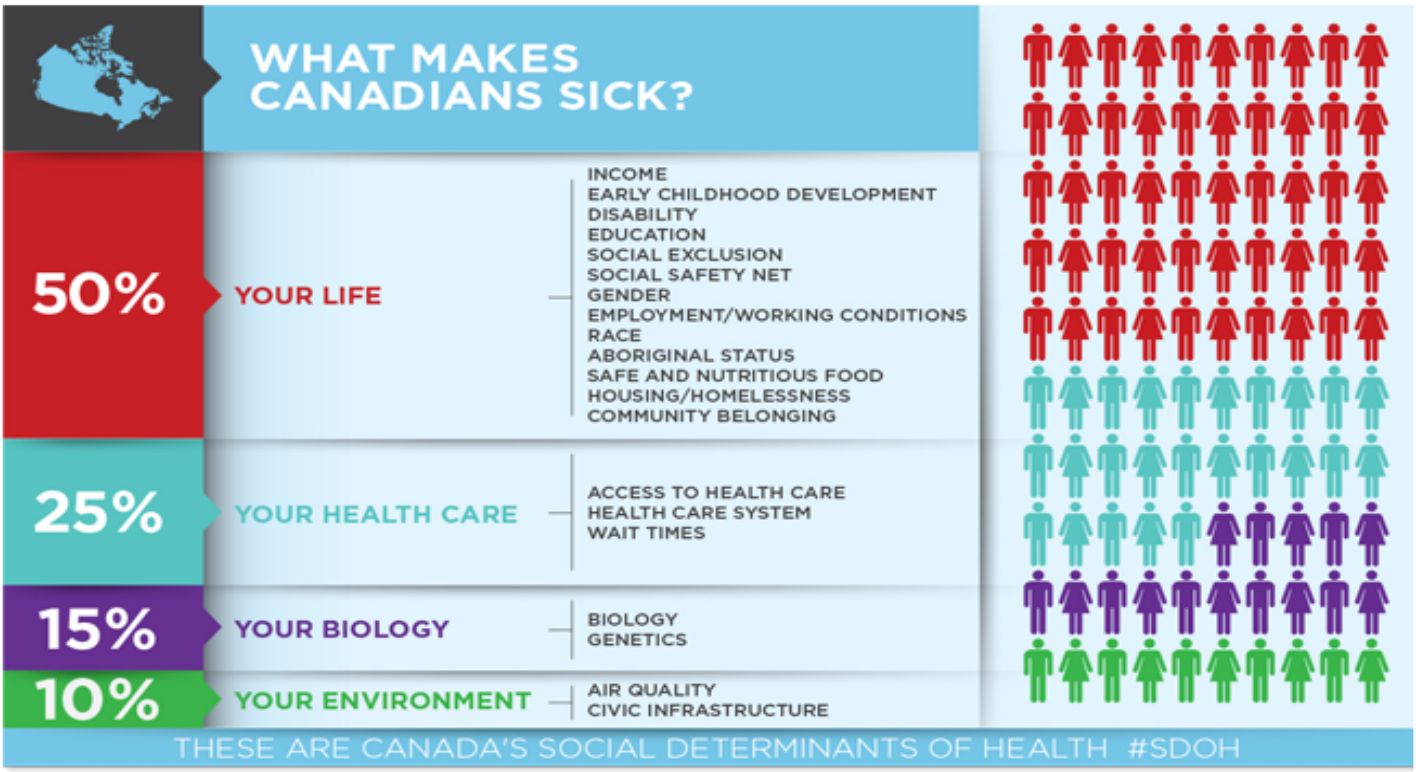
In this section of the brief, we provide information about:

- what makes us sick (Figure 1);
- key features of a primary-care 'home' (Table 1);
- benefits of a primary-care 'home' (Table 2); and
- the Ontario health system (Box 2).

What makes 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.(15) But the health system, particularly primary care, can do more than just provide 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.

Figure 1: What makes Canadians sick? (Figure from the Canadian Medical Association)(15)



What is a primary-care 'home'?

The overall goal of a primary-care 'home' is to be able to offer comprehensive, coordinated, and continuing care to the population it serves through a team-based approach.(16) There are 10 pillars that have been used to define the primary-care 'home' model. Of these, six are most relevant to how patients experience care, which we summarize in Table 1.

Table 1. Primary-care 'home' pillars

Pillar	Description
Provide patient-centred care	• Care that is focused on the individual patient and tailored based on their specific needs
Provide access to a most responsible care provider	• This is the 'point person' for each patient's care and could be a family physician or nurse practitioner who work as part of a team.
Deliver care using teams of providers	• A primary-care 'home' 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 and other professionals such as physiotherapists and social workers.
Ensure timely access to care	• A primary-care 'home' would provide access to care when you're sick. • This typically means interacting with a care provider or one of their team members on the same or next day when an appointment is requested.
Provide comprehensive care	• Patients receive access to a broad range of care and services, which could include home and community care (e.g., home care and travel to medical appointments), as well as public health services (e.g., screening).
Ensure continuity of care	• A primary-care 'home' ensures the full range of care is seamlessly linked across providers, teams and settings.

Ontario has implemented Family Health Teams over the last decade as one model of care that closely resembles a model for a primary-care 'home'. However, as outlined in the next section about the problem, this model has not been rolled out in a way that achieves coverage for all Ontarians in need of team-based care (e.g., the sickest Ontarians).

Most recently, the government of Ontario issued a discussion paper focused on strengthening patient-centred healthcare in Ontario.(17) While the paper only provides proposals at this point, it provides a 'window of opportunity' for making progress towards building a primary-care 'home' for every Ontarian. The paper has also put accountability for providing full coverage for all Ontarians by a primary-care 'home' on the table.

Given that these are recent proposals, the government is actively involved in identifying how best to move forward to address them. One approach for achieving these goals that has received much attention in recent months is to have more decentralized planning and management for primary care in regions and sub-regions. These smaller geographic areas would be responsible for ensuring universal access to primary care for all citizens within a geographic region, much like how students can access their schools.

What are potential benefits of building a primary-care 'home' for every Ontarian?

There are many potential benefits that could result from building a primary-care 'home' for every Ontarian, which we summarize in Table 2.

Table 2. Summary of benefits of primary-care 'homes'

Health-system goals in Ontario	Potential benefits
Improve access	• Primary-care 'homes' appear promising to: o increase access to specialists given that they support primary-care providers working in teams;(18;19) o improve patients' care experiences and satisfaction;(1;18-21) o improve clinician experiences;(18-21) and o reduce clinician burnout when rosters are an appropriate size.(1;18-20)
Inform patients	• Primary-care 'homes' have high rates of use of technologies such as secure electronic message threads and telephone calls to prepare for patient visits.(1;18)
Connect services	• Primary-care 'homes' have been shown to improve: o patient-perceived level of care coordination;(19-21) and o care processes for delivering preventive services.(20;21)
Protect the system	• Primary-care 'homes' have been found to: o reduce primary care office visits (with larger declines over time) as a result of increases in use of secure electronic messages and telephone encounters;(1) o reduce care in sub-optimal settings like emergency departments;(1;18-20;22) and o keep costs manageable (there is mixed evidence on costs but the evidence suggests that investments in additional staffing are recovered).(1;19)

Box 2: The health system in Ontario

Features most relevant to primary care

- 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.
- 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.(5)

Features most relevant to home and community care

- 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.
- 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, 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).(8)
- 75 community health centres (CHCs) serve approximately 500,000 people in Ontario with 250,000 of these accessing primary-care services.

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

- 69 Health Links (of an anticipated total of 90) support the delivery of integrated care for those with complex needs.

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

The problem:

Why is building a primary-care 'home' for every Ontarian necessary but challenging?

>> It requires an approach that provides all Ontarians with timely access to primary care

Several factors contribute to the challenges of building a primary-care 'home' for every Ontarian. These factors broadly relate to:

- Ontarians have unequal access to primary care and many lack timely access when they are sick;
- the patient is not always put at the centre of care
- a lack of coordination in the health system makes it difficult for patients to be easily connected to what they need;
- past reforms have tried, with some success, to address these challenges; and

- achieving more fulsome success will require taking on system-level challenges that citizens prioritize for us.

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.(23) This puts Ontario slightly above the national average and in the middle when compared to similar countries.(23;24) 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.(17)

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 (extends from Prescott and Cardinal on the east, north to Perth and Smith Falls, and back to Bancroft).(23)

Many Ontarians indicate that primary care is not available when they need it. Recent estimates indicate that only 40% of Ontarians report receiving a same- or next-day appointment when they are sick. While this is similar to the national average of 38%, it is the lowest in a recent comparison of 13 countries.(24) Similarly, 56% report difficulty accessing care after hours,(24) which is likely because 24/7 care is not mandated in 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).(24) An added difficulty is balancing the need for timely access against a culture in the health system of 'more is better', and the need for an immediate answer.

Providing timely access to care is likely to become more challenging because of increased demands being placed on the health system given the growing number of people living with one or more chronic diseases such as diabetes, cancer, heart disease, mental health and addictions, and arthritis. It has been estimated that 29% of Canadians have one chronic health condition, 15% have two chronic health conditions, and 11% have three or more.(25) Amongst those who are considered to be the sickest Canadians, 70% have two or more chronic health conditions.(25) This affects many groups in the province, including:

- older adults: 43% of Ontarians over the age of 65 are living with two or more chronic health conditions, and the risks grow steadily with age;(26)
- younger adults: 12% of younger adults have three or more chronic conditions;(27)
- women: 14% of Canadian women have two or more chronic health conditions as compared to 11% of men (across all age groups);(27) and
- vulnerable groups: 40% of low-income Canadians have one or more chronic health conditions, compared to 27% of high-income Canadians.(25;27;28)

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.(23) 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%).(23)

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,(29) despite this being important for improving patients' outcomes;(30-34) 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.

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.

A lack of coordination in the health system makes it difficult for patients to be easily connected to what they need

Lack of coordination makes it difficult to provide a population-level team-based approach that offers care and support based on patient need. 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.

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

The component of the health system in Ontario that most closely resembles the primary-care 'home' model are the 184 Family Health Teams that have been implemented in the province.(35) 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."(10) Family Health Teams serve a roster of patients and ensure they receive comprehensive, coordinated 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.(36) Family Health Teams have also achieved high satisfaction among patients and physicians.(34;35)

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 multiple chronic conditions who typically 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.(4)

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.(4)

Achieving more fulsome success will require taking on system-level challenges that citizens prioritize for us

Fixing these issues is not easy and requires taking on many system-level challenges. A big part of the challenge for building a primary-care 'home' for all Ontarians 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.

Doing this is difficult and, in addition to the factors outlined earlier, there are several additional components of the health system that complicate the situation, including:

- physicians are currently not able to create a new team-based practice such as a Family Health Team, and most cannot move into an existing team-based practice except in "areas of high physician need";(37;38)
- primary-care providers other than physicians (e.g., nurses, physiotherapists, dietitians and pharmacists), as well as teams led by these providers, are typically not eligible for public payment (or at least not on terms that make independent healthcare practices viable on a large scale);
- the way physicians are paid is one reason for why access to team-based care in Ontario is unequal, and why those who are sicker and living in urban areas are less likely to receive team-based care, because most capitation contracts in Ontario are only adjusted for age and sex and do not take into account medical complexity or other factors that could make patients sicker; and
- most physicians feel 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 and settings of care (e.g., hospital- and home-based care).(39)

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. We have selected three elements of a comprehensive approach for which we are seeking public input. These elements would:

1. Ensure all Ontarians receive the care they need when they need it;
2. Put the patient at the centre of care; and
3. Ensure the full range of care is seamlessly linked across providers, teams and settings.

Together, these elements emphasize the six pillars of the primary-care 'home' model that were identified earlier as being the most visible changes to how citizens would access care.

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 broader questions we posed at the start of this brief related to the three elements

- Element 1: What do you want and expect from a primary-care 'home' to make sure you get the care you need when you need it? What do you expect in terms of:
  - receiving timely access (e.g., should care be available on the same or next day?);
  - receiving timely access if for some reason your most responsible care provider is not available the same or next day;
  - who you see and your relationship with them (e.g., family physician or nurse practitioner); and
  - how care is provided (e.g., from teams of providers and using email and/or electronic health records)?
- Element 2: What does patient-centred care mean to you? What would be helpful to support you:
  - to take ownership of your health; and
  - understand how to manage your own care?
- Element 3: What do you want and expect from a primary-care 'home' to ensure all of your care is seamless?

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

The first element aims to address the patient's medical 'home' pillars 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:

1. providing patient-driven scheduling to ensure timely access (i.e., access to same- or next-day appointment, with priority for those who need it most);
2. using team-based models differently to provide same- or next-day access to care for all Ontarians, with those who are sickest seeing a physician, those who are healthy and need routine care seeing another team member (e.g., a nurse practitioner), and those seeking after-hours care being linked to an available team member; and
3. using secure email and telephone encounters to enhance access to, prepare for, follow-up from, or substitute for in-person visits.

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:

- advance access 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;(40)
- patients and clinicians report improved healthcare access, greater satisfaction and enhanced quality of healthcare in the family health team model;(34)
- 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;(41) and
- 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 conditions such as diabetes, but evidence about its costs and acceptability to patients and providers is uncertain.(42)

Element 2 – Put the patient at the centre of care

The second element aims to address the patient's medical 'home' pillars of providing patient-centred care and delivering care using teams of providers.

This could include:

1. developing personalized care plans where patients and clinicians collaboratively develop a plan to address the patients' health issues;
2. promoting self-management resources;
3. supporting shared decision-making with care providers (e.g., through decision aids); and
4. engaging patients in their care through electronic health records that allow for lab test results review, online medication refills and provision of "after visit summaries."

We identified several systematic reviews relevant to the four activities listed above that could be included in this element.

Key findings from these reviews include:

- 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;(43)
- approaches to self-management:
    - 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;(44)
- 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,(45;46) but decision aids (materials that help individuals and/or their caregivers make decisions about their healthcare) have been found to be helpful because they:
    - increase knowledge about healthcare options;(47-50)
    - encourage consumer involvement;(50)

  - support realistic perception of outcomes and risk;(48;50-53)
  - reduce decision-related conflict;(50)
  - increase patient-practitioner communication;(50) and
  - support professionals to provide information and counselling about available choices;(47) and
- 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.(54)

Element 3 – Ensure the full range of care is seamlessly linked across providers, teams and settings

The third option aims to address the patient's medical 'home' pillars of providing comprehensive care and ensuring continuity of care.

This could include:

1. engaging care coordinators for the sickest patients who assume responsibility for ensuring patients are transitioned across providers, teams and settings;
2. having a patient's primary-care 'home' coordinate outreach and follow-up for discharges from hospital and emergency or urgent care visits; and
3. ensuring effective communication between care providers.

We identified several systematic reviews relevant to the three activities listed above that could be included in this element.

Key findings from these reviews include:

- approaches used to improve coordination of care significantly reduce the number of people with chronic conditions (except for those with mental illness) being admitted to hospital, as well as emergency department visits for older adults;(55)
- 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;(56)
- 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;(57) and

- 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.(58;59)

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 (for example, 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 are summarized in Table 3.

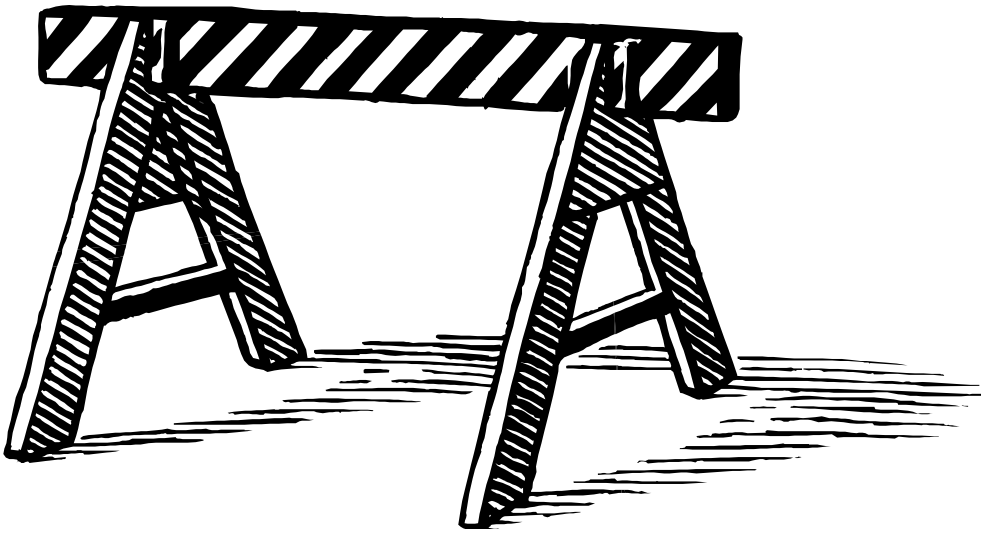


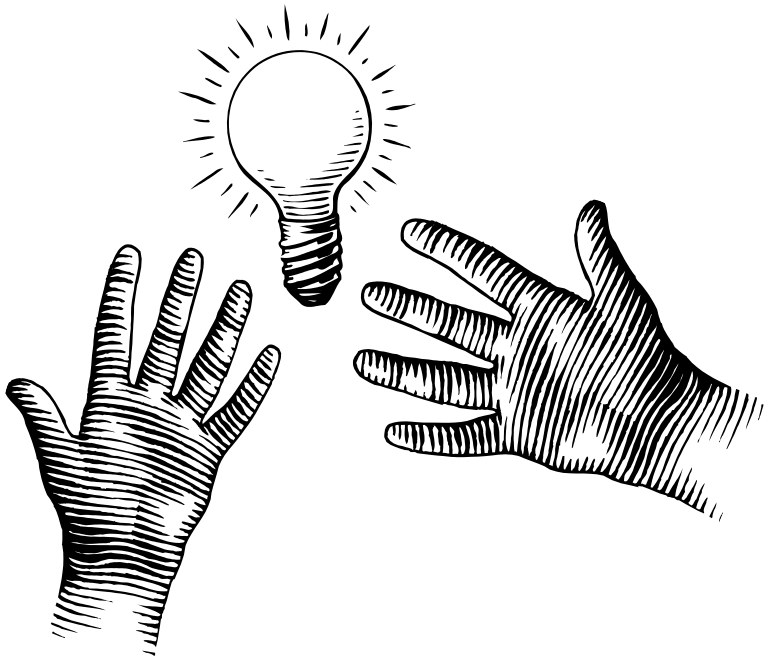
Table 3: Potential barriers to implementing the elements

Element	Description of potential barriers
Element 1 - Ensure all Ontarians receive the care they need when they need it	• Citizens, healthcare providers, organizations and/or policymakers could view this as another different approach that requires investment, but doesn't lead to real change in the system. • Some citizens may not like the idea of no longer receiving routine care from a family physician (and instead from a nurse-practitioner), or may feel uncomfortable using email to communicate with their healthcare provider. • Expectations from citizens for timely access may be difficult to balance against what is feasible given existing resources. • Healthcare providers may resist the idea of working in a model that ensures same- or next-day access to care. • Healthcare providers may oppose any efforts to increase sharing of resources across teams and/or reallocating funding within the province. • Healthcare providers and organizations may initially find it difficult to change how they schedule appointments.
Element 2 – Put the patient at the centre of care	• Not all citizens may like the idea of being more involved in and responsible for their care. • Some healthcare providers may initially feel uncomfortable providing more responsibility to the patient for their care. • Policymakers lack access to transparent performance measures of patient-centred outcomes, which limits their ability to monitor progress of efforts to put the patient at the centre of care.
Element 3 - Ensure the full range of care is seamlessly linked across providers, teams and settings	• Healthcare providers may find it difficult to ensure outreach to all patients discharged from hospital or emergency departments without electronic health records that link care across providers and settings. • Organizations and policymakers may be hesitant to invest in hiring care coordinators without knowing if their costs will be recovered. • Healthcare providers, organizations and policymakers will face significant challenges for implementing clinical information systems that can be integrated for use across all care settings and providers in the province.

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:

- **Harnessing increased attention:** Recently there has been much attention on reforming primary care in Ontario. When combined with the recognition that Family Health Teams are not providing a primary-care 'home' for every Ontarian, this attention could help support action towards changing team-based care in the province to provide access to a primary-care 'home' for all Ontarians.
- **Drawing on momentum created by high-profile proposals:** Recent high-profile proposals to reform primary care in Ontario, including the highly publicized proposal from the province to strengthen patient-centred care, emphasize many of the activities included in the element to put the patient at the centre of care.(17;60)
- **Meeting health-system goals:** A primary-care 'home' model incorporating all 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) support people and patients; and 4) protect the universal health system.(12)



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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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