



EVIDENCE >> INSIGHT >> ACTION

**Dialogue Summary:
Creating Community-based Specialty Clinics in Ontario**

22 May 2013

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 the regional/provincial level 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.

Authors

Kaelan A. Moat, M.Sc. PhD(c), Lead, Health Systems Evidence, McMaster Health Forum, and Doctoral Candidate, Health Policy PhD Program, McMaster University

John N. Lavis, MD PhD, Director, McMaster Health Forum, and Professor, McMaster University

Funding

The funding for the stakeholder dialogue (and the evidence brief that informed it) was provided by the Ontario Ministry of Health and Long-Term Care through a Health System Research Fund grant entitled Harnessing Evidence and Values for Health System Excellence. The McMaster Health Forum receives both financial and in-kind support from McMaster University. The views expressed in the dialogue summary are the views of the dialogue participants and should not be taken to represent the views of the Ontario Ministry of Health and Long-Term Care, McMaster University or the authors of the dialogue summary.

Conflict of interest

The authors declare that they have no professional or commercial interests relevant to the dialogue summary. The funders reviewed a draft dialogue summary, but the authors had final decision-making authority about what appeared in the dialogue summary.

Acknowledgements

The authors wish to thank Ileana Ciurea and the staff of the McMaster Health Forum for assistance with organizing the stakeholder dialogue. They also thank Justin Neves for taking notes during the dialogue to supplement their own and for clarifying points in the draft dialogue summary.

Citation

Moat KA, Lavis JN. Dialogue Summary: Creating Community-based Specialty Clinics in Ontario. Hamilton, Canada: McMaster Health Forum, 22 May 2013.

Dialogue

The stakeholder dialogue about creating community specialty clinics in Ontario was held on 22 May 2013 at the McMaster Health Forum in Hamilton, Ontario, Canada.

Product registration numbers

ISSN 1925-2226 (print)

ISSN 1925-2234 (online)

Table of Contents

SUMMARY OF THE DIALOGUE 5

SUMMARIES OF THE FOUR DELIBERATIONS..... 6

 DELIBERATION ABOUT THE PROBLEM 6

 DELIBERATION ABOUT POLICY AND PROGRAMMATIC OPTIONS..... 8

 Element 1 - Make a binding long-term commitment to prospective specialty clinics about
 the ‘rules of the game’ 8

 Element 2 - Commission specialty clinics through a process that ensures transparency and
 accountability..... 9

 Element 3 - Ensure that an efficient governance mechanism is in place for commissioned
 specialty clinics 10

 Considering the full array of elements 11

DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS 11

DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES..... 12

SUMMARY OF THE DIALOGUE

Dialogue participants generally agreed that there are many surgical procedures, diagnostic tests and specialty assessments that could be provided in the community, but are not. Dialogue participants also generally agreed that there are a number of interdependencies in delivery arrangements that need to be carefully considered in any move from providing services in hospitals to providing services in community-based specialty clinics, that there are a number of concurrent changes to financial arrangements that can facilitate the transition or that can increase anxiety among hospitals about their financial sustainability, and that there is a patchwork of governance arrangements that translates into differences in what patients can expect depending on what or where care is provided. Dialogue participants generally supported several of the possible rationales/objectives for the move from hospitals to community-based specialty clinics: 1) improving access (i.e., increasing the volume of services provided); 2) reducing costs; and/or 3) improving efficiency (i.e., increasing the volume of services provided for a given budget). There was little commentary about the rationale/objective of improving the patient experience or the provider experience.

There was general agreement among dialogue participants that there is a need for an overarching framework that outlines the ‘rules of the game’ (i.e., the methods to identify services that can be provided in community-based specialty clinics, set appropriateness criteria for the services, set price/volume/quality criteria for the services, and bundle the services in ways that make sense for specialty clinics) and flexibility in the framework’s application given unique community needs that won’t be well served by a ‘one-size-fits-all’ approach. Dialogue participants generally agreed that most types of organizations that provide specialty care should be eligible to be considered as a community-based specialty clinic (but that LHIN-governed clinics should be ineligible and that changes to organizational arrangements would be needed for independent clinics to be eligible), that requests for proposal would be preferable to the more restrictive procurement process, that local ‘impact assessments’ should be used (again to enable and support flexibility), and that fulsome reporting is required. Dialogue participants also generally agreed that the combination of the Excellent Care for All Act and ‘dynamic contracting’ would be sufficient as the governance mechanism for commissioned specialty clinics, as well as that collaboration, not competition, should be a guiding principle for the secondary and tertiary care sector.

Many participants agreed that the most important step in the short term would be to strike an expert panel that would be responsible for engaging health system stakeholders to: 1) take stock of the situation in Ontario regions; 2) identify opportunities for specialty clinics that could improve access and reduce costs (and thereby improve efficiency) while maintaining quality; 3) build on lessons learned from other sectors; 4) establish goals and objectives against which progress can be measured; and 5) determine how various health system stakeholders can support the transition to specialty clinics. Some dialogue participants suggested that it would be important in the medium term to establish and learn from pilots, and in the long term to establish and operationalize an overarching framework that will guide the transition to and evolution of specialty clinics in ways that are sensitive to regional (and local) needs and that are responsive to advances in technologies and service delivery.

SUMMARIES OF THE FOUR DELIBERATIONS

DELIBERATION ABOUT THE PROBLEM

Dialogue participants generally agreed that there are many surgical procedures, diagnostic tests and specialty assessments that could be provided in the community, but are not. However, several dialogue participants argued that many hospitals are already providing such services ‘in the community’ through, for example, hospital-governed clinics and day hospitals (and that other hospitals could do the same). These participants questioned whether such community-based specialty clinics operated by hospitals are being counted as part of the proposed transition.

Dialogue participants also generally agreed that there are:

- a number of interdependencies in delivery arrangements (e.g., care pathways that rely on a well-functioning communication and referral system) that need to be carefully considered in any move from providing services in hospitals to providing services in community-based specialty clinics;
- a number of concurrent changes to financial arrangements that can facilitate the transition (e.g., the introduction of prospective payment for select episodes of care – known as quality-based procedures – as a funding mechanism) or that can increase anxiety among hospitals about their financial sustainability (e.g., the possible change in funding for laboratory services); and
- a patchwork of governance arrangements (including local accountability arrangements, provincial regulatory frameworks, and provincial oversight responsibilities) that translates into differences in what patients can expect depending on what or where care is provided (e.g., in hospitals compared to independent health facilities and to physician offices).

Having said that, one dialogue participant noted that health system leaders often cited issues like these “as a shield so [we] don’t have to change.”

A small number of dialogue participants disagreed about the importance of one key governance arrangement – the Public Sector Labour Relations Transitions Act – as a constraint on any proposed transitions in where services are provided. The reasons for the disagreement related to either the flexibility that is still possible within existing labour-relations agreements (e.g., removing steps in the process that don’t add value, focusing on expectations about

Box 1: Background to the stakeholder dialogue

The stakeholder dialogue was convened in order to support a full discussion of relevant considerations (including research evidence) about a high-priority issue in order to inform action. Key features of the dialogue were:

- 1) it addressed an issue currently being faced in Ontario;
- 2) it focused on different features of the problem, including (where possible) how it affects particular groups;
- 3) it focused on three elements of a comprehensive approach to addressing the policy issue;
- 4) it was informed by a pre-circulated evidence brief that mobilized both global and local research evidence about the problem, three elements of a comprehensive approach to addressing the problem, and key implementation considerations;
- 5) it was informed by a discussion about the full range of factors that can inform how to understand the problem and approach addressing it;
- 6) it brought together many parties who would be involved in or affected by future decisions related to the issue;
- 7) it ensured fair representation among policymakers, stakeholders and researchers;
- 8) it engaged a facilitator to assist with the deliberations;
- 9) it allowed for frank, off-the-record deliberations by following the Chatham House rule: “Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed”; and
- 10) it did not aim for consensus.

Participants’ views and experiences and the tacit knowledge they brought to the issues at hand were key inputs to the dialogue. The dialogue was designed to spark insights – insights that can only come about when all of those who will be involved in or affected by future decisions about the issue can work through it together. The dialogue was also designed to generate action by those who participate in the dialogue, and by those who review the dialogue summary and the video interviews with dialogue participants.

outcomes) or the opportunities presented when the move is taking place to accommodate growth rather than as a zero-sum game.

Most dialogue participants took as a given the government's proposed focus on the not-for-profit status of community-based specialty clinics. The few dissenting voices argued that it can be difficult to distinguish not-for-profit from for-profit entities, and that the focus on not-for-profit entities might mean that the system loses the opportunity for the transition (because not-for-profit entities cannot raise the capital required to purpose-build or purpose-adapt clinics) or for innovation (that for-profit clinics might introduce).

Dialogue participants generally supported several of the possible rationales for a move from hospitals to community-based specialty clinics (or, said another way, the objectives against which the transition could be monitored and evaluated), such as:

- improving access (i.e., increasing the volume of services provided) through the establishment of purpose-built or purpose-adapted facilities, which was argued to be particularly important going forward given demographic trends and other factors that will contribute to a much greater demand for services;
- reducing costs for the types of services that can be provided in specialty clinics; and/or
- improving efficiency (i.e., increasing the volume of services provided for a given budget).

On the other hand, there were mixed views about the rationale/objective of improving health (or quality of care), particularly given the evidence presented in the evidence brief, and given that hospitals now have well-established quality-improvement frameworks (as required by the Excellent Care for All Act). One dialogue participant noted that quality of care could be improved by the introduction of community-based specialty clinics if the comparator is physician offices (where at least some of the surgical procedures, diagnostic tests and specialty assessments are provided, but without clinic-wide, as opposed to professional-specific, oversight) rather than hospitals. There was little commentary about the rationale/objective of improving the patient experience (except insofar as improving access, and specifically reducing wait times, would improve the patient experience) or improving the provider experience. Most dialogue participants then articulated the overall rationale as seeking to improve access and reduce costs (i.e., improve efficiency) while maintaining quality.

Several dialogue participants pointed to potential negative consequences of a move from hospitals to community-based specialty clinics: 1) reductions in access in the short term if the transition disrupts traditional utilization and referral patterns (particularly in rural and northern communities where the hospital is often the 'nucleus' of secondary and tertiary care in the local health system); 2) reductions in access in the long term if a one-size-fits-all approach is used, but particular types of service bundling (e.g., 'focused factories') or types of organization (e.g., independent clinics) are not viable in smaller urban centres or in rural and northern centres; 3) increases in the difficulty that hospitals have in recruiting and retaining specialists and other health professionals given that community-based specialty clinics could be a more attractive work environment for many of them; and 4) increases in average costs per case in the hospitals that stop providing surgical procedures, diagnostic tests and specialty assessments given that they would be left with a much more complex and sick patient population. Related to the last point, one dialogue participant strongly encouraged the group to not consider the move from hospitals to specialty clinics as part of a system-wide cost-reduction exercise, but as an effort to improve access overall and to reduce costs for particular types of services.

DELIBERATION ABOUT POLICY AND PROGRAMMATIC OPTIONS

Element 1 - Make a binding long-term commitment to prospective specialty clinics about the ‘rules of the game’

There was general agreement among dialogue participants that there is a need for:

- an overarching framework that outlines the ‘rules of the game’ (i.e., the methods to identify services that can be provided in community-based specialty clinics, set appropriateness criteria for the services, set price/volume/quality criteria for the services, and bundle the services in ways that make sense for specialty clinics); and
- flexibility in the framework’s application given unique community needs that won’t be well served by a ‘one-size-fits-all’ approach, which includes keeping all service-bundling options on the table:
 - ‘focused factory’ (e.g., Shouldice Hospital);
 - single sub-specialty clinic (e.g., Kensington Eye Institute);
 - single specialty clinic (e.g., Queensway Health Centre’s Surgicentre);
 - multi-specialty targeted clinic (e.g., regional cancer centres across Ontario, independent sector treatment centres in the United Kingdom);
 - multi-specialty general clinic (e.g., Hotel Dieu Hospital);
 - one-stop specialty clinic; and
 - one-stop integrated specialty clinic.

With regard to who should be charged with developing the ‘rules of the game,’ particularly the methods that identify services, set appropriateness criteria, and set price/volume/quality criteria, several dialogue participants argued in favour of striking an expert panel to support the decision-making process. Other dialogue participants suggested that it wasn’t important who assumed this role, but that it was important for the expert panel to have input from practice/team leaders drawn from affected regions and communities (and one dialogue participant suggested that the panel should also have input from some ‘challenging voices’). Dialogue participants had mixed views about the role that the Ministry of Health and Long-Term Care should play in developing the ‘rules of the game.’ Regardless of who develops the rules, however, some dialogue participants noted that the rules will at times need to be fine-tuned regularly (within reason) given the pace with which technologies and service delivery are evolving, and that we’re dealing with complex adaptive systems.

Turning to the service-bundling options, a number of dialogue participants suggested that any of the options could work, but that the optimal approach in any given region or community would be dependent on local conditions. On the other hand, a few dialogue participants argued that a process was needed to narrow down these options to those that are likely to provide the biggest improvements in access, reductions in cost and/or improvements in efficiency, while maintaining quality. One dialogue participant suggested that fewer options would also make it easier to monitor the implementation and evaluate the impact of the proposed move from hospital to the community. (One dialogue participant suggested that the ‘rules of the game’ should also include the criteria against which the move is evaluated.) When asked whether they could select a service-bundling option that they thought had the greatest likelihood of achieving the above objectives, several dialogue participants selected the ‘focused factory’ option. In response to this, another dialogue participant asked how many ‘focused factories’ a facility can have under one roof, noting that the answer could be many.

On the specific issue of identifying services that can be provided in community-based specialty clinics, dialogue participants debated whether to include services that require overnight stays. Most dialogue participants felt that this decision could best be made at the level of a region or community in light of a careful consideration of the services being provided (e.g., hip and knee replacements and select ophthalmological procedures among low-acuity patients) and/or local circumstances (e.g. situations in which

patients must be driven a long distance to receive care at a specialty clinic). While some dialogue participants expressed concern that having both hospitals and specialty clinics accommodate overnight stays might lead to confusion about the differences between the two types of facilities, a number of participants indicated that acuity of care, not length of stay, should be the factor that differentiates hospitals and specialty clinics.

Element 2 - Commission specialty clinics through a process that ensures transparency and accountability

Dialogue participants strongly supported the principles of transparency and accountability in the commissioning process, and they generally agreed that:

- 1) most types of organizations that provide specialty care should be eligible to be considered as a community-based specialty clinic within a given region (or community within a region), including:
 - a. hospital-governed clinic (e.g., Holland Orthopaedic and Arthritic Centre),
 - b. day hospital (e.g., Women's College Hospital),
 - c. hospital-aligned clinic (e.g., Kensington Eye Institute), and
 - d. independent but hospital-linked clinic (e.g., associated medical clinics in Quebec);
- 2) requests for proposal would be preferable to the more restrictive procurement process;
- 3) local 'impact assessments' should be used (again to enable and support flexibility); and
- 4) fulsome reporting should be mandated (e.g., adherence to appropriateness criteria and adverse-events reporting, adherence to staff-training and site-inspection requirements, ratings of patient experience, and financial data).

Several dialogue participants also suggested that eligible organizations should in turn be able to contract out services that can more efficiently be provided by others (including hospitals contracting out to independent clinics).

Dialogue participants generally agreed that Local Health Integration Network (LHIN) governed clinics should be ineligible because including such clinics would involve a change in LHINs' role from purchaser to purchaser *and* provider. That said, many participants agreed that LHINs need to be engaged in some way with assessments of the eligibility of organizational types in their region, requests for proposal, and local 'impact assessments' whether or not they are a formal party to the accountability agreements. Some dialogue participants suggested that LHINs could integrate experts into their administrative structures to oversee the transition process. One dialogue participant noted that LHINs in northern regions might need particular flexibility to work through appropriate arrangements with local communities and with the larger clinics and academic health science centres with whom they could partner, while another noted that LHINs in urban centres might need particular flexibility to ensure that the location of new clinics improves access for marginalized populations.

Dialogue participants had mixed views about the eligibility of fully independent clinics. One dialogue participant noted that independent health facilities, as one example, already have 'skin the game' (i.e., investments in people, processes and infrastructure), a track record of innovation and a growing number of requests from hospitals to partner with them. Some other dialogue participants felt that such clinics should not be eligible to become community-based specialty clinics unless significant changes could be made to the organizational arrangements within which they function. A number of dialogue participants suggested that it was essential that there is excellent communication between (and optimally, integration of key processes across) the various organizations involved in the delivery of procedures, tests and assessments, but particularly between hospitals and independent clinics (e.g., to support emergency referrals). These participants argued that focusing on communication and integration would help to ensure both continuity of care and the establishment of appropriate and efficient care pathways. As one participant stated, it is important that there is "confidence in the person on the other end of the phone." Some participants suggested that recent developments in information technology (including the potential for sharing electronic medical records) made communication and integration much more feasible than in the past. Another

participant argued that communication and integration would be more likely to be successful with a flexible governance framework than within an overly rigid one.

Dialogue participants did not explicitly address what, if any, infrastructure investments should be covered by government.

Most dialogue participants agreed about the need to engage an expert panel in the development and revision of requests for proposal (and more generally in the approach to contracting) to ensure that contracts are informed by the best available research evidence, are appropriate to local conditions, and are highly sensitive to the issue of patient selection. One dialogue participant suggested that there is much to learn from the experiences of implementing the system of Community Care Access Centres in Ontario, with respect to ensuring transparency and accountability in the commissioning process in the absence of mature markets. Other dialogue participants indicated that there is also much to learn from the experiences of Cancer Care Ontario.

Element 3 - Ensure that an efficient governance mechanism is in place for commissioned specialty clinics

When the deliberations turned to an efficient governance mechanism for community-based specialty clinics, dialogue participants focused primarily on the legislative/regulatory and quality-improvement frameworks for these clinics. Their comments took into account the outcomes of earlier deliberations, which included the desirability of being flexible with the ‘rules of the game’ (including how services are bundled) and with the types of organizations that would be eligible to be considered a community-based specialty clinic within a given region.

Dialogue participants generally agreed that the combination of the Excellent Care for All Act and ‘dynamic contracting’ based on price/volume/quality criteria would be sufficient as the governance mechanism for commissioned specialty clinics. The Act was considered to be sufficiently targeted to ensure accountability in terms of quality improvement, while contracts were considered sufficiently dynamic to ensure that adjustments could be made in light of innovations in technology and service delivery. In other words, dialogue participants did not see the need for dedicated specialty clinic governance (informed by the Independent Health Facilities Act or Regulation 114/94, which governs out-of-hospital premises), broader secondary and tertiary care governance (that would cover independent health facilities, out-of-hospital premises and hospitals), fully comprehensive secondary and tertiary care governance (that would cover all three of these types of organizations as well as physician offices), or a form of regional governance (that would cover all specialty services as well as their intersections or integration with primary care and public health within a regional model). That said, a few dialogue participants wondered aloud whether politicians may be uncomfortable without a legislative framework for specialty clinics, or with the conflicts that might arise between pieces of legislation. Also, one dialogue participant noted that this approach would require ‘excellent purchasers.’

Dialogue participants also tended to agree (or were silent about) existing legislation not needing to be adapted to achieve a level playing field among hospitals, independent health facilities, out-of-hospital premises, physician offices and any new community-based specialty clinics. As well, there was general agreement among dialogue participants, despite suggestions to the contrary earlier in the dialogue (e.g., with calls for contract ‘auctions’), that collaboration, not competition, should be a guiding principle for the secondary and tertiary care sector given the pressures for service integration and enhancing the patient experience.

Most dialogue participants agreed that the situation with respect to clinics offering optional upgrades of marginal or uncertain benefit (e.g., cataract lens or artificial joints) was continually changing, existed in a grey zone between advertising and suggesting optimal care, was difficult to assess in terms of whether the motivation was profit for the provider or optimal care for a particular patient, and was difficult to monitor (e.g., there may be preferential acceptance of patients willing to pay for optional upgrades, or there may be

alternative forms of payment, such as donations, that are solicited instead). Many participants suggested that the best way to address optional upgrades was not through restricting advertising, but rather by focusing on independent assessments of the appropriateness of services delivered (and reporting of upgrades charged for and eligible to be charged for).

Turning to clinical governance and educational roles at provider/hospital/regional/provincial levels, dialogue participants were particularly focused on the training of specialists given the province's largely hospital-based approach to training. These participants suggested that there was a need to remain cautious about moving too many specialist-provided services out of hospital because it could negatively affect the current training environment in Ontario unless agreements could be negotiated with specialty clinics to accommodate trainees rotating through their facilities.

Considering the full array of elements

When dialogue participants turned their attention to the full array of elements, they did not fundamentally alter their views about each element. Instead they reiterated their support for:

- 1) an overarching framework that outlines the 'rules of the game' and flexibility in the framework's application;
- 2) most types of organizations that provide specialty care being eligible to be considered a community-based specialty clinic (with the exception of LHIN-governed clinics and, unless changes can be made to organizational arrangements, independent clinics), requests for proposal being used, local 'impact assessments' being required, and fulsome reporting being mandated; and
- 3) a combination of the Excellent Care for All Act and 'dynamic contracting' being the governance mechanism for commissioned specialty clinics, as well as collaboration, not competition, being the guiding principle for the secondary and tertiary care sector.

One dialogue participant noted that the process seemed to be "starting in the wrong place... with hospitals and doctors, rather than with communities, their needs" (e.g., in the area of chronic disease management, particularly for patients with multimorbidity) and the full array of existing community-based organizations. Another suggested that it would be helpful to think of primary care as the foundation on which any high-functioning community-based specialty clinics would need to be built.

DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS

Dialogue participants generally agreed that such a fundamental shift in the way that secondary and tertiary care is delivered in the province would be a challenging transition, with likely unintended consequences that would need to be addressed at all levels of the system. As such, they argued for a methodical, long-term approach to implementation that would accommodate both the complexity of what is being envisioned and the time frames that are needed to adjust strategic plans, master plans and fundraising plans, among others. One dialogue participant said that what was needed was, "ideally an evolution that will culminate in a revolution." That said, a few participants argued for moving fairly quickly, at least with pilots, to "work out the kinks." and one participant noted that moving quickly would be made easier if there was agreement that no new legislation was needed.

The potential barriers that were singled out by dialogue participants were at the level of providers and organizations. Some participants suggested that there may be some hesitancy among specialists to move between hospitals and community-based specialty clinics on a regular basis, but one suggested that engaging them throughout the planning and development process could help to address this. More participants identified the potential for resistance from hospitals for one or more of three reasons: 1) most if not all of the funds to pay specialty clinics would be 'carved out' of hospital budgets, and hospitals would be left with more

complex and sick patients and hence with much higher average costs per case (which could over time lead to increasing concern about their perceived efficiency); 2) hospitals need to retain a critical mass of highly trained specialists in order to provide care to complex and sick patients; and 3) a significant component of hospitals' role as training centres for health professionals would need to be shared with specialty clinics (to ensure that future health professionals gained experience in the full range of services that historically had been provided in hospitals), which could leave hospitals a less attractive location for educators and with fewer trainees available to support the care of more complex and sick patients. Regarding the first of these three points, one participant noted that hospitals have been unable to identify what size carve-out (e.g., 5% or 15%) would threaten their viability, while another suggested that they would always say any carve-out would threaten their viability. but the question is where can 'better value for money' be obtained.

On the positive side, however, one dialogue participant noted that hospital boards and executive teams understand the challenges facing the system (i.e., increasing demands coupled with human and financial resource limitations) and see the need for new ways of doing things, while others noted that training is already being transitioned in part to community-based settings, and that this transition is typically viewed quite favourably. One dialogue participant suggested that the push for improving access and reducing costs through the greater use of community-based specialty clinics could lead to "a rising tide lift[ing] all boats."

DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES

Dialogue participants identified possible next steps for the short, medium and long term that would facilitate the introduction of community-based specialty clinics in Ontario. Many participants suggested that the most important step in the short term would be to strike an expert panel that would be responsible for engaging health system stakeholders to:

- 1) take stock of the situation in Ontario regions;
- 2) identify opportunities for specialty clinics (e.g., service-bundling options) that could improve access and reduce costs (and thereby improve efficiency), while maintaining quality, in different types of communities;
- 3) build on lessons learned from other sectors (e.g., Community Care Access Centres, Cancer Care Ontario) and from organizations active in this sector (e.g., College of Physicians and Surgeons of Ontario);
- 4) establish goals and objectives against which progress can be measured; and
- 5) determine how various health system stakeholders can support the transition to specialty clinics.

One dialogue participant suggested that the stock-taking should include a review of where patient safety is not now adequately protected. Another participant argued that the stock-taking should be part of a forward commitment to capacity planning within the secondary and tertiary care sector more generally, while a third noted that the capacity planning could best be done once a framework had been established.

In the medium term, some dialogue participants suggested that it would be important to establish and learn from pilots, and in particular to confirm whether they could improve access, reduce costs and/or improve efficiency, while maintaining quality. One dialogue participant cautioned the group on this point, however, noting that pilots can be a way of postponing or averting tough decisions.

In the long term, dialogue participants generally agreed about the need to establish and operationalize the overarching framework that will guide the transition to and evolution of specialty clinics in ways that are sensitive to regional (and local) needs and that are responsive to advances in technologies and service delivery. As one dialogue participant said, we "need a framework for creative, dynamic local solutions, for risk management and for managing unintended consequences."



McMaster
HEALTH FORUM

>> Contact us

1280 Main St. West, MML-417
McMaster University
Hamilton, ON Canada L8S 4L6
Tel: +1.905.525.9140 x 22121
Fax: +1.905.521.2721
Email: mhf@mcmaster.ca

>> Follow us

mcmasterhealthforum.org
healthsystemsevidence.org



tinyurl.com/mhf-iTunesU
tinyurl.com/mhf-YouTube
tinyurl.com/mhf-Facebook
tinyurl.com/mhf-Twitter

EVIDENCE >> INSIGHT >> ACTION