

Dialogue Summary

Enhancing the Delivery of Comprehensive
Care for People Living with HIV in Canada

14 May 2019



HEALTH FORUM

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**Dialogue Summary:
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McMaster Health Forum

The McMaster Health Forum's goal is to generate action on the pressing health-system issues of our time, based on the best available research evidence and systematically elicited citizen values and stakeholder insights. We aim to strengthen health systems – locally, nationally, and internationally – and get the right programs, services and drugs to the people who need them.

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Conflict of interest

John Lavis is currently Chair of the Board of Directors of the Ontario HIV Treatment Network, which is one of the funders of the stakeholder dialogue. The rest of the authors declare that they have no professional or commercial interests relevant to the dialogue summary. The funders played no role in the identification, selection, assessment, synthesis or presentation of the research evidence profiled in the dialogue summary.

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Dialogue

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SUMMARY OF THE DIALOGUE

Dialogue participants focused their deliberations on five broad areas that they saw as key aspects of the problem: 1) social and structural challenges including stigma and discrimination are fundamental to addressing challenges, but continue to lack traction and commitment to change; 2) lack of emphasis on prevention and making available a broad menu of testing options that meet the needs of different communities; 3) lack of coordination across care pathways and throughout the lifespan; 4) limited access to timely data and the many different forms of evidence needed to inform policy and programmatic decision-making; and 5) mechanisms and resources are not in place to support learning across provinces, territories and Indigenous communities.

In deliberating about the elements, dialogue participants focused on four areas requiring action that transcend the elements of a potentially comprehensive approach to addressing the problems that were presented in the evidence brief:

- 1) acknowledging that HIV continues to be exceptional and needs to be accounted for in the pursuit of any next steps;
- 2) ensuring person-centred and adaptive approaches are used for actions taken that relate to elements 1 and 2 (which focused on strengthening comprehensive HIV care in health systems and providing supports across social systems to address the many additional challenges that people living with HIV face);
- 3) underpinning all actions taken with enhanced efforts to address stigma and normalize HIV prevention, testing, care and support; and
- 4) focusing on achieving the ‘Triple Aim’ of excellent patient experience, improved patient outcomes, and keeping per capita costs manageable.

Apart from these four overarching themes, participants focused much of their deliberations on the first and second elements, emphasizing the need for a combined health and social-system approach to strengthening care for those with HIV. Within these two elements, participants also called for a greater emphasis on team-based care that prioritizes mental health and addictions services, and for care that is culturally competent, safe and responsive.

For next steps that should be taken, dialogue participants identified the need to:

- 1) focus on improving delivery of prevention, care and support to achieve the 90-90-90 targets (and the fourth 90 focused on improving quality of life), while recognizing that there may need to be adaptations to meet the unique and often more complex needs of those in the remaining 10% of each of the targets (i.e., the 10-10-10);
- 2) continue to strengthen primary-care-based models by echoing the many voices calling for enhanced person- and family-centred care (and include the full complement of primary-care-based providers, such as physicians, nurses and pharmacists);
- 3) identify groups of individuals with shared challenges that can be collectively supported, and shared strengths that can be built upon;
- 4) create wrap-around social services and primary care and inject primary-care elements into social-systems settings (e.g., housing, supervised injection sites and prisons); and
- 5) develop a learning collaborative to support spread and scale of successful prevention, care and support initiatives.

SUMMARIES OF THE FOUR DELIBERATIONS

DELIBERATION ABOUT THE PROBLEM

All participants generally agreed with the way the problem was framed in the brief, which highlighted that:

- the burden of HIV remains an important public-health issue and continues to affect those who are often stigmatized and marginalized in society;
- people with HIV who are on medications are living longer with HIV and with more chronic conditions;
- progress still needs to be made on meeting targets for reducing the burden of HIV, which will require addressing complex and inter-related challenges that are often faced by people living with HIV; and
- many system-level factors can make it complicated to ensure that people living with HIV are supported through transitions in care and across health and social systems.

However, the following five additional and complementary themes emerged from the deliberation:

- 1) social and structural challenges including stigma and discrimination are fundamental to addressing challenges, but continue to lack traction and commitment to change;
- 2) lack of emphasis on prevention and making available a broad menu of testing options that meet the needs of different communities;
- 3) lack of coordination across care pathways and throughout the lifespan;
- 4) limited access to timely data and the many different forms of evidence needed to inform policy and programmatic decision-making; and
- 5) mechanisms and resources are not in place to support learning across provinces, territories and Indigenous communities.

Social and structural challenges including stigma and discrimination are fundamental to addressing challenges, but continue to lack traction and commitment to change

Dialogue participants strongly emphasized how social and structural challenges including stigma and discrimination continue to drive challenges in preventing, treating and supporting individuals with HIV. In particular, dialogue participants highlighted three structural and social challenges: 1) persisting stigma; 2) geographic differences in the availability of supports within and between provinces and territories; and 3) a lack of commitment to meeting 90-90-90 targets.

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 Canada;
- 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 potentially comprehensive approach for 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 approach elements, and key implementation considerations;
- 5) it was informed by a discussion about the full range of factors that can inform how to approach the problem and possible elements of an approach to 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.

We did not aim for consensus because coming to agreement about commitments to a particular way forward can preclude identifying broad areas of agreement and understanding the reasons for and implications of specific points of disagreement, as well as because even senior health-system leaders typically need to engage elected officials, boards of directors and others about detailed commitments.

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.

First, dialogue participants described how enduring HIV-related stigma remains a significant problem. Participants noted that some of the enduring stigma towards HIV relates to the continued criminalization of non-disclosure, with some participants remarking that it perpetuates discrimination, fear of being testing and misinterpretation by the public about the risk of transmission. It was highlighted that despite a few provinces (B.C. and Ontario) having changed their guidance for the prosecution of non-disclosure, changes have not been consistently pursued across the country. Other participants remarked on the types of stigma and discrimination that stem from the many marginalized populations at risk of HIV, including LGBTQ+ individuals, men who have sex with men, people who inject drugs, and sex workers, among others. Given the many different populations that should be considered, participants described the continued work that is needed to establish safe and supportive environments, with many pointing to the need for enhanced education about Indigenous rights and continued establishment of gay-straight alliances.

Second, throughout the deliberation dialogue participants consistently returned to the geographic differences across the country and within provinces in terms of the extent to which HIV is discussed, and to which supports are made accessible. Some participants noted that while both health- and social-system supports are widely available in major urban centres such as downtown Toronto, access to such supports are typically significantly less accessible (or not accessible) in rural, remote and Indigenous communities.

Finally, one dialogue participant described their disappointment with the decision to delay the commitment to meet the 90-90-90 targets from 2020 to 2030, perceiving this delay as a lack of commitment. Other participants took issue with the targets but from different perspectives. One participant mentioned that they focused on the wrong subset of the population and should instead be concentrated on the last 10% in each of the targets, which are the hardest populations to reach. The participant described being worried that the health system would become complacent once the 90-90-90 targets are met, and not take on the challenge of reaching those who are most marginalized and face the most significant challenges. Finally, another participant explained the 90-90-90 targets were not well suited to high-income countries such as Canada and do not consider what they referred to as the 'fourth 90', which focuses on enhanced quality of life and living longer with chronic conditions.

Lack of emphasis on prevention and making available a broad menu of testing options that meet the needs of different communities

Dialogue participants described that while prevention is a key pillar of the Pan-Canadian Sexually Transmitted and Blood Borne Infections Framework, it did not feature prominently in the evidence brief or in discussions about the cascade of care, which is considered to begin at the diagnosis of HIV. A few dialogue participants suggested this was too late and prevention strategies should be central to any approach to strengthen the delivery of care for people living with HIV. In particular, one dialogue participant noted the lack of emphasis in promoting Pre-Exposure Prophylaxis (PrEP) as a prevention strategy.

As a related point, many participants noted the difficulties of getting into the cascade of care for HIV and suggested that HIV testing should be positioned as an entry point, particularly in rural areas where infrastructure for HIV testing, care and support may not be broadly available. Select participants criticized the lack of emphasis that has been placed on testing across the country, noting that while it may be very prevalent in urban cities there remain many areas of the country where, despite the advancement in testing technology and point-of-care approaches, not everyone is being reached by existing approaches. Participants pointed to ongoing issues of awareness about testing, as well as access to and uptake of testing due to geographic proximity and availability of testing options that ensure anonymity and connection to appropriate follow-up services.

Lack of coordination across care pathways and throughout the lifespan

Closely connected to the previous section about the lack of emphasis on making available a broad menu of testing options, dialogue participants described how even once individuals are ‘in’ the cascade of care there is very little coordination between services, and that individuals are not always effectively retained in care. In particular, dialogue participants described challenges in finding care that addresses the whole person, noting that services don’t effectively coordinate the unique aspects of support for HIV with other health services. This was noted as a particularly important concern as individuals age and require care that addresses HIV alongside other age-related and chronic conditions.

As a consistent theme throughout the deliberations during the dialogue, participants described the additional complexities of accessing needed care in rural and remote areas, given that much of the HIV-specific care is centralized in urban centres. As a result, many end up having to coordinate many aspects of needed care and supports across a large geographic area. Moreover, participants acknowledged that even when individuals are able to access trusted care in rural communities, providers may not have significant experience in treating and managing HIV.

Finally, in discussing the provision of care and support, participants noted a general lack of effective use of peers despite their potential to help with system navigation (e.g., where to access safe and anonymous services) and with coordinating care across the cascade.

Limited access to timely data and the many different forms of evidence needed to inform policy and programmatic decision-making

Many dialogue participants remarked on the lack of timely data available related to HIV. One participant noted that “the fact that we are still relying on 2016 data in 2019 is extraordinary.” The participant went on to describe that the inability to quickly capture and share data inhibits the potential to quickly learn and innovate. One dialogue participant provided the example of not having sufficient data to determine whether the observed increase in HIV rates was the result of testing more individuals, or whether it represented an actual increase in the prevalence of the disease.

However, while all dialogue participants agreed that access to timely data was a problem, they differed in their views on the extent to which it was something that could be resolved. One participant noted that the delay and non-systematic approach to data collection is the result of having federated health systems and the many complexities that result from it, including agreeing on common indicators and establishing data-sharing agreements. In contrast, other participants had a more positive perspective, but also noted that the difficulty of coordinating data collection with individual providers and AIDS service organizations across the country will be challenging to overcome. One participant also indicated that while there was some data about HIV in Indigenous communities, there was a need for more, but that this must be collected, owned and used by the communities themselves.

Several dialogue participants questioned why the system relied exclusively on data when many forms of evidence are needed to inform policy and programs. As one example, dialogue participants pointed to the potential to use oral histories or the experiences of individuals, particularly among communities of individuals where data collection may be difficult or have considerable ethical implications.

Mechanisms and resources are not in place to support learning across provinces, territories and Indigenous communities

Throughout the deliberation about the problem, dialogue participants frequently described local innovations that had been developed to meet the needs of individual communities. In hearing many of these innovations, one dialogue participant noted that there are no explicit mechanisms in place to support learning across

provinces, territories and Indigenous communities. The participant noted that while rural communities in Ontario may have little in common with experiences in downtown Toronto, they likely share similarities with rural areas in other provinces with whom they could exchange lessons learned. Participants noted that lessons should also be exchanged between multiple levels of governments and across provinces, with the recognition that innovation and spread is unlikely to stem from the federal level.

While most participants agreed that they could learn from each other, they expressed two reservations about the idea of a learning collaborative. The first is that establishing such a collaborative network would likely require investing resources, which participants noted were not readily available. Second, participants emphasized that the scale and spread of any innovation requires it to be adaptable based on contextual understandings of local cultural and social systems.

DELIBERATION ABOUT ELEMENTS OF A POTENTIALLY COMPREHENSIVE APPROACH

In deliberating about the elements, dialogue participants focused on four areas requiring action that transcend the elements in the evidence brief:

- 1) acknowledging that HIV continues to be exceptional and needs to be accounted for in the pursuit of any next steps;
- 2) ensuring person-centred and adaptive approaches are used for actions taken that relate to elements 1 and 2 (which focused on strengthening comprehensive HIV care in health systems and providing supports across social systems to address the many additional challenges that people living with HIV face);
- 3) underpinning all actions taken with enhanced efforts to address stigma and normalize HIV prevention, testing, care and support; and
- 4) focusing on achieving the ‘Triple Aim’ of excellent patient experience, improved patient outcomes, and keeping per capita costs manageable.

Apart from these four overarching themes, participants focused much of the deliberation on the first and second elements, emphasizing the need for a combined health and social-system approach to strengthening care for those with HIV. Within these two elements, participants also called for a greater emphasis on team-based care that prioritizes mental health and addictions services, and for care that is culturally competent, safe and responsive.

Element 1 – Strengthening comprehensive HIV care within the health system

Dialogue participants spent a considerable amount of time deliberating about this element and how to strengthen comprehensive HIV care within the health system. Participants broadly agreed on strengthening primary care as a starting point to ensure that it is sufficiently adaptive to meet the unique needs of those with HIV. To do this, participants identified three activities that could be pursued to complement those suggested in the evidence brief:

- 1) identifying those with shared health and social challenges and developing approaches to wrap-around care that meets these needs;
- 2) implementing team-based approaches that bridge health and social systems; and
- 3) expanding the range of providers delivering care for those with HIV, especially where there is a lack of primary-care providers.

Identifying those with shared health and social challenges and developing approaches to wrap-around care that meets these needs

As previously mentioned, dialogue participants struggled to find a balance between the typical basket of care and the need for HIV exceptionalism. One participant suggested that this could be established in primary care by developing wrap-around services for groups of individuals with shared challenges, such as access to care in

rural areas or social conditions such as poverty. These uniting challenges could help to attain a critical mass of individuals to organize services around and to consider locally contextualized models to get people into the care they need. Participants had mixed views on whether a chronic-care model or a person-centred medical-home model should be used for this purpose. However, most agreed that the core changes needed to move towards implementing effective wrap-around care would need to include modifying existing funding models to focus on outcomes of care (e.g., bundled payments and value-based funding), and delivery arrangements such as professional scope of practice to enable providers to use their full skill sets to provide needed care and supports.

Implementing team-based approaches that bridge health and social systems

To build wrap-around care, dialogue participants focused on the need to create team-based approaches to care that bridge health and social systems. Participants noted that for certain populations that are at-risk of HIV, “treating” social conditions such as poverty and homelessness can be as, if not more, important than addressing specific health-related conditions. Therefore, participants strongly emphasized the need to include social-care professionals into interdisciplinary teams to ensure that care and supports are contextualized to meet the unique needs of each person. One participant described the need to ensure that teams provide care to those most in need, noting that especially in Ontario those able to access team-based services tend to be healthier and wealthier segments of the population.

Many participants also called for mental health and addictions services to be embedded into all care provided to individuals with HIV. This was identified as important given the overlap between mental health and addictions and risk factors for HIV, as well as for providing support throughout the treatment and management of HIV.

Expanding the range of providers delivering care for those with HIV, especially where there is a lack of primary-care providers

A number of dialogue participants mentioned that there were shortages of primary-care providers able to deliver care to those with HIV, particularly in rural and northern communities. Participants called for an expansion to the types of providers able to deliver HIV-specific care. In particular, many participants suggested that the role of pharmacists could be expanded to ensure greater access to providers that individuals trust.

Element 2 – Providing supports across social systems to address all of the challenges faced by people living with HIV

In deliberating about element 2, dialogue participants suggested merging the sub-elements with those from element 1, remarking on how providing comprehensive care for those living with HIV requires the integration of both health- and social-system supports, making the distinction between the two elements not particularly useful. Participants suggested three additional sub-elements that cut across both elements: 1) allowing social services to ‘take the lead’ where appropriate; 2) embedding cultural competence, safety and responsiveness; and 3) supporting community-based organizations and community leaders to thrive.

Allowing social services to ‘take the lead’ where appropriate

In deliberating on the importance of services to address social conditions, dialogue participants questioned why the lead of integration is assumed to be the health system. Instead, participants suggested moving away from a medical model and allowing social services to take the lead where needed, particularly to address pressing issues such as finding stable housing and poverty. One participant described having implemented a similar model for antenatal care for homeless women, whereby safe, stable housing was the focus and was then complemented by the delivery of needed health services. Participants who agreed with this approach suggested that placing social services at the centre ensured they didn’t get lost in the complex delivery of health services, and was better able to consider the individual as a whole.

Embedding cultural competence, safety and responsiveness

Dialogue participants agreed that critical to providing high-quality health and social services is ensuring that individuals can seek care in an environment they feel is safe, non-stigmatizing and adequately understands and addresses their unique needs. Participants noted that this includes having some staff that reflect the socio-cultural, linguistic or ethnic backgrounds of individuals seeking care. However, they suggested this could also be a role filled by peers, who could help to signal to individuals where to seek care. Participants described cultural safety as ensuring individuals feel respected and safe when they interact with the healthcare system, whereas responsiveness was articulated as the ability to learn from and relate to individuals respectfully.

Supporting community-based organizations and community leaders to thrive

In considering ways to strengthen health and social systems, dialogue participants reiterated the importance of community-based organizations and the tailored services they provide. However, many participants expressed concern that in the integration of care, leadership positions would be filled by those working at hospitals and more powerful organizations within the health system, thereby reducing the voice of community organizations. As a result, participants called on established organizations to better support community-based initiatives and leaders to enable them to thrive. Participants suggested this could be done by ensuring representation of community organizations in the leadership of any initiatives to strengthen care.

Element 3 – Adopting a rapid-learning and improvement approach to incrementally strengthen health and social systems

For element 3, dialogue participants agreed that a rapid-learning orientation would be advantageous. To move forward with implementing such a model, participants identified four specific actions that first need to be taken: 1) identify and develop an inventory of assets in health systems across the country; 2) empower individuals with advocacy skills and support their engagement in decision-making; 3) determine common data sets that could be used and shared across provinces; and 4) foster stronger lines of accountability for HIV outcomes.

Identify and develop an inventory of assets in health systems across the country

Many dialogue participants, particularly those working at a provincial or regional level, described not being aware of initiatives outside of their own system. They suggested that the first step to implementing a rapid-learning approach would be to create an inventory of assets and gaps to understand how the basket of services (including drug funding) differ between provinces, as well as to better understand what has been prioritized as outcomes across provinces and territories. Participants described that the ability to compare across provinces would allow them both to understand where they needed to help to fill gaps, as well as identify opportunities to learn from others.

Empower individuals with advocacy skills and support their engagement in decision-making

Dialogue participants all agreed that despite advancements in engaging patient and citizens across all levels of health and social systems, there is still room for improvement. It was emphasized that such improvements will be essential for the first characteristic of a rapid-learning framework, which focuses on being anchored on the needs, perspectives and aspirations of people living with HIV through the ‘Greater Involvement of People Living with HIV/AIDS/ Meaningful Involvement of People Living with HIV/AIDS’ principles (GIPA/MIPA), to improve care experiences and health at manageable per capita costs and with positive provider experiences. To do this, one dialogue participant specifically highlighted the need for patients to be better equipped with advocacy skills and knowledge of their rights as patients.

Determining common data sets that could be used and shared across provinces

Building on the challenge described in the problem section of the summary, dialogue participants noted that “everyone is collecting different data,” which compounds the challenge of interoperability, beyond the regulatory challenges of sharing data. This aligns well with the second characteristics of the rapid-learning framework, which is focused on being driven by timely data and evidence. Participants discussed the potential of creating a “data reservoir,” but determined that the first step is to collectively decide on a number of key indicators that could be commonly collected across the country.

Participants also deliberated about the need for rapid learning at the level of clinical interactions, noting that they should establish common indicators to collect on primary-care performance that could be fed back to professionals in efforts to quickly improve their practice.

Foster stronger lines of accountability for HIV outcomes

Finally, dialogue participants described the need to create greater lines of accountability for HIV outcomes, aligning with the fifth characteristic of the rapid-learning framework, which is focused on aligned governance, financial and delivery arrangements (e.g., to allow systems to adjust who can make what decisions, how money flows and how the systems are organized and aligned to support rapid learning and improvement at all levels). In particular, dialogue participants suggested that stakeholders need to be prepared to take responsibility for whether the right ‘needles move.’ Participants suggested that this needs to begin by clearly defining the outcomes of interest, ensuring the right indicators are in place to measure them, and then determining who holds the responsibility for ensuring outcomes are met and for adjusting course when they are not. Importantly, participants stated that this includes defining ‘needles to move’ at a national level, but also determining specific outcomes that may be locally important to a given community.

Considering the full array of approach elements

As mentioned in the introduction to the deliberation about the elements, participants focused on four areas requiring action that transcend the elements presented in the evidence brief:

- 1) acknowledging that HIV continues to be exceptional and needs to be accounted for in the pursuit of any next steps;
- 2) ensuring person-centred and adaptive approaches are used for actions taken that relate to elements 1 and 2 (which focused on strengthening comprehensive HIV care in health systems and providing supports across social systems to address the many additional challenges that people living with HIV face);
- 3) underpinning all actions taken with enhanced efforts to address stigma and normalize HIV prevention, testing, care and support; and
- 4) focusing on achieving the ‘Triple Aim’ of excellent patient experience, improved patient outcomes, and keeping per capita costs manageable.

The first theme, acknowledging that HIV continued to be exceptional and needs to be accounted for in the pursuit of any next steps, was at the centre of many deliberations throughout the day. Dialogue participants described the challenge of balancing the need for exceptionalism in treatment alongside its presentation as an increasingly chronic disease. Ultimately, participants agreed that HIV should continue to be treated with a degree of exceptionalism given the significant stigma and concerns around disclosure that continue to surround its treatment. One dialogue participant suggested that the case for exceptionalism can be attributed to the condition changing an individual’s care-seeking behaviour (e.g., where they feel sufficiently comfortable and safe to seek care). This echoes key themes from the citizen panels convened on the same topic prior to the dialogue, where individuals described having to leave their town to seek treatment to avoid stigma and discrimination.

Related to the first theme, the second was the ongoing need for efforts to address stigma and to normalize HIV prevention, testing, care and support. Participants noted that without this underpinning any actions

taken following the stakeholder dialogue, there would continue to be significant barriers in access to care. Participants emphasized the need to create and draw attention to safe spaces, to shift the narrative around HIV, and to encourage (and make it easier to participate in) regular testing in areas where it is not currently the norm.

Third, in deliberating on element 1 and 2, participants consistently reiterated the need for person-centred and adaptive approaches to be integrated into any actions to strengthen the delivery of services. Participants described this as being critical for ensuring that individuals and their families are involved in making care decisions, that all services are respectful of and responsive to individual preferences, needs and values, and that they are sufficiently flexible to adapt to changes along the disease trajectory and an individual's lifespan.

Finally, closely related to many of the calls for clear objectives and improved data collection, many participants mentioned using the Triple Aim of excellent patient experience, improved patient outcomes and manageable per capita costs to guide efforts to monitor and evaluate care for those with HIV.

DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS

Dialogue participants described four key barriers and two windows of opportunity for moving forward with any of the elements of a potentially comprehensive approach. The first three of the four barriers related to the integration of care required to pursue element 1 and 2: 1) that the development of integrated or whole-person care may be constrained by financial arrangements and reporting requirements built into the different funding streams across government programs in health and social systems; 2) there are power imbalances between the different organizations and stakeholders involved in providing care and support for people living with HIV, which may make discussions around integration difficult (e.g., hospitals and credentialed professionals as compared to community and non-credentialed providers); and 3) challenges in navigating different priorities and 'languages' used across sectors and systems (i.e., health and social). Finally, unrelated to the challenge of integration, one participant described how embedding the HIV targets under the broader Pan-Canadian STBBI framework has been used as a tool to delay progress rather than to enable change.

With regards to windows of opportunities, dialogue participants described the many promising pilot projects across the country that have the potential to be scaled up and spread to other communities. Second, participants described the significant health reforms in Ontario as an opportunity to strengthen person-centred approaches used in care for people living with HIV, particularly in the primary-care sector.

DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES

For next steps that should be taken, dialogue participants identified the need to:

- 1) focus on improving delivery of prevention, care and support to achieve the 90-90-90 targets (and the fourth 90 focused on improving quality of life), while recognizing that there may need to be adaptations to meet the unique and often more complex needs of those in the remaining 10% of each of the targets (i.e., the 10-10-10);
- 2) continue to strengthen primary-care-based models by echoing the many voices calling for enhanced person- and family-centred care (and include the full complement of primary-care-based providers, such as physicians, nurses and pharmacists);
- 3) identify groups of individuals with shared challenges that can be collectively supported, and shared strengths that can be built upon;
- 4) create wrap-around social services and primary care and inject primary-care elements into social-systems settings (e.g., housing, supervised injection sites and prisons); and
- 5) develop a learning collaborative to support spread and scale of successful prevention, care and support initiatives.



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