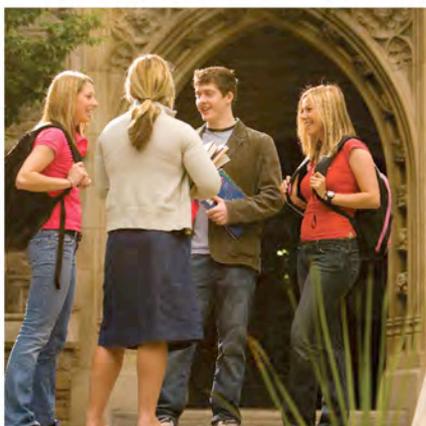


DIALOGUE
SUMMARY



BUILDING A PRIMARY-CARE
'HOME' FOR EVERY ONTARIAN



11 MARCH 2016

EVIDENCE >> INSIGHT >> ACTION

**Dialogue Summary:
Building a Primary-Care 'Home' for Every Ontarian**

11 March 2016

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.

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SUMMARY OF THE DIALOGUE

Dialogue participants generally agreed with the challenges presented in the brief, which related to a lack of equitable and timely access to patient-centred primary care, and a lack of coordination across providers, teams and settings. They also agreed that past reforms have tried (with some success) to address these challenges, but many system-level challenges still remain. Building on this, participants focused on the problem as it relates to the patient and provider level and the system level. At the patient and provider level, participants identified three key challenges: 1) lack of equitable and timely access; 2) lack of relational continuity across sectors (particularly with specialty care); and 3) lack of person-centred care. At the system level, participants identified two main challenges: 1) difficulty balancing a patient- and system-level focus; and 2) lack of evolution of primary-care models over time due to widespread thinking that the primary-care models implemented a decade ago were a panacea. Subsequently, these models have not been extensively evaluated or iteratively adjusted over time and may no longer fully meet the needs of some Ontarians (e.g., people living with multiple chronic conditions).

Participants identified several considerations for moving forward with the three elements of a potentially comprehensive approach that were presented in the evidence brief. For element 1 (defining a ‘made in Ontario’ approach), participants indicated that Ontario already has considerable infrastructure available in the form of existing care models and practices, that can help to achieve the goals of the primary-care ‘home’ model. However, participants indicated that new ways of working together that leverage existing resources, as well as different approaches to funding, are needed to ensure that the appropriate provider complement is available (e.g., in terms of staffing) to ensure patients have access to the full spectrum of primary and allied care. For element 2 (conducting rapid-cycle evaluations), participants emphasized the need for ongoing quality-improvement processes across the entire system based on population-level data and input from citizens and other stakeholders, rigorous evaluations against agreed upon measures, and enhanced infrastructure to support evaluation and the engagement of citizens and other stakeholders. Lastly, for element 3 (supporting system-wide implementation), participants identified the need for learning and training opportunities (e.g., coaching and facilitation) to support implementation at the practice level, and the need for leadership to support within and across sector collaboration and innovation.

Participants identified four types of activities and considerations that need to be the focus going forward: 1) a multifaceted approach to support practice change; 2) additional resources and a better alignment of incentives to achieve system-level goals, along with allowing sufficient time for these resources and incentives; 3) an ‘alliance model’ (instead of a patchwork) operating both across sectors and between practices (e.g., building a network of primary, speciality, and home and community care at the Local Health Integration Network (LHIN) and sub-LHIN levels); and 4) engaging patients and their families in developing, implementing and evaluating a ‘made in Ontario’ model along with organizational structures to support this type of work.

SUMMARIES OF THE FOUR DELIBERATIONS

DELIBERATION ABOUT THE PROBLEM

Participants were generally enthusiastic about the idea of building a primary-care 'home' for every Ontarian, and agreed with the challenges presented in the brief for doing so, which included factors related to:

- Ontarians having inequitable access to primary care and many lacking timely access when they have a health problem or issue;
- the patient not always being put at the centre of care as a result of a lack of coordination and limited engagement of patients and citizens;
- past reforms having tried, with only some success, to address these challenges; and
- widespread success requiring many system-level challenges to be addressed.

Building on these challenges, participants focused on the problem as it relates to the patient and provider level and the system level, which we describe in detail below.

Notably, participants in the stakeholder dialogue agreed with participants in the citizen panel that primary-care 'home' may not be the most appropriate term to use. Instead, participants agreed that 'hub' better describes the type of model being considered, and that the focus should be on patients as they move through the system and engage with primary, specialty, home and community care.

Challenges related to patient and provider perspectives

Participants explored the issue of access from both the patient and provider perspective, and three themes emerged: 1) lack of equitable and timely access; 2) lack of relational continuity across sectors (particularly with specialty care); and 3) lack of person-centred care.

Lack of equitable and timely access

Participants identified access as an important issue, but differed in their views about it. For some participants the key access issue is whether all patients are able to access a regular primary-care provider and preferably a full-service comprehensive family practice. The need for access to a full-service comprehensive family practice

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 potentially comprehensive approach (among many) 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 elements of a potentially comprehensive approach for 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 approach the problem and possible elements for 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 on 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.

was seen as particularly important for groups who are most in need of a primary-care ‘home’ model, such as those with complex care needs (e.g., people living with multiple chronic conditions, particularly mental health and addictions). However, others argued that not everyone wants a primary-care provider, especially young men who tend not to need to access care regularly. Participants also identified timely access as an important part of the issue. Some raised concerns about patients often not being able to obtain a same-day or next-day appointment, with some emphasizing that this is a pressing issue for many Ontarians (especially those living with multiple chronic conditions) who may not have anyone else to advocate for their access to other forms of care and support. However, several other participants identified timely access to specialists and addictions and mental health services as the more pressing issue, as these were seen as the types of care that patients most often have to wait the longest to access.

Lack of relational continuity across sectors

In addition to access, participants further identified the need for greater relational continuity within primary care and between primary and specialty care. Building on discussions about lack of equitable and timely access, one participant argued that instead of defining access in terms of next-day appointments, “what’s important is the relational continuity of care.” Another participant indicated that many patients are more focused on seeing their regular provider, even if it is a day or two later, than seeing the next available provider. Other participants identified the need for greater care coordination within primary care and between primary and specialty care for ensuring patient care is effectively and seamlessly managed.

One participant identified an equity dimension to this issue, noting that patients who receive optimal care coordination are often benefiting from informal networks facilitated by providers, but that may result in some patient groups (e.g., people living in rural communities) not receiving the same standard of care.

Participants agreed with the need for “a most responsible care provider,” and that a more formal approach to role designation could address current gaps in continuity of care, and create greater efficiency across the system. Another participant added that relational continuity should extend to everyone in the organization, and that all staff should be accountable to patients in the same way (including non-clinical staff). This discussion about relational continuity paralleled discussions during the citizen panel in which participants expressed frustration over not having continuity in their care and experiencing challenges negotiating access.

Lack of person-centred care

Participants generally agreed that primary care should be doing more to meet the needs of those being served, but identified a range of factors that make it difficult for patients to access care and navigate primary, specialty, and home and community care. For example, many participants noted that the system is confusing for patients to navigate because care is often not organized with the patient in mind. To illustrate this point, several participants shared their own difficulties navigating the system, despite having expert and ‘insider’ knowledge about how the system works and what they need. One participant suggested that the challenges faced with achieving coordinated care in the system stem from a lack of integration among primary, specialty, and home and community care. Building on this, another participant agreed that it is important to think beyond primary care, but indicated that the term ‘patient’ does not resonate with other sectors and suggested ‘person-centred care’ as an alternative term. Another participant agreed that person-centred care is important, but added that the terms needs to be clarified and education offered to encourage their use across the health system.

Challenges related to system-level perspectives

At the system level, participants noted that many of the patient- and provider-level challenges stem from widespread thinking that the models of primary care that were implemented in the province a decade ago were a panacea. This thinking was seen by some as having prevented much needed adjustment and

innovation over time and, as a result of a lack of evolution of these models, some Ontarians (e.g., those living with multiple chronic conditions) are not receiving care that fully addresses the challenges they are facing. In this context, participants identified that the two main system-level challenges relate to: 1) the difficulty of balancing a patient- and system-level focus; and 2) the limitations of primary-care models that have not kept pace with the changing needs of providers and patients.

Balancing a patient- and system-level focus

Participants discussed the need to expand how primary care is currently understood and offered in Ontario, with one participant stating: “We need to take the telescope and aim it at the person, but we also need to see the larger system.” Participants agreed that there needs to be more of a systems-level approach to managing care in the province, but noted that currently primary care is treated as a separate and distinct part of the system. One participant said that they “think the problem to some extent is that primary care is being talked about separately [but] we need more integration.” Many participants agreed with the need for greater integration within primary care and between primary care and other sectors, and especially to improve the system’s capacity to respond to the needs of people with complex health issues. Finally, several participants noted the absence of a social determinants of health approach within the current system, which could help support patients across multiple sectors. One participant emphasized that what the system lacks is a “philosophy of care oriented to helping people access social supports, creating culturally safe spaces, and supporting community development and community governance.”

Lack of evolution of primary-care models over time

Participants discussed the way primary care is funded in Ontario, and many expressed strong concerns with the lack of recent investment in the sector. One participant explained that, as compared to other parts of the health system, there has been a disinvestment in primary care. The same participant further remarked that where there has been growth in primary-care funding, the money has gone to paying physicians and not to building primary-care teams comprised of other care and service providers. One participant noted a lack of transparency over how funding decisions are made and how funds are allocated and spent, although this was contested by other participants. Many participants identified current funding issues as the legacy of earlier payment model reforms, which were initially viewed positively, but have since fallen out of favour with policymakers. A participant explained that “people believe those initial investments are no longer working,” and that they’re “not getting value for money.” Some participants disagreed with this sentiment, and argued instead that those initial investments served to expand care in the province and make it more accessible. Despite these differing views, participants did generally agree that the funding models need to be updated and made more relevant for the current context in the province.

DELIBERATION ABOUT APPROACH ELEMENTS

Participants generally agreed that a comprehensive approach to building a primary-care ‘home’ for every Ontarian will require harnessing existing resources to: develop a ‘made in Ontario’ approach (element 1); implement rapid-cycle evaluations and regular citizen and stakeholder engagement to identify why adjustments are needed to the approach, and to ensure accountability (element 2); and support the system-wide implementation of the ‘made in Ontario’ approach (element 3). Below we provide an overview of the key themes that emerged during the deliberations about each of the elements.

Element 1 - Harness existing resources to develop an approach for providing a primary-care ‘home’ to all Ontarians

During deliberations about element 1, participants expressed strong support for ensuring all Ontarians receive the care they need when they need it, putting the patient at the centre of care, and ensuring the full range of

care is seamlessly linked across providers, teams and settings. Participants supported the 10 primary-care 'home' pillars identified in the evidence brief, with one participant saying they "resonate strongly" (see Table 1 in the evidence brief for a list and description of the pillars).

Towards building a 'made in Ontario' primary-care 'home' approach (or primary-care hub, which most preferred as a term), participants acknowledged that Ontario has considerable infrastructure, resources and examples of successful practices that already follow the type of model outlined in the evidence brief. However, participants indicated that these need to be further invested in, refined and scaled-up across the province. One participant noted that "there are really high performing medical home models in Ontario that we need to learn from." Specifically, participants identified existing Family Health Teams comprised of family physicians, nurse practitioners, registered nurses, social workers, dietitians and other professionals as examples of the primary-care 'home' model. However, participants noted that efforts to use these models as part of a population-based approach will need to address the uneven availability of Family Health Teams across the province, different team compositions, and that not every physician wants, or is able, to work in a team-based model. As a way to address this and leverage existing resources, one participant suggested the use of "shared care agreements" that would enable providers to share staff and patients (e.g., a physician refers their patient to a social worker employed as part of a team located elsewhere, but remains their primary-care provider). Participants agreed this could improve the patient experience and continuity of care.

Participants further discussed the need to develop new ways of working within and across existing models and types of care in the province (e.g., within and across team and non-team based models, and between primary and specialty sectors) Participants were especially eager to see greater support for collaboration between primary- and specialty-care providers to ensure timely, comprehensive and coordinated care, with one participant stating that "primary care and secondary care need to come together, and we need a learning framework." Participants specifically identified the potential to use case managers to coordinate care between primary, specialty, and home and community care. Some participants also wondered about whether walk-in clinics and emergency rooms should be integrated within teams, with many indicating that further integration could improve care through better approaches to prioritize care based on patient need, and more effective use of resources to meet these needs. Patient portals, in the form of secure web-based applications that allow patients to access their health information, communicate with providers, and receive test results, were identified as a possible mechanism through which to equip patients to be partners in their care and improve coordination. Lastly, participants discussed how the wide range of components of the system should be integrated, with some calling for more shared decision-making with patients, and greater use of "communities of practice" among providers. One participant specifically suggested that every practice in the province can move along a trajectory over time towards incorporating aspects of the medical home model, while recognizing the need for diversity in terms of how it is operationalized across practices.

Funding allocation was identified as another important determinant of whether existing resources can be harnessed towards a 'made in Ontario' model. Some participants expressed concern about retaining staff in Family Health Teams given the lower pay in these settings compared to hospitals, and given lack of resources allocated to providing access to allied healthcare providers. Other participants called for appropriate budgets to support the broader array of programs, services and drugs that comprise primary care, as well as the recruitment, training and retention of staff. In deliberating about the potential budget implications for these investments, several participants pointed to the possible cost savings that could be achieved with the scale-up of teams (e.g., from reducing the unnecessary duplication of services), and suggested innovative ways of redistributing surpluses. For example, one participant described a funding model used in another jurisdiction whereby increased provider accountability and resulting changes to prescribing and other practices resulted in significant savings, which were then given back to physicians to pay for non-covered services for patients in need.

Element 2 - Implement rapid-cycle evaluations and regular citizen and stakeholder engagement to identify what adjustments are needed to the approach and to ensure accountability

During deliberations about element 2, participants agreed that decision-makers need to have accurate and timely evidence to make ongoing adjustments and ensure accountability in an Ontario primary-care 'home' approach. Overall, participants agreed with the importance of having regular and ongoing evaluations, but some questioned the language of 'rapid cycle' used in the evidence brief. One participant pointed out that "some of these things take a long time. There needs to be frequent evaluations and an understanding of outcome measures, but achieving them may take time." Also emphasizing the need for evaluation, another participant noted that "inequities in the system are real and serious ... when you understand the needs then you can make system-level change and figure out how to deliver care." Several participants pointed to the need to expand capacity in the province for conducting ongoing evaluations.

Many participants specifically emphasized the need to build the capacity of all physicians (and not just those working in specific types of primary-care models that already require them to plan, execute and report on quality-improvement activities) to contribute to ongoing evaluations and use the evidence from the evaluations to continually move their practice along a learning trajectory. Some participants specifically noted that supporting physicians to engage in and use this type of evaluation will require setting realistic expectations which recognize that individual healthcare providers and practices may be starting at different levels. For example, one participant suggested that "some [practices] need tailored evaluations, whereas others need more cookie-cutter evaluation and monitoring approaches." A tailored and stepped approach was suggested with flexibility in terms of the measurements and targets that are used.

Given concerns related to gaps and limitations in current data collection and reporting practices, particularly for diverse communities and vulnerable sub-populations, some participants also emphasized the need to build capacity related to outcome (and process) measurement. Specifically, participants called for the establishment of goals and measures that relate both to outcomes and to the pillars of the primary-care 'home' model (as a means to achieving the outcomes). While participants differed in terms of what they considered to be a useful number of outcome measures, they generally agreed on the importance of keeping the number manageable. One participant stressed that what Ontario needs is "a small number of meaningful measures ... derived from electronic medical records [and] patient satisfaction surveys ..." In keeping with discussions about cross-sector collaboration and integration, one participant suggested the need for "a cascade of measures as we move between levels," and that "not just outcome but also process measures are needed." One participant indicated that getting agreement on a measurement framework will be essential, but such a framework needs "to be flexible and attuned to the trajectory of where the practice or region is." Finally, another participant identified the need for better management and leadership to set realistic goals as a precursor to meaningful evaluation.

Participants also generally agreed on the importance of building minimum measurable standards (but with some room for flexibility) that can be used in accountability frameworks. At the provincial level, to address what was seen as a lack of clear expectations and accountability frameworks (including inconsistent reporting of results back to patients and the broader public), participants called for greater accountability to ensure evaluations are conducted and the findings used to inform system-level change. For physician and team accountability, participants identified several key areas requiring measurable standards, including ensuring timely access to care, providing high-quality care, and supporting continuity of care. However, some participants expressed weariness with the onus for changes falling only on primary-care providers, and they called for shared accountability within and between parts of the health system. Participants also discussed whether patients should be held accountable for their use of healthcare (e.g., penalties for misusing emergency rooms). While opinions varied, participants generally preferred a patient engagement and empowerment approach. One participant argued that "the patient responsibility discussion should really be about patient activation and motivation instead of the negative framing of patient accountability."

The last area participants identified as requiring greater capacity involved data platforms and research infrastructure, and two priorities were identified: 1) enhancing the quality of the existing data; and 2) supporting decision-makers' and primary-care providers' ability to access and make use of the data and research evidence. Several participants agreed that existing data platforms and greater infrastructure in Ontario are not adequate to support data collection, utilization, learning and improvements. Other participants called for better collaboration with university-based researchers and research groups to bring in complementary data (e.g., data which are not currently captured in provincial monitoring initiatives but are being collected as part of province-wide research projects), and analysis skills to inform planning at the LHIN or sub-LHIN level.

In addition to providing suggestions for how to build capacity for evaluation, participants discussed the importance of directly engaging citizens and other stakeholders in identifying appropriate standards and measures, and in strategic planning. However, several participants noted that citizen engagement needs to be combined with a clear process for acting on citizen recommendations. Towards achieving this, a participant suggested that infrastructure for supporting meaningful patient and citizen engagement over time should be developed. Other participants indicated that citizen engagement should be added as an additional primary-care 'home' pillar as a way of affirming its importance to the model.

Element 3 - Support the system-wide implementation of a primary-care 'home' approach to reach all Ontarians

During deliberations about element 3, participants agreed with the need to take what is learned from evaluations of the primary-care 'home' model, make adjustments as needed, and support system-wide implementation, which could include engaging in the citizen and stakeholder engagement activities discussed under element 2, as well as using strategies to support change at the organizational and system level. Participants identified the need for a multi-sector and system-wide approach to governance, leadership, planning and training to support the implementation of a primary-care 'home' model for all Ontarians. The majority of participants felt strongly that the responsibility for implementation should not rest with primary care, with one participant saying, "primary care can't solve the system-level problems." To which another participant added that "some of the solutions need to come from other parts of the system."

Participants discussed the need for practice-/team-based learning to support the uptake of the primary-care 'home' model in general, and to use findings from the ongoing evaluations discussed in element 2 in particular. As one participant explained, "once we have the measures, you need to figure out how to get the data out there and support change with practice facilitation and coaching." Participants were generally supportive of opportunities for physicians to learn directly from each other (e.g., mentoring and coaching) and/or that bring physicians together in groups to build communities of practice. One participant noted that "there is a science now about how you help practices learn through coaching, and that evidence-base should be drawn on." Several participants stressed that physicians are social learners who value trust and mentorship, and are unlikely to benefit from just online-learning opportunities. Moreover, participants identified the need to develop improved training infrastructure and technical support based on successful models from other jurisdictions, which can then be adapted for Ontario.

In keeping with deliberations from element 1 and 2, participants also emphasized the need for flexibility during the implementation process. For example, one participant indicated that "there needs to be a clear focus on learning trajectories appropriate to where practices, teams or communities are starting from." Another participant added that "in the trenches, we need coaching and facilitation to turn the 'mom and pop' shops on the trajectory to coming up to the population-based model."

In addition to discussing implementation of the primary-care 'home' model, participants also discussed the need for system-level governance and leadership to enable province-wide implementation. One participant highlighted that "we need to move our thinking and leadership to system-level leadership [and]...create a

culture of system leaders.” Participants discussed whether innovation in leadership, management and quality improvement should be prescribed or emerge organically. Some participants expressed that implementation, and related monitoring and evaluation, should develop organically within diverse settings across the province to ensure it is locally relevant (e.g., leadership in rural and northern communities may be different than elsewhere). Other participants raised concerns that such an organic approach could lead to a fragmenting of services and result in further inequities in the system.

Participants identified a role for LHIN and sub-LHIN levels in developing a regional or sub-regional ‘quality table’ to discuss what is happening in primary care and other sectors (e.g., mental health and addictions, and public health) to avoid working in ‘silos’, and link what is happening locally to what is happening across the province. One participant suggested a hybrid governance model (between the prescribed and organic) that would entail working at three levels: 1) in communities with hubs that are locally governed; 2) at the sub-LHIN level; and 3) at the LHIN level.

Considering the full array of options

Participants generally agreed about the need for each of the elements. In particular, when considering the full array of options, participants affirmed the importance of the 10 primary-care ‘home’ pillars presented in the evidence brief, but further highlighted the importance of citizen engagement, with some suggesting it be included as an additional pillar. Across the elements, participants also emphasized the need for system-level transformation and a paradigm shift in leadership, funding, data-collection infrastructure, monitoring and evaluation, and education to ensure the effective implementation of a primary-care ‘home’ model for all Ontarians.

DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS

Participants identified several considerations related to supporting an ongoing process of practice change in the province towards a population-based primary-care ‘home’ model. Some participants focused on identifying the trajectories of learning that are needed at different levels across the province and to facilitate using evidence-based approaches. For example, one participant highlighted that there are now evidence-based resources that provide a step-by-step approach for using practice facilitation and other related methods to support practice-level change to a new model. Some participants suggested supporting practice change at the LHIN or system level, while others noted the importance of letting this happen at the provider and practice level. Noting that change likely needs to be supported at both levels, one participant emphasized that some providers and practices will be able to move along this trajectory on their own (as an example of micro-level organic change), but others will need more concrete macro-level supports (such as centrally supported practice facilitation models) to move along a learning trajectory to doing things in a new way. Another participant indicated that an important component of supporting these types of changes will be “to get more data into the hands of physicians,” and further emphasized that “instead of waiting for physicians to ask for it, the data should just be given to them so that they can act on it.” Another participant suggested that Health Quality Ontario could facilitate such data support by engaging in a process to develop and implement measures across the system and ensure they get the resulting data into the hands of physicians and other stakeholders who can use it. Lastly, several participants noted the importance of ongoing citizen- and stakeholder-engagement to underpin all parts of the implementation process, including the development of the ‘made in Ontario’ model, identification of meaningful measures for use in evaluations, and supporting implementation in a way that addresses local needs and realities.

DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES

Most participants agreed with one participant who suggested that there is general consensus about the need for a primary-care ‘home’ model (albeit with a different name that conveys patient-centredness and possibly uses ‘hub’ instead of ‘home’). As result, when asked about what they could do to help push forward this opportunity for significant change in the health system, participants identified four types of activities or considerations that need to be the focus going forward. First, several participants emphasized the need for a multifaceted approach to support practice change. In addition to the considerations related to implementing practice change outlined above in the section about implementation considerations, one participant indicated that there are existing supports for change management in the province, and that a key first step should be to publicize these supports and build synergies to maximize their impact across the system. Moreover, several other participants emphasized the need for fostering leadership at the provider/practice, organizational and policy levels, with some specifically indicating that involving individual physicians in leadership will be necessary to achieve buy-in and increase their likelihood of participating in quality improvement and change management.

Second, one participant noted (and several agreed) the need for additional resources and a better alignment of incentives to achieve system-level goals. One participant specifically indicated that moving forward with reform in this area “needs to be afforded enough time and money to make this work.” Another participant highlighted their interest in pursuing initiatives to strengthen workforce planning in the province to support the implementation of a population-based primary-care ‘home’ model. However, some participants questioned whether significant injections of new resources would be needed, and instead thought that much of what was discussed could be achieved through re-allocations made possible by reducing ‘waste’ in the system (and thereby achieving better efficiency), and better disease prevention (to reduce the burden on the system in the long term).

Third, some participants highlighted the need to move forward with an ‘alliance model’ (instead of a patchwork) operating both across sectors and between practices (e.g., building a network of primary, speciality and home and community care at the LHIN and sub-LHIN levels). One participant working in community care highlighted their interest in contributing to such an approach given that it would help those with complex needs to access the team-based care that many are not currently receiving.

Lastly, the need for engaging patients and their families was identified as a critical component of the process for developing, implementing and evaluating a ‘made in Ontario’ model. One participant specifically emphasized the need for infrastructure in the province to support this type of work, with another suggesting that work is already underway to do this as part of the province’s “Patients First” initiative.



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