



Strategic Directions for Strengthening Primary Care in Ontario

Overview of Process and
Recommendations of the Primary
Healthcare Planning Group

Final

December 2011



Acknowledgements

The Primary Healthcare Planning Group (PHPG) would like to thank all Working Group members who took the time from their busy schedules to provide thoughtful advice to guide the development of recommendations that will strengthen the primary care sector in Ontario (Refer to Appendix 2 for a list of all Working Group Members).

The PHPG would also like to acknowledge the Co-Chairs of each Working Group for their leadership in bringing together diverse groups of individuals and developing a rich set of recommendations in a short period of time.

The PHPG would especially like to thank a small team of talented and hard-working staff who were instrumental in leading the direction of Working Group meetings and delivering reports within tight timeline



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Table of Contents

I.	Introduction	1
	Primary Healthcare Planning Group	1
	About this Document	3
II.	Definitions, Principles and Frameworks	4
	A Focus on Primary Care within the context of a Primary Healthcare Framework	4
	Definition of Accountability	4
	Domains of Primary Care Organization and Functions of Governance	5
	Framework for Quality in Primary Care	5
	Principles Defining Efficiency	6
	Dimensions of Access	6
III.	The Imperative for Change	7
	A. Accountability	7
	B. Governance and Organization	7
	C. Quality	8
	D. Efficiency	8
	E. Access	8
IV.	Key Messages of Working Group Reports	10
	A. Accountability	10
	B. Governance and Organization	10
	C. Quality	12
	D. Efficiency	14
	E. Access	14
V.	Strategic Directions for Strengthening Primary Care in Ontario	16
	A. Strategic Focus: Strategically Aligned Goals, Measures and Priorities	18
	A.1. Develop and Communicate an Overarching Statement of Goals and Objective for Primary Care	18
	A.2. Implement a Cohesive Framework to Measure Performance in the Primary Care Sector	18
	A.3. Establish a Dedicated Resource for Performance Monitoring and Feedback	18
	A.4. Develop and Regularly Update Evidence-based Clinical Practice Guidelines and Best Practices	19
	A.5. Develop Provincial, Local, and Practice Level Performance Targets and Priorities	19
	B. Strategic Focus: Integration Supported by Governance	19
	B.1. Enhance the Integration of Interdisciplinary Health Professionals in Primary Care Practice	20
	B.2. Enhance Horizontal Integration within the Primary Care Sector	20
	B.3. Formalize Vertical Integration of Primary Care with the Rest of the Healthcare System	20
	B.4. Adopt a Population Needs Based Planning with a Focus on Unique Populations	21
	B.5. Support Integration by Establishing Effective Regional Governance Structures	21
	C. Strategic Focus: Patient Centred Approach	22
	C.1. Continue the Formal Enrolment of Patients with Primary Care Providers	22
	C.2. Develop and Implement a Mechanism to Engage Patients in Self-Care and Healthcare Planning	22
	C.3. Implement Patient Experience Surveys	22
	C.4. Implement Mechanisms to Enhance Timely Access to Care for Patients	22
	D. Strategic Focus: Accountability Levers and Incentives	23
	D.1. Establish a Capacity for Regular Public Reporting as a Lever to Enhance Accountability	23
	D.2. Consider Accreditation as a Mechanism for Enhancing Accountability for Quality	23
	D.3. Establish a Mechanism for Ongoing Review and Redesign of Primary Care Financial Incentives	23
	D.4. Establish Effective and Enforceable Accountability Agreements to Drive Performance	24
	D.5. Implement Appropriate Components of <i>Excellent Care for All Act</i> in Primary Care	24
	E. Strategic Focus: Continuous Quality Improvement	25
	E.1. Implement Electronic Records with Standardized Functionality and Data Entry Requirements	25
	E.2. Provide Education, Training and Support for Quality Improvement	25
	E.3. Establish a Provincial Quality Improvement Leadership Capacity	26
	E.4. Establish a Program for Quality Improvement Research and Evaluation	26

VI. Integrated Recommendations Regarding Execution of Strategy.....	27
VII. Primary Care Planning Meeting: Dialogue Summary.....	28
A. Overview of Deliberations Regarding All Working Group Recommendations.....	28
B. Overview of Deliberations Regarding Working Group Recommendations	28
B.1. Improving Accountability in Primary Care	28
B.2. Strengthening Primary Care Organization and Governance	29
B.3. Strengthening Primary Care Access	29
B.4. Increasing Efficiency in the Family Practice Setting.....	29
B.5. Improving Quality in Primary Care	29
C. Overview of Deliberations Regarding the Draft Integrated Report.....	30
D. Summary of Round Table Deliberations on Enablers, Barriers and Priorities for Implementation.....	30
D.1. Priorities:	30
D.2. Enablers:.....	31
D.3. Barriers:	31
APPENDICES.....	a
Appendix 1: Glossary of Acronyms.....	a
Appendix 2: Membership of the Primary Health Care Planning Group and Five Working Groups.....	c
Appendix 3: Consolidated List of Recommendations of Each Working Group.....	f

I. Introduction

A strong primary care foundation is a key characteristic of high-performing health systems that achieve better outcomes and lower costs. A strong primary care system is one which is robust across all of its dimensions of care: primary and secondary prevention, screening and early detection of illness, coordination of acute care with appropriate follow up, smooth transitions across clinicians, settings, and services.

Primary care reform has been the focus of renewed interest in the last decade in Ontario and continues to be the subject of focus as a core element within the broader health system transformation taking place in the province. Over the past ten years Ontario has invested heavily in building a primary care foundation. Of note are the impressive strides made in:

- A substantial shift in models of care including the move from solo practices to group practices;
- Inclusion of interdisciplinary health professionals in primary care teams;
- A dramatic increase in the number of Ontarians attached to a primary care provider;
- Rollout of major chronic disease prevention strategies such as Integrated Cancer Screening; and,
- Establishment of quality improvement resources and enhanced recruitment and retention of primary care health human resources.

However, according to recent reports, policy papers and conference proceedings, and as outlined in further detail in the reports of the Primary Healthcare Planning Group (*see below*) and accompanying documents, there continue to be major missed opportunities in maximizing the benefits of Ontario's investments in primary care. Ontario continues to lack a system-wide and sustainable approach to strengthening primary care that includes all relevant stakeholders and provides a directional framework.

Primary Healthcare Planning Group

In June of 2010, the McMaster Health Forum held a dialogue^{*} on the topic of "Supporting Quality Improvement in Primary Healthcare in Ontario", where participants emphasized the need for an overarching framework for improving primary healthcare in Ontario. Forum participants recommended that a planning group be established with a mandate to draft and build consensus on a strategy for strengthening primary healthcare in Ontario.

The Primary Healthcare Planning Group (PHPG, The Planning Group[†]) was established in the fall of 2010 with a mandate to:

- Draft and build consensus on a strategy for strengthening primary care in Ontario; and,
- Plan a meeting at which the proposal would be debated by a broad-based group of stakeholders.

Chaired by Susan Fitzpatrick, Assistant Deputy Minister, Negotiations and Accountability Management Division at the Ministry of Health and Long-Term Care, the Planning Group included membership from Ontario Medical Association (OMA), Registered Nurses' Association of Ontario (RNAO), Ontario College of Family Physicians (OCFP) and Association of Ontario Health Centres (AOHC).

^{*} Participants included representatives from the: Government of Ontario, stakeholder organizations (e.g., Ontario Medical Association (OMA), Ontario College of Family Physicians (OCFP), Registered Nurse Practitioners' Association of Ontario (RNAO), Association of Ontario Health Centres (AOHC), Association of Family Health Teams of Ontario, Dietitians of Canada), Local Health Integration Networks (LHINs), Quality Improvement and Innovation Partnership (QIIP), Cancer Care Ontario (CCO), regulatory bodies and academics.

[†] See Appendix 1 for a glossary of acronyms used in this report.

In establishing the priorities for the primary care sector, the Planning Group proposed a Preliminary Framework for Strengthening Primary Care in Ontario. This framework specified improvements in Quality, Access, and Efficiency as goals for the primary sector, enabled and reinforced by Governance and Accountability mechanisms.

Figure 1: Preliminary Framework for Strengthening Primary Care in Ontario



The Planning Group also recommended that a Working Group (WG) be established to investigate challenges and opportunities and provided recommendations for improvement in each of the areas identified in the framework.

As a result, in the Spring of 2011, the following five WGs were established:

- Quality in Primary Care
- Strengthening Primary Care Access
- Increasing Efficiency in Family Practice Settings
- Improving Accountability in Primary Care
- Strengthening Primary Care Organization and Governance

The PHPG established the following guiding principles to direct the recommendations of the five WGs:

- Include a long-term vision for primary healthcare in Ontario, but also express a series of short-term goals that can be implemented in a staged fashion
- Fully leverage existing investments already in the system to drive results
- Focus on a system-wide and sustained approach to supporting quality improvement across the full continuum of care
- Utilize the primary care models to support the system's priority commitments of most impact to primary care including:
 - Excellent Care for All Strategy
 - Ontario Diabetes Strategy
 - Emergency Room/Alternative Level of Care
 - Family Healthcare For All
- Enhance accountability within the primary healthcare sector and among providers
- Consider constraints facing the system in the current economic climate
- Reflect external stakeholder and expert capacity and available literature and reports

The WGs, each led by two Co-Chairs, brought together over 50 providers, stakeholders, and experts from over 25 organizations and met over the spring and summer to consider best data, evidence and practices to develop a set of recommendations. A web-based tool "Box.Net" was used for the sharing of files and document management.

Each WG submitted a final report to the Planning Group in the late summer. These reports can be accessed by clicking on the attachments to this document or via URL: <http://www.box.net/files#/files/0/f/0>.

About this Document

The purpose of this document, “Strategic Directions for Strengthening Primary Care in Ontario” is to provide a high level summary and synthesis of the recommendations of the five WG reports. This document is not intended to fully capture the considerations, committee work and research that informed recommendations as each WG report is comprehensive and each should be reviewed in detail. Rather this report summarizes the definitions, frameworks, imperatives for change and key findings of each WG. It also identifies cross-cutting themes across all recommendations and integrates common recommendations within identified themes.

To develop the set of strategic directions integrated recommendations, recommendations in each WG report were analyzed by first identifying common themes (e.g., performance measurement, training and support, information technology, etc.) that were collated into five major areas of strategic focus. Recommendations were combined to produce a set of integrated recommendations. A draft report was discussed at a Primary Care Planning Meeting in the Fall of 2011, where all five WGs came together to discuss and provide feedback on the WG reports as well as the integrated set of recommendations. This final report reflects the discussions that took place at the Planning Meeting and has been reviewed by the WG Co-Chairs.

This report is organized into five sections, each bringing together key elements of the five WG reports. In the next section, **Definitions, Principles and Frameworks**, key terminologies and frameworks used by the PHPG and WGs are outlined.

The **Imperative for Change** section sets the context by identifying the deficiencies in the current primary care system and the factors that drive on-going reform, as established by each WG. This section is organized by the five areas of focus: accountability, governance, quality, efficiency, and access.

In the **Key Messages of Working Group Reports**, a high-level summary and synthesis of the main recommendations by each WG is provided.

In the section **Strategic Directions for Strengthening Primary Care in Ontario**, the integrated set of recommendations based on analysis of recommendations of the five WG reports as outlined above are presented

In the section **Integrated Recommendations Regarding Execution of Strategy**, recommendations to enable implementation of WG recommendation are outlined.

II. Definitions, Principles and Frameworks

This section summarizes the definitions, principles and frameworks used by the PHPG and WGs to develop their recommendations. While the definitions and frameworks proposed by the Planning Group and five WG may need further revisions for broader adoption and endorsement, it is clear that a common language that can be used consistently and clearly among providers and stakeholders is critical for effective communication and collaboration as well as for research and policy development and implementation.

A Focus on Primary Care within the context of a Primary Healthcare Framework

The terms primary care and primary healthcare are not interchangeable. These concepts are not always clearly defined and different organizations have offered various definitions for these concepts. Starfield's definition of primary care and the World Health Organization's (WHO) definition of primary health care are most widely accepted by stakeholders and health care providers in Ontario (Refer to Box 1). The PHPG recommended the use of these definitions and directed the WGs to focus on primary care within the context of a primary healthcare framework.

Box 1: Definitions of Primary Care and Primary Healthcare

<p>Primary Care</p>	<p>Primary care is that level of a health service system that provides entry into the system for all new needs and problems, provides person-focused (not disease-oriented) care over time, provides care for all but very uncommon or unusual conditions and coordinates or integrates care provided elsewhere or by others. It thus is defined as a set of functions that, in combination, are unique to primary care. Primary care also shares characteristics with other levels of health systems: accountability for access, quality and costs; attention to prevention as well as therapy and rehabilitation; and teamwork. Primary care is not a set of unique clinical tasks or activities; virtually all types of clinical activities (such as diagnosis, prevention, screening and various strategies for clinical management) are characteristic of all levels of care. Rather, primary care is an approach that forms the basis for and determines the work of all other levels of health systems. Primary care addresses the most common problems in the community by providing preventive, curative and rehabilitative services to maximize health and well-being. It integrates care when there is more than one health problem and deals with the context in which illness exists and influences the responses of people to their health problems. It is care that organizes and rationalizes the deployment of all resources, basic as well as specialized, directed at promoting, maintaining and improving health.</p>
<p>Primary Healthcare</p>	<p>Primary Health Care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.</p>

Definition of Accountability

The Accountability WG defined accountability as a mechanism by which parties take responsibility for their action. Within healthcare, accountability can be described in terms of payer accountability (where resources

go), provider accountability (how resources are used and how services are delivered, individually or within a team), and patient accountability (how resources are used).

Domains of Primary Care Organization and Functions of Governance

The Governance Working Group concentrated its efforts on providing recommendations in four domains aimed at enhancing care for all Ontarians, as illustrated in Box 2 below:

Box2: Domains of Primary Care Organization and Governance

	Horizontal Integration Within the Primary Care Sector	Vertical Integration of Primary Care with Other Parts of the Health System
Patient Level	1. How can primary care resources be more effectively linked to each other to provide better quality care for patients?	2. How can the healthcare system ensure more effective coordination and integration of patients between primary care and other health system resources?
Strategic Planning Level	3. How can primary care providers in a community or region more effectively work together to plan for the varied needs of all patients locally and/or regionally?	4. How can a governing body (e.g., LHINs) effectively align, plan for and resource appropriate health providers to ensure the effective and efficient provision of health services for a population?

Horizontal Integration within the Primary Care Sector (Quadrants 1 and 3): Horizontal integration is about connecting primary care providers (intra-, inter-, multi-, trans-disciplinary) to each other more effectively to make the best use of the available resources - both at the patient and the strategic planning level. Horizontal integration at the patient level includes designing mechanisms (virtual or structural) to more effectively link primary care providers (e.g., family physicians, nurses/nurse practitioners, mental health and social workers, dietitians, pharmacists, etc.) so that they can provide better quality care to their individual patients and their collective community. At the strategic planning level, horizontal integration would focus on creating formal linkages amongst various primary care practices that are geographically, demographically and clinically aligned to gain economies of scale and establish accountability for access, quality of care, and coordination of activities within a community and/or a geographic region. This may also entail changes in current policies and practices to permit greater coordination (e.g., allowing patients registered in one family practice or a FHT to be seen in another).

Vertical Integration of Primary Care with other health system providers (Quadrants 2 and 4): Vertical integration at the patient level is about ensuring better care coordination between primary care and the other health providers in Ontario (e.g., CCACs, acute care, specialty medical care, mental health, public health, community and social services, palliative care, long term care, etc.) At the strategic planning level, vertical integration is about establishing formal linkages between the primary care sector and the other parts of the health system, including non-primary care provider organizations, as well as those involved in health system planning, funding, and monitoring (e.g., LHINs, PHUs) to ensure the high quality, seamless care for patients.

Functions of Governance: According to the Governance WG, governance involves the combination of structures, policies, and processes to ensure that an entity delivers value to its “shareholders” (i.e. produces the expected health outcomes within the allocated funding envelope). The WG refers to governance as a function, not necessarily a governing body, that encompasses the functions of (1) planning and resource allocation; (2) monitoring, (3) holding accountable and subsequent rewarding.

Framework for Quality in Primary Care

A high quality healthcare system is defined in *The Excellent Care for All Act, 2010* as one that is: accessible; appropriate; effective; efficient; equitable; integrated; patient-centred; population health-focused; and safe.

Quality Improvement (QI) involves a structured process that includes assessment, refinement, evaluation and adoption of processes by an organization and its providers to achieve measurable improvements in outcomes to meet or exceed expectations.

The Quality WG recommended that the Triple Aim Framework developed by the Institute for Healthcare Improvement (IHI) be used for quality improvement in primary care at the practice, local, regional and provincial levels (Refer to Box 3). The Triple Aim Framework focuses on three objectives for the system and recommends a set of indicators for measuring performance that are aligned with those objectives.

Box 3: The Triple Aim Framework

Three Objectives For the System

- Improve the health of the population
- Enhance the patient experience of care (including quality, access and reliability)
- Reduce, or at least control, the per capita cost of care

Principles Defining Efficiency

The Efficiency WG defined an efficient family practice as one that is: able to assess and improve quality; supported and integrated by technology; and, built on the backbone of teamwork and interdisciplinary care. The efficient family practice provides timely access to patients within an office design that reflects provider workflow and patient needs, and is able to balance supply and demand for non-appointment work, synchronize patient and provider information, predict and anticipate patients' needs, optimize rooms, staff, and equipment while managing constraints.

Dimensions of Access

The Access WG recommended that access should be equitable, timely, continuous, comprehensive, evidence-informed, and culturally safe and proposed definitions for each of these dimensions (refer to Box 4).

Box 4: Definitions of Dimensions of Access

Equitable	Addresses unfair differences in health status, access to healthcare and health-enhancing environments, and treatment within the health and social service system
Timely	Patients are able to access their primary care provider within 48 hours
Continuous	Care is connected and coherent, and the management of a patient's care over time is coordinated amongst providers
Comprehensive	The provision, either directly or indirectly, of a full range of services to meet patient's health care needs. This includes health promotion, prevention, diagnosis and treatment of common conditions, referral to other clinicians, management of chronic conditions, rehabilitation, palliative care and, in some models, social services
Evidence-informed	An approach to policy decisions that is intended to ensure that decision making is well-informed by the best available research evidence.
Culturally Safe	Pertains to being respected and having cultural location, values and preferences taken into account, as well as explicitly linking service delivery to cultural respect and awareness. The concept includes cultural sensitivity, cultural competence and involves the recognition of unequal power relations.

III. The Imperative for Change

Building on the proceedings of the McMaster Health Forum, existing data, information and reports, as well as some original research and analysis, each WG described the current state of the primary care sector as it pertains to their respective area of focus. Using this description as a base, each WG identified gaps and challenges, then made the case for change.

This section summarizes the current state and key drivers of change, as articulated by the five WGs.

A. Accountability

- There is no cohesive strategy or approach in place to measure how the primary care sector is performing relative to goals for which it is accountable.
- The activities of interdisciplinary teams are not well understood, as formal monitoring mechanisms are lacking. There is no quantitative sense of the impact interdisciplinary approaches to primary care are having on patients, peer providers and the system in general.
- Current accountability mechanisms (primarily accountability agreements) do not reflect the multidirectional nature of primary care.
- Accountability monitoring for primary care services, for example, through the Medical Claims Payment System, is more focused on identifying areas of potential abuse than measuring the degree to which the system is performing.
- There is no consistent and timely approach to corrective action or remediation in circumstances where it is determined that accountability requirements are not being met. The approach differs depending on the compliance issue and type of service provider.

B. Governance and Organization

- The governance change imperative is anchored in the belief that a strong and well-organized primary care sector is the key factor in achieving positive population health outcomes and the sustainability of our publicly funded healthcare system.
- A cohesive organization and infrastructure that can help to articulate and set a common direction to achieve primary healthcare goals is missing; likewise for standard setting and monitoring.
- Primary care models have different accountabilities and accountability arrangements. The system could benefit from greater coordination and integration.
- In Ontario, there are not currently any primary care governance structures that effectively ensure planning and resource allocation, monitoring and accountability are achieved. The governance structures that do exist in Ontario may achieve some but not all of the needed functions of governance.

- Currently, relatively few formal linkages exist between primary care providers and the rest of the healthcare system, although there are many informal ways in which various parts of the sector interact to better support and integrate with primary care providers.

C. Quality

- The Quality WG framed the rationale for change by examining the findings of the Commonwealth Fund Surveys (2009, 2010) and Health Quality Ontario (2010, 2011) reports, which demonstrate that primary care in Canada and Ontario lags behind other wealthy industrialized countries in terms of access, quality management, use of EMRs and team-based care. For example, Canada falls in the bottom three among all participating countries with respect to a significant number of key quality indicators.
- Although there are a variety of quality improvement initiatives taking place in Ontario, there is no system-wide and sustained approach to supporting quality improvement in primary care. Quality improvement programs across the range of primary care models in Ontario are fragmented and limited in coverage.

D. Efficiency

- Current physician service agreements outline responsibilities for providing after hours care, obligations to provide on-call support through a telephone health advisory service and commitments to provide comprehensive care. These agreements do not obligate physicians to address efficiency, provide timely access for patients or assess quality measures within the practice.
- One aspect of the current primary care system in Ontario that continues to underperform, and that has a dramatic impact on the efficiency of office practice, is the transition of care for patients moving between providers. Electronic medical records, data management and data quality is key to establishing the integration capacity of the primary healthcare system. Building a system on common standards and shared terminology will allow for quality improvement at the system and practice level.
- A careful review of process at the practice level is not a consistent activity. Such review(s) can help to identify efficiencies in how patients encounter the practice and how providers encounter patients. This includes a review of panel size, office design and workflow.
- Quality at the practice level could be enhanced through the development and dissemination of evidence-informed practice guidelines. The complexity of patient care is requiring providers to adopt a wider range of services and to provide more care to a greater number of patients and conditions. The lack of available and up-to-date practice guides and resources can often disrupt workflow and result in inefficiencies at the practice level.
- Inefficiencies in an interdisciplinary practice setting are resulting from not capitalizing on the full scope of clinical practice of health providers and thus failing to avoid duplication and/or gaps in care. Clearly defining the role of the non-clinical team members (administration) is of utmost importance to achieve greater efficiency, but this is not always done.

E. Access

Equitable

- There is insufficient data collected and used to promote a needs-based approach to primary care, required for more equitable access. Specific data deficiencies hindering a more equitable approach include:

Strategic Directions for Strengthening Primary Care in Ontario Overview of Process and Recommendations of the Primary Healthcare Planning Group

socioeconomic indicators, patient and provider data (address, postal code), and data on the impact of interdisciplinary health providers.

- There is currently a lack of focus on the challenges associated with mental health, addictions and complex co-morbidities in the province's approach to access.
- The complexity of various primary care models presents an information barrier to some patients in accessing appropriate primary care services.

Timely

- There is a shortage of after hours primary care coverage across the province, where many patients have difficulty accessing care from their own provider(s) within 48 hours. This has resulted in inappropriate use of the ER.

Continuous

- There are persistent barriers to cross-model collaboration amongst primary care providers, including the absence of interoperable EMRs, lack of robust system of patient navigation across the continuum of care and an "access bonus" provided to physicians that has the unintended effect of prohibiting some patients from seeing other providers, even if appropriate to do so.

Comprehensive

- Only a subset of patients have access to interdisciplinary models of care and the restricted scope of non-physician primary care providers limits access to comprehensive primary care.

Evidence-Informed

- Primary care providers are not fully utilizing evidence-informed guidelines currently available
- Patients, families and communities are generally not provided opportunities for input into their care or for planning.
- There is a lack of patient perspective and active community engagement in primary care planning, implementation and evaluation.

Culturally Safe

- There continues to be inequitable health outcomes for the Aboriginal population, francophones, new immigrants, racialized populations and other vulnerable populations including LGBTQ, people living with disabilities and people living in poverty.

IV. Key Messages of Working Group Reports

This section is intended to provide a brief snapshot of the reform initiatives that each WG is proposing. Please refer to Appendix 3 for the full list of recommendations of each WG.

A. Accountability

Guiding Principles:

- The recommendations of the Accountability WG were driven by the following guiding principles:
 - Practical and focused; Recommendations need to have a defined objective linked to deficiencies in current accountability structures and processes.
 - Changes should be bold where needed; Bold changes are needed to enhance accountability, but they should not jeopardize effective primary care reforms that are currently underway.
 - Inclusiveness; Recommendations for improved accountability need to include the full range of primary care providers within the system.
 - Follow up work to be done where most appropriate; Follow up work associated with the recommendations should reflect existing mandates and responsibilities.

Key Messages:

- A structure should be put in place to act on the recommendations of the PHPG.
- Organizations in the primary care sector need to come together with a shared, sustained commitment to identifying Ontario's goals for primary care, measure and report on system performance in relation to those goals and work together if those goals are not being met. Primary care should operate based on the premise that it is where most Ontarians should be cared for.
- Clear and measurable objectives should be developed for the Ontario's primary care sector. A simplified and efficient primary care measurement and monitoring strategy should be designed and implemented to assess how the primary care sector is performing relative to these objectives.
- Physician incentives and premiums relating to preventive care, after hours care, chronic disease management, patient enrolment and others should be reviewed.
- Policies should be developed to guide corrective action where accountability requirements are not being met, and funders must follow these policies.
- Strategies to monitor the delivery of after hours care; advanced access; and to analyze the activities of interdisciplinary health providers in primary care should be developed.

B. Governance and Organization

Guiding Principles:

- The recommendations of the Governance WG were driven by the following guiding principles:
 - Centrality of Primary Care: Ensures and promotes the importance of primary care in the system as the

foundation of the healthcare system. Supports primary care practitioners to deliver comprehensive services and to maintain continuity of care as the essence of primary care service delivery.

- **Collective Responsibility and Joint Planning:** Governance and organizational structures will enable primary care to take collective responsibility to meet the primary care needs of all patients at a local level. Planning would be both bottom-up and top-down.
- **Maintains Current Employment Relationships and Associated Compensation Channels:** While accountabilities may change, employment relationships are maintained (e.g., physicians do not become employees of government and those compensated by OHIP remain so).
- **Excellent Care for All (ECFA):** Supports ECFA's intent to make "health care organizations responsible and accountable to the public and focused on creating a positive patient experiences and delivering high quality care."
- **Professionalism and Stewardship:** Confidence that healthcare clinicians and administrators intend to act in the best interests of patients and their families (professionalism) and that government will support professional obligations --- and not unintentionally create disincentives for doing so (Stewardship).
- **Team-based:** Supports inter and intra-professional primary care delivery (i.e., interdependent, collaborative care models amongst healthcare professionals)
- **Simplicity and Flexibility:** An effective vertical and horizontal organization of primary care is one that is simple and feasible to implement across the province while at the same time flexible so that it can be customized to allow for the heterogeneity of population and local needs.
- **Patient or Client Centred:** An approach in which patients/clients are viewed as whole persons in the context of their family and community; it is not merely about delivering services where the client is located. The "patient-centred clinical method" involves advocacy, empowerment, and respecting the client's autonomy, voice, self-determination, and participation in decision-making.
- **Leverage and Limited Duplication:** Where possible, uses existing resources and structures.
- **Single Focus:** Aims for a single coordinating and integrating body within a focal point or geography.

Key Messages:

- The Governance WG recommends a "strong form of governance" (i.e., a body with the authority to achieve the three functions of governance 1) Planning and resource allocation, (2) Monitoring and (3) Holding accountable with subsequent rewarding contingent on performance. This form of governance is not seen as "managing" primary care practices but rather as enabling healthcare professionals at the local and regional levels to meet the goals of the Excellent Care for All Act, 2010.
- Based on a review of Ontario and other jurisdictions, the three functions of effective primary care governance can only be achieved when all three elements come under the responsibility of a single governance structure; however, that governance structure needs to be informed by the strong voice of primary care providers through their active participation in its planning and decision-making processes. Effective coordination and integration within the primary care sector and between primary care and other health system providers cannot be achieved with different loci of accountability.
- A "bottom-up" and "top down" planning process should be put into place to ensure a strong and cogent voice for family physicians, primary care nurses and other primary care professionals at the local, regional and provincial levels.
- Since care is delivered primarily at the local level, each of the three options below incorporates the concept of Primary Care Councils and Sub-Councils. Primary Care Councils would be established at the LHIN or equivalent level (Options A and C) and Sub-Councils would be established at the micro-region level (Options A, B and C). Similar to those in British Columbia and Australia, the Primary Care Councils/Sub-Councils, locally and/or regionally would be "tables" to identify and jointly plan for addressing primary care needs, and would work cooperatively with other health service providers in their community. They could be given some discretionary funds to incent behaviours, but, in general, would have limited ability to hold providers accountable.
- Three options for a governance model are proposed:

- Option A: A regional governance model based on LHINs or a LHIN-like structure that performs the three functions of governance and supports Primary Care Councils/Sub-Councils.
 - Option B: Integrated Health Systems (IHS) in the naturally occurring referral areas that performs the three functions of governance and supports a Primary Care Council;
 - Option C: A nested option that involves an overarching regional governance model based on LHINs or LHIN-like structures (macro level), along with Integrated Health Systems in naturally occurring referral areas (meso level), supporting Primary Care Sub-Councils (micro level) in communities and a Primary Care Council at the regional level.
- In each of the governance models, the Ministry would set provincial goals for which LHINs or IHSs (or a combination of both) would be accountable. These regional structures would develop plans to ensure population health needs are met with the balanced input of primary care providers and representatives from the broader healthcare system (through the Primary Care Councils and Sub Councils).
 - For either of the options, sufficient resourcing and funding authority to these regional structures so that their governance activities are not impeded.
 - The regional governance structures should write and enforce Accountability Agreements between themselves and provider organizations in their jurisdictions including primary care providers. This implies the transfer of current Accountability Agreements with the Ministry.
 - The regional governance structures establish MOUs between themselves and Primary Care Councils based on provincial standards.
 - The regional governance structures (LHINs or IHSs) would have the discretion to reallocate resources to ensure the greatest value for the province's healthcare investments.
 - Physician remuneration under the joint OMA-Ministry agreement would not be affected.
 - Recognizing that many primary care providers may initially be challenged to meet accountability requirements, the Ministry should incent and support all family practices to strengthen their ability to function as group practices; and encourage solo physicians to practice in inter-professional team models.
 - Finally the WG also recommended that HQO and e-Health be instructed to provide centralized support to the governing bodies so as to promote efficiencies and to avoid duplication.

C. Quality

Guiding Principles:

- The recommendations of the Quality WG are driven by the following guiding principles:
 - The ultimate purpose of quality improvement efforts is to improve patient experience, health outcomes and efficient use of resources. This is accomplished by providing the training, resources and support that enable primary healthcare practices and organizations to imbed continuous quality improvement in day-to-day clinical practice.
 - Quality improvement efforts should emphasize enablers and supports rather than accountability requirements and voluntary rather than mandatory participation.
 - Quality enablers and supports should be available to all primary healthcare practices and organizations irrespective of organizational or payment model.
 - Quality improvement is driven first and foremost by pride in performance and a desire to meet patients' health needs rather than external rewards or penalties.
 - Quality improvement occurs through incremental system change at the practice, organizational and health system levels.
 - You cannot improve what you cannot measure. Data drive improvement by identifying where change is needed and assessing the impact of improvements and innovations.

Strategic Directions for Strengthening Primary Care in Ontario

Overview of Process and Recommendations of the Primary Healthcare Planning Group

- Successful and sustained quality improvement requires the willing commitment of clinical and administrative leaders and the ongoing engagement of clinical, administrative and support staff.
- An appropriate balance is needed between provincial, regional, and local or practice level targets and priorities to ensure responsiveness to the needs of practice populations and communities and to encourage innovation.
- Quality improvement efforts need to be practical and evidence-based.
- Quality improvement methods and tested innovations have been developed and are available for adaptation to specific practice and organizational contexts.
- Improvement is always possible based on the philosophy of “Start where you are. Use what you’ve got. Do what you can.” (Arthur Ashe)
- To avoid undermining intrinsic motivation, performance measurement and reporting for improvement purposes should remain separate from measurement and reporting for accountability purposes, health system management or access to funding or financial incentives. However, the same measure may sometimes be appropriate for more than one of these purposes.

Key Messages:

- As the starting point for a coherent quality improvement agenda for primary care, reflective of the Excellent Care for All Act, 13 quality enablers were identified and recommendations were prepared for each enabler. These included:
- Improving performance measurement by using the Triple Aim framework and the Health Quality Ontario attributes of a high performing health system.
- Effectively measuring primary care performance drawing on EMR/Electronic Health Record (EHR), administrative and patient survey data.
- Performance measurement data disseminated widely to drive change and inform decisions.
- Public reporting of healthcare performance at the regional and provincial levels but not mandatory for primary care practices and/or organizations.
- Performance priorities and targets mainly set at the practice and community levels, taking into consideration: regional; provincial; and national priorities.
- EMRs/EHRs that include the following critical elements: proactive, patient based; show planned care for individual patients; allow measurement; have common data standards and capacity to share data.
- Continuing the spread of formal patient enrolment models (PEMs) is a key success factor for: expanding the number of collaborative interprofessional primary healthcare teams and for promoting and enabling interprofessional collaborative practice opportunities.
- Identify effective approaches to patient self-management and patient involvement in service design through evaluative studies.
- Fund targeted research and evaluation studies that will inform healthcare practice and policy making.
- Pilot and evaluate promising but untried quality-related innovations .prior to system-wide implementation.
- Support the development of quality improvement leadership capacity among primary healthcare clinicians and administrative staff
- Make quality improvement training and support available to all primary care providers and organizations over time
- Local provider networks that engage patients and the public could play a key role in promoting, supporting

and coordinating quality improvement initiatives and in sharing quality improvement expertise and experience among local providers

D. Efficiency

Guiding Principles:

- Three key principles should be adopted:
 - Efficiency in the family practice setting and throughout the primary care sector should not negatively impact on other areas of the healthcare system.
 - The family practice setting is a key part of a patient-centred healthcare system but cannot be expected to resolve all efficiency issues within the healthcare system.
 - Developing efficiency in the family practice setting will enhance provider ability to deliver care to patients. Implementation of change in the family practice setting needs to be considered from both provider and the patient's perspective.

Key Messages:

- Some key building blocks are necessary to establish the change processes required to improve efficiency, workflow and provider roles within the family practice setting. These include: expanded use of interdisciplinary teams; after hours care; telephone health support; electronic health and information technology; expanded scopes of practice and extended service delivery; advanced access; facilitated patient attachment and a focus on comprehensive care.
- The focus of primary care must include increased coordination of interdisciplinary services, expanding beyond structured team-based care to include integration with other primary and community-care providers and the broader healthcare system.
- The integration of patient care and efficient delivery of primary care services will benefit from effective e-health integration and patient-centered communication technology.
- Expanded provider training and curriculum on efficiency in the family practice setting will offer the necessary educational supports to implement the changes proposed.

E. Access

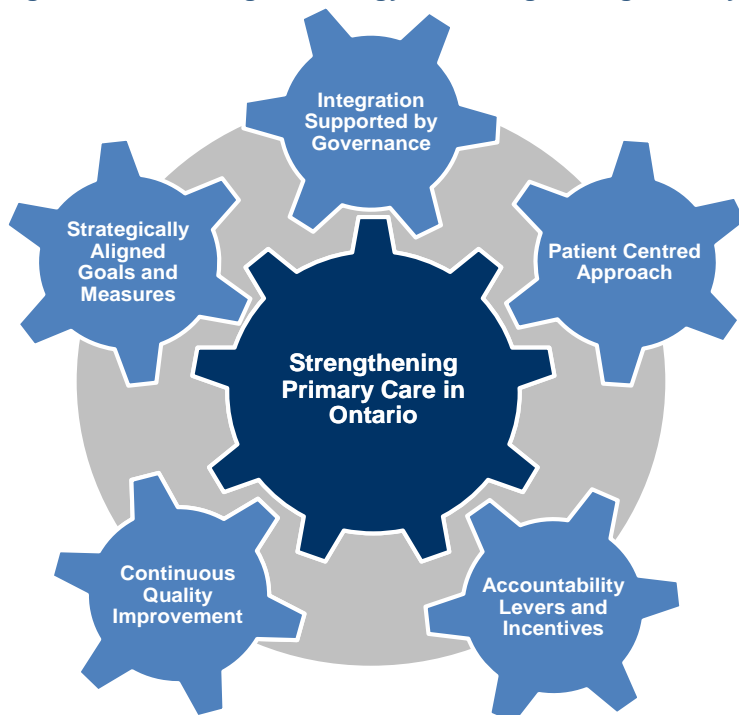
- Vision for strengthening primary care access:
“Primary care access where patients have equitable, timely, and continuous access to primary care that is comprehensive, evidence-informed and culturally safe while being acceptable to patients across all regions of the province and according to the local needs of diverse populations.”
- More equitable access can be achieved by using a population-needs-based, equity-oriented planning approach to primary care which incorporates: strategies for some unique populations; central repository for primary care data; strategy to focus on patients with complex co-morbidities; and to determine appropriate resource levels for optimal return on investment.
- More timely access can be achieved by requiring: all primary care models to provide 3 hours of after hours care per physician and NP per week; providers to work in collaboration with other providers to provide 24/7 cover by March 2015; patients to have access to their primary care provider within 48 hours.
- More continuous access can be achieved by: requiring all models of primary care to increase after hours care options; leveraging of system navigators and case managers; phasing out of walk-in clinics - to be replaced by planned after hours care.

- More comprehensive access can be achieved by: making IHP models available for those Ontarians who want to be attached to them; ensuring IHP teams have an appropriate mix, are fully functional and provide a full basket of services; use of EMR and innovative methods of primary care (i.e., mobile clinics, telemedicine, virtual wards; information database to be developed to facilitate patient referral).
- More evidence-informed care can be achieved if primary care providers ensure: all aspects of primary care access are guided by sound research and evidence, incorporating input from patients, families and communities; and patient access and satisfaction surveys are implemented.
- More culturally safe primary care can be achieved if: a focus on key communities is used to address inequalities to health care to those communities; cultural safety education is provided; cultural workers, translators, community workers work alongside primary care providers; training is provided for members from these communities; and indicators are developed to measure provision of culturally safe care.

V. Strategic Directions for Strengthening Primary Care in Ontario

The five WG reports provide a wealth of observations, conclusions and recommendations for the government and others to consider. A review of the reports demonstrates remarkable consensus and congruity around a number of core directional themes. Further, the specific recommendations made by each WG (see Appendix 3) concerning their particular area of focus support these core directional themes and point to a set of broad integrated recommendations relevant across all WGs. Together these form the basis for an emerging five-pronged strategy for strengthening primary care in Ontario.

Figure 2: Five Pronged Strategy for Strengthening Primary Care in Ontario



Strategic Directions for Strengthening Primary Care in Ontario

Overview of Process and Recommendations of the Primary Healthcare Planning Group

Box 5: Strategic Directions for Strengthening Primary Care in Ontario

Strategic Focus	Strategic Direction
Strategically Aligned Goals, Measures, and Priorities	<ul style="list-style-type: none"> ▪ Develop and Communicate an Overarching Statement of Goals and Objectives for Primary Care ▪ Implement a Cohesive Framework to Measure Performance in the Primary Care Sector ▪ Establish a Dedicated Resource for Performance Monitoring and Feedback ▪ Develop and Regularly Update Evidence-based Clinical Practice Guidelines and Best Practices ▪ Develop Provincial, Local, and Practice Level Performance Targets and Priorities
Integration Supported by Governance	<ul style="list-style-type: none"> ▪ Enhance the Integration of Interdisciplinary Health Professionals in Primary Care Practice ▪ Enhance Horizontal Integration Within the Primary Care Sector ▪ Formalize Vertical Integration of Primary Care with the Rest of the System ▪ Adopt a Population Needs Based Planning with a Focus on Unique Populations ▪ Support Integration by Establishing Effective Regional Governance Structures
Patient Centred Approach	<ul style="list-style-type: none"> ▪ Continue the Formal Enrolment of Patients with Primary Care Providers ▪ Develop and Implement Mechanisms to Engage Patients in Self-Care and Healthcare Planning ▪ Implement Patient Experience Surveys ▪ Implement Mechanisms to Enhance Timely Access to Care for Patients
Accountability Levers and Incentives	<ul style="list-style-type: none"> ▪ Establish a Capacity for Regular Public Reporting as a Lever to Enhance Accountability ▪ Consider Accreditation as a Mechanism for Enhancing Accountability for Quality ▪ Establish a Mechanism for Ongoing Review and Redesign of Primary Care Financial Incentives ▪ Establish Effective and Enforceable Accountability Agreements to Drive Performance ▪ Implement Appropriate Components of Excellent Care for All Act in Primary Care
Quality Improvement	<ul style="list-style-type: none"> ▪ Implement Electronic Records with Standardized Functionality and Data Entry Requirements ▪ Provide Education, Training and Support for Quality Improvement ▪ Establish a Provincial Quality Improvement Leadership Capacity ▪ Establish a Program for Quality Improvement Research and Evaluation

A. Strategic Focus: Strategically Aligned Goals, Measures and Priorities

A strong primary care system should be based on goals and objectives that are developed jointly by all stakeholders, effectively communicated to the sector, and form the basis for a performance measurement framework that is continually monitored. In such a system, evidence-based clinical practice guidelines are developed and regularly updated and inform performance targets and priorities.

A.1. Develop and Communicate an Overarching Statement of Goals and Objective for Primary Care

Development and communication of an overarching statement of goals and objectives for the primary care sector is viewed as essential to facilitating the engagement and alignment of providers and strengthening the primary care sector.

Recommendation 1:

The Ministry, in consultation with professional and provider associations, regulatory colleges, patient groups and other stakeholders in primary care, should develop and effectively communicate a clear and measurable statement of goals and objectives for which the primary care system should be held to account. These objectives should include at minimum:

- Timely, continuous, and comprehensive access to care
- Integration and coordination of care to and from other parts of the system
- Patient satisfaction
- Provider satisfaction
- Appropriate resource utilization
- Patient outcomes
- Attraction, retention, and distribution of health human resources in primary care
- Culturally safe care

A.2. Implement a Cohesive Framework to Measure Performance in the Primary Care Sector

Performance measurement is important to improvement since it allows for the identification of opportunities for improvement, tracking progress against organizational goals and comparing of performance against both internal and external standards. A cohesive framework for measuring the performance of the primary care sector against clearly articulated goals and objectives is a key enabler for strengthening primary care in Ontario.

A performance measurement framework encompassing practice, local, regional, and provincial levels should be based on the Triple Aim Framework (improved population outcomes, enhanced patient experience, and reduction/control of per capita costs) as well as Health Quality Ontario's attributes of a high performing health system (safe, efficient, effective, person-centred, accessible, equitable, integrated, population focused, and appropriately resourced).

Recommendation 2:

A Working Group should be established under the auspices of Health Quality Ontario to design a performance measurement framework including indicators to examine how the primary care system is performing against its goals and objectives at the practice, local, regional and provincial levels.

The Working Group should include a broad range of relevant stakeholders as well as public input.

A.3. Establish a Dedicated Resource for Performance Monitoring and Feedback

A dedicated capacity for monitoring performance is critical for monitoring the performance of the primary care sector. It should also have capacity to share reports and feedback with key stakeholders. Individual or practice

level performance data should be shared with the individual or practice in the form of confidential feedback to drive change. Performance data at all levels should be shared with key decision makers for the purpose of policy development and performance management.

Recommendation 3:

A dedicated resource for ongoing and proactive monitoring of performance at the practice, local, regional, and provincial level should be established with the ability to draw on draw on Electronic Medical Records, Electronic Health Records, relevant registries and clinical information systems, and patient survey data.

A.4. Develop and Regularly Update Evidence-based Clinical Practice Guidelines and Best Practices
Research, development and adoption of evidence-based standards of care, both in the form of guidelines for clinical practice (e.g., care pathways for complex patients) as well as best practices for healthcare resource utilization (e.g., implementation of Advanced Access) is critical to promote delivery of high-quality primary care to Ontarians. In developing evidence, it is recommended that input from patients, families and communities be incorporated in addition to consultation of experts and providers.

Recommendation 4:

The Ministry should work with Health Quality Ontario, the Ontario Health Technology Advisory Committee, primary care providers and experts, and professional associations to identify and periodically update evidence-based clinical practice guidelines to address quality and best practices for healthcare resource utilization.

A.5. Develop Provincial, Local, and Practice Level Performance Targets and Priorities
A performance target is a quantitative expression of an objective by an organization or individual and is a key enabler of quality improvement. Performance targets should be developed at the provincial, local, and practice levels. Provincial targets and priorities should be carefully selected based on short and long-term health system goals, available capacity, available high-quality data, evidence of potential for improvement, and impact on patient care and take into account national targets if available. The success of designing and implementing performance targets in quality improvement is dependent on consultations with stakeholders and providers at the practice and local levels.

Recommendation 5:

The Ministry in partnership with Health Quality Ontario should establish a process for collaborative development of provincial targets and priorities for primary care. The Ministry should also establish a process for collaborative development of performance priorities and targets at the practice and local levels, taking into consideration provincial targets and priorities if available.

B. Strategic Focus: Integration Supported by Governance

Integration across sites (i.e., horizontal integration within the primary care sector), levels of care (i.e., vertical integration of primary care with the rest of the healthcare system), populations (planning, resource allocation, monitoring and holding accountable at a defined population level), and between interdisciplinary health professionals within primary care models is identified by all WG reports as important to achieving goals of improving accountability, access, efficiency, and quality. Establishing a regional governance structure that sets the roles and responsibilities of all stakeholders, allocates resources, and monitors and rewards for performance is essential to supporting integration.

B.1. Enhance the Integration of Interdisciplinary Health Professionals in Primary Care Practice

Integration of Interdisciplinary Health Professionals (IHPs) can enable improvements in the areas of quality, access, accountability, and efficiency. A long-term strategy should be developed to enable the full integration of IHPs in primary care practice. In developing the strategy, the following guidelines should be taken into account:

- A formal mechanism should be developed to track and analyze the activities of IHPs to better understand the impact they are having in primary care, including in Family Health Teams, Nurse-Practitioner Led Clinics, Community Health Centres and Aboriginal Health Access Centres.
- Teams should vary in size, composition and organizational structure to meet local community needs and should include system navigators and case managers to coordinate patient care; cultural workers, translators, and community workers; and primary care providers from the cultural community being served.
- To achieve efficiencies and improved outcomes, IHP teams should be fully functional, working at the full level of competency, focusing on the patient's needs and recognizing the importance of continuity in building trusting provider-patient relationships.
- IHP teams should provide a full basket of services including at a minimum the basket of services identified by the Provincial Coordinating Committee on Community and Academic Health Science Centre Relations (PCCCAR).
- Northern and remote primary care models should be assisted in recruiting and retaining optimal IHP teams.

Recommendation 6:

The Ministry, in consultation with stakeholders, should develop a long-term strategy to continue the integration of IHPs into primary care practice with a vision that all Ontarians who want to be attached to IHP models should be able to do so regardless of funding or provider payment methods.

B.2. Enhance Horizontal Integration within the Primary Care Sector

Horizontal integration of primary care practices – specifically, integration and alignment between models and sites – is critical to enhance quality and efficiency within the primary care sector.

Recommendation 7:

The Ministry should move to incent and effectively support all primary care models to strengthen their ability to function as true group practices capable of delivering timely (24/7 coverage) and comprehensive care. The Ministry should further incent solo practice physicians to practice in formal or virtual multi-practice groups.

B.3. Formalize Vertical Integration of Primary Care with the Rest of the Healthcare System

Vertical integration of primary care – specifically, integration alignment with the rest of the system – is key for addressing challenges in transitions of care practices and improving the quality of care across the full continuum of the patient journey.

Recommendation 8:

Primary Care Councils and Sub-Councils should be established at the regional and/or local levels to support vertical (and horizontal) integration. The Councils should work cooperatively with primary care practices and other health services providers in their community to:

- Identify and jointly plan for addressing primary care needs in their community
- Provide a mechanism for the diffusion of best practices
- Achieve performance targets
- Ensure effective and efficient patient navigation through the healthcare system

B.4. Adopt a Population Needs Based Planning with a Focus on Unique Populations

Planning and resource allocation for primary care should be developed at a defined population level, be based on the needs of the population, and draw on patient addresses and socio-demographic data, and include a customized approach for addressing the needs of unique populations or priority disease conditions. The planning process should ensure a strong and cogent voice for family physicians, primary care nurses and other primary care professionals at the local, regional and provincial levels.

Recommendation 9:

Ontario should adopt a population needs-based, equity oriented and patient focused approach to plan primary care for all Ontarians with unique strategies for sub-populations based on demography or disease.

Unique planning and resource allocation strategies should be developed for five sub-populations: aboriginal; francophone, northern and remote; southern rural; and urban populations with a focus on racialized communities, new immigrants, the lesbian, gay, bisexual, transgendered and queer community, as well as people with disabilities.

A strategy should be developed to identify and focus on patients with complex co-morbidities in order to: determine appropriate resource levels for optimal return on investment; ensure that complex and vulnerable populations receive acceptable care that results in equitable health outcomes; and reduce usage of Emergency Departments and Alternate Levels of Care.

B.5. Support Integration by Establishing Effective Regional Governance Structures

An effective governance function is critical for supporting integration and achieving consistent improvements in quality, access, efficiency, and accountability. Effective governance involves: (1) planning and resource allocation; (2) monitoring; and (3) holding accountable with subsequent rewarding contingent of performance.

Since primary care is primarily organized, structured and delivered locally, regional levels of governance should be established. Options for regional governance include:

- Option A: A regional governance model based on Local Health Integration Networks (LHINs) or a LHIN-like structure that performs the three functions of governance and supports Primary Care Councils/Sub-Councils.
- Option B: Integrated Health Systems (IHS) in the naturally occurring referral areas that performs the three functions of governance and supports a Primary Care Council;
- Option C: A nested option that involves an overarching regional governance model based on LHINs or LHIN-like structures (macro level), along with Integrated Health Systems in naturally occurring referral areas (meso level), supporting Primary Care Sub-Councils (micro level) in communities and a Primary Care Council at the regional level.

Recommendation 10:

Regional governance structures should be established with sufficient resources and funding authority to:

- Provide support and infrastructure for primary care regional planning (i.e. Primary Care Councils and/or Sub-Councils)
- Establish Memoranda of Understanding with Primary Care Councils and/or Sub-Councils
- Ensure the allocation of resources to ensure the greatest value for the province's healthcare investments

The Ministry should continue to enhance initiatives under eHealth Ontario, Ontario MD, and/or develop other IT initiatives to support regional governance structures with reliable and timely data to support planning and resource allocation (e.g., tracking of patient addresses), quality improvement (e.g., patient referral systems).

C. Strategic Focus: Patient Centred Approach

A fundamental tenet of *Excellent Care for All Act (2010)* is the notion that care must be organized around the patient to best support his or her health. This patient-centred approach is equally a critical foundational element to strengthening primary care.

C.1. Continue the Formal Enrolment of Patients with Primary Care Providers

Patient enrolment is a mechanism that reinforces patient-provider relationships and responsibilities and is critical to proactive, population-based preventive care and chronic disease management and to systematic practice-level performance measurement and quality improvement.

Recommendation 11:

Ontario should continue the formal enrolment of individuals with primary care providers and groups as an important strategy in improving patient and system results.

C.2. Develop and Implement a Mechanism to Engage Patients in Self-Care and Healthcare Planning

Patient engagement in the form of both patient self-management as well as involvement in service design and planning is a key driver of improvement in primary care.

Recommendation 12:

Ontario should conduct evaluative studies to determine best approaches and develop and implement a mechanism for engaging patients in their care and in service delivery planning and design.

C.3. Implement Patient Experience Surveys

A patient-centered approach should also include measurement and monitoring of patient satisfaction through patient surveys. Conducting patient satisfaction surveys is a core requirement of *Excellent Care for All Act (2010)* in hospitals and should be expanded to primary care.

Recommendation 13:

Ontario should develop and implement province-wide patient experience surveys at the practice-level.

C.4. Implement Mechanisms to Enhance Timely Access to Care for Patients

Since timely access to care is critical for enhancing patient experience, mechanisms should be developed to enhance timely access to care such as adoption of Advanced Access, increased after-hours care, development of innovative models such as mobile clinics, and utilization of technology for patient communication. Proposed measures for timely access to care include: wait times to see a primary care provider for immediate care, third next available appointment, and number of hours of after-hours care per provider per week.

Recommendation 14:

There should be a determination of the necessary direction and support needed to enable all primary care providers to adopt Advanced Access principles, making timely access to appropriate care more widely available.

In addition, mechanisms should be established to foster increased after-hours options across primary care services and models by including requirements for a minimum number of hours of after-hours care

per provider per week.

Innovative models of delivery of primary care services (e.g. mobile clinics and virtual wards) should be evaluated and leveraged for enhancing timely access to care.

Primary care providers should seek their patients' input on the adoption of technology in communicating directly with patients (e.g., phone or email).

D. Strategic Focus: Accountability Levers and Incentives

Within Ontario's healthcare system, accountability is multi-directional and can be described as payer accountability (where resources go), provider accountability (how resources are used and how services are delivered individually or in teams), and patient accountability (how resources are used). Levers of accountability include a graduated spectrum of "soft" policy approaches and design of effective incentives to financial penalties and corrective action.

D.1. Establish a Capacity for Regular Public Reporting as a Lever to Enhance Accountability

One powerful lever to improve accountability is public reporting of performance against measures and targets over time and in comparison to other regions, taking into account differences in population characteristics. Mandatory public reporting is not recommended for individual primary care practices.

Recommendation 15:

A mechanism for regular public reporting on performance against local, regional, and provincial goals and targets should be established, taking into account variations in population demographics.

D.2. Consider Accreditation as a Mechanism for Enhancing Accountability for Quality

Accreditation in the primary care sector is a potential driver of accountability for quality. Accreditation is a rigorous external evaluation process that comprises self-assessment against a given set of standards, an on-site survey, followed by a report with or without recommendations, and the award or refusal of accreditation status. Accreditation can be voluntary or mandatory.

Stronger evidence on the applicability, usefulness and potential impacts of an accreditation initiative for primary care in Ontario is required before a definitive recommendation can be made. A synthesis of international experience with primary healthcare accreditation and the evidence regarding its impact is currently underway under the auspices of the Canadian Health Services Research Foundation and should contribute to informing decision making.

Recommendation 16:

Ontario should consider the development and implementation of accreditation in the primary care sector based on experience elsewhere, evidence on impacts and the results of current examinations, including a study underway at Canadian Health Services Research Foundation.

D.3. Establish a Mechanism for Ongoing Review and Redesign of Primary Care Financial Incentives

While financial rewards and incentives can be powerful tools for change, they have the potential to have perverse effects on behaviour. It is recommended that the impact of rewards on behaviour be regularly

reviewed, and incentives be re-designed, if necessary. A number of existing incentives are identified as priorities for review.

Recommendation 17:

Ontario should establish a mechanism for ongoing review and redesign of financial incentives for primary care providers. As a priority, a review of existing premiums, bonuses and incentives associated with physician compensation should be conducted including recommendations for better alignment with primary care system goals and objectives. At a minimum, the following high priority items require review:

- Preventive care incentives
- After hours premiums and other incentives to enhance access to primary care
- Patient enrolment incentives
- Chronic disease management incentives
- Other incentives to enhance access to primary care

D.4. Establish Effective and Enforceable Accountability Agreements to Drive Performance

Accountability Agreements should be established between parties accountable for primary care delivery and results e.g., the Ministry and regional governance structures) including requirements for performance (financial, clinical, or other) and provisions for corrective action or remediation. Establishment of Accountability Agreements between parties as well as a consistent and timely approach to audit and evaluation of compliance with accountability requirements and corrective action or remediation are recognized as key enablers of strengthening the primary care sector by WGs.

Recommendation 18:

The Ministry should work with stakeholders to determine how providers and/or governance structures should be held accountable at the practice, local, and regional levels for measures of quality and effective resource utilization.

The Ministry, in consultation with accountability partners, should develop a policy or series of policies to be adhered to in circumstances where accountability requirements are not being met and where corrective action/remediation is required. Policies should reflect a graduated and consultative approach to corrective action. Funding organizations, including the Ministry and LHINs should be subject to these policies, particularly as it relates to the principles of timeliness and responsiveness.

D.5. Implement Appropriate Components of *Excellent Care for All Act* in Primary Care

Inclusion of provider obligations, expectation and enforcement of compliance through legislation is another lever of accountability. Application of the components of the *Excellent Care for All Act, 2010* to the primary care sector emerged as a key theme across all WG reports.

Recommendation 19:

Primary care should be the next priority for implementation in the *Excellent Care for All Act, 2010*.

The Ministry, in partnership with Health Quality Ontario, should initiate a process that engages key providers and stakeholders to plan for the application of the *Excellent Care for All Act, 2010* to the primary care sector.

E. Strategic Focus: Continuous Quality Improvement

Development, maintenance, and effective utilization of resources, processes, and infrastructures that make individual organizations as well as the whole system capable for quality improvement is critical for strengthening primary care.

E.1. Implement Electronic Records with Standardized Functionality and Data Entry Requirements
Establishment of Electronic Medical Records (EMRs) at the practice level and Electronic Health Records (EHRs) that integrate patient information in the broader health and community sector are essential resources for improvements in quality, access, efficiency, accountability and resource allocation and planning.

Recommendation 20:

All primary care models should be required and supported to implement EMRs as soon as possible. EMR functionality should be designed based on the critical elements of highly functioning EMRs identified by the Agency for Healthcare Research and Quality (AHRQ) and Institute for Healthcare Improvement (IHI):

- Proactive patient based
- Planned care for individual patients
- Measurement
- Ability to customize data presented
- Ease of use
- Interoperability
- Data availability across the continuum of care
- Automation
- Others (*See Quality Working Group Recommendations 6 and 7 in Appendix 3 for more detail*)

EMR data entry standards should be established – based on broad consultations – that enhance quality of data collection and capacity for data sharing. Ontario MD specification for EMRs certification standards should be continuously improved in order to enable all inter-professional team members to access patient records as per security profiles.

E.2. Provide Education, Training and Support for Quality Improvement

Providing educational and training resources to providers and organization is fundamental to quality improvement support. A number of topics are proposed as priorities for quality improvement training and support.

Recommendation 21:

Quality improvement training and support should be made available over time to all primary care providers and organizations and be embedded in all healthcare professional training programs.

The following areas of priority for quality improvement training and support are proposed:

- Advanced Access
- Meaningful use EMRs
- Office workflow and efficient patient cycle time design
- Expanded roles of IHPs in primary care practices
- Cultural safety

E.3. Establish a Provincial Quality Improvement Leadership Capacity

Leadership development is identified as a key enabler of quality improvement. The Quality WG recommends the development of programs to build leadership capacity amongst providers and administrative staff which would have significant return on investment in terms of organizational effectiveness.

Recommendation 22:

Programs, delivered through Health Quality Ontario, professional associations, and universities should be created to support the development of quality improvement leadership capacity amongst primary care providers and administrative staff.

E.4. Establish a Program for Quality Improvement Research and Evaluation

A continuing flow of research and evaluation to inform primary healthcare policy and practice is an essential underpinning of a high-performing primary healthcare system and needs to be supported by adequate funding of research, evaluation and research training.

Recommendation 23:

Ontario should establish a program of quality improvement research and evaluation with priority topics as follows:

- Approaches to patient engagement
- Approaches to quality improvement training and support
- Costs and benefits of primary care accreditation
- Team-based incentives as opposed to physician ones
- Relationship between team composition and structure and outcomes of care

VI. Integrated Recommendations Regarding Execution of Strategy

A time-limited dedicated resource with capacity to oversee the detailed design, implementation, and communication of the recommendations of the PHPG is identified by all WGs as critical to success.

Recommended Approach for Execution

To ensure that the work of the Primary Health Care Planning Group and its constituent Working Groups continues, the Ministry should create a time-limited Primary Healthcare Secretariat tasked with implementing the recommendations of this initiative. At a minimum, the mandate of the Secretariat should include the following:

- Prioritize the recommendations of WGs and develop an implementation plan for action;
- Communicate to providers and Ontarians the Ministry's commitment to improving quality, access, efficiency, accountability, and governance in reference to the *Excellent Care for All Act, 2010*;
- Work with partners and stakeholders to develop and contribute to the implementation plan;
- Assign resources to support implementation activities;
- Adapt and amend the recommendations to reflect changes in the environment such as regulatory or legislative changes, fiscal changes, etc.;
- Track progress with respect to the implementation of key recommendations.

VII. Primary Care Planning Meeting: Dialogue Summary

A Planning Meeting took place on September 20th, 2011 to bring together all those that had been involved in shaping the recommendations of the five WGs and to discuss and validate the emerging themes and integrated recommendations as identified in the draft integrated report. The recommendations of individual WGs were first presented by Co-Chairs and discussed, following which, the emerged themes as outlined in the draft integrated report were presented and discussed. Sufficient time was allocated to hear feedback from the group on recommendations of individual reports as well as the integrated report. Roundtable discussions of the barriers, enablers and priorities for implementation constituted the latter part of the meeting.

A. Overview of Deliberations Regarding All Working Group Recommendations

The following outlines a summary of discussions by meeting participants pertinent to the recommendations of all Working Groups (WGs):

- The need for clarifying and consistently using appropriate terminology to differentiate *primary care* and *primary healthcare* was reiterated. The focus of the PHPG is on primary care, informed by a primary healthcare framework.
- Patient-centered care: “one size does not fit all” and not all patients are the same. Participants noted cautions in taking a homogenous approach to a diverse population. It was suggested customized planning approaches (e.g., systematic collection of data, delivery strategies, etc.) be taken for unique populations and frequent fliers.
- Implementation and change management:
 - Participants noted that caution should be taken to avoid overwhelming the field with change. It was noted that it would be important to appropriately engage leaders and assist practices to achieve goals and ensure that change does not negatively impact service provision. In addition, it was proposed that a readiness assessment be conducted to avoid such risks.
 - Some participants raised the importance of engaging patients as the group moves forward with the implementation of recommendations, particularly since patients were not directly involved in the development of recommendations.
 - There were discussions concerning the cost of implementation of recommendations. While some participants were of the opinion that some of the recommendations were costly to implement especially during a climate of fiscal constraints, other participants noted that implementation should be through a reallocation or reprioritization of existing funds

B. Overview of Deliberations Regarding Working Group Recommendations

The following outlines a summary of discussions by meeting participants which are relevant to recommendations of specific WGs:

B.1. Improving Accountability in Primary Care

- There were cautions around recommendations related to performance measurement proposed by the Accountability WG. Of note, some participants noted that a specific focus on measurement of activities could translate to a lesser focus on activities that are of value, but are not necessarily measured. It was

suggested that an approach was not taken that focused attention only on those activities that can be measured. In addition, it was suggested that the search for the “perfect measure” should not delay performance measurement.

- A focus on appropriateness of care was discussed as a critical enabler of improvement: “More care did not always mean better care”.

B.2. Strengthening Primary Care Organization and Governance

- The fragmented infrastructure of primary care was noted as a challenge by some participants who suggested that a real shift to group practice, including both the integration of solo physicians to inter-professional groups as well as inclusion of IHPs into groups was necessary. Other participants suggested that this shift to true group practice should be balanced with patient choice.
- A few participants provided cautions regarding a shift from a covenant model based on professionalism to a contract model based on accountability agreements and governance.
- It was suggested by some participants that the options proposed by the Governance WG did not include consideration for primary care models other than CHCs, or FHTs and proposed that more work be done in designing effective governance models.

B.3. Strengthening Primary Care Access

- Some participants suggested that a degree of variability in primary care models could be helpful so as to allow for customization and flexibility to respond to demands of a certain geography or patient demography.
- Some participants noted the importance of developing an overarching human resources strategy for the province that outlines, amongst others, the scope of IHP work so as to ensure effective utilization of their skills.
- Concerns were raised by some participants regarding the establishment of set targets for some services. In particular for commitment to providing an appointment for patients within 48 hours or providing 3 hours of after-hours services, as recommended by the Access WG. These participants suggested that instead of establishing *hard* measures, a focus on *timely* access be communicated.
- The recommendations around provision of “culturally safe care” ignited some discussion around the portion of the population that uses communication technology such as emails or telephone consultations. Some participants raised concerns that the fact that these services were provided by some physicians as an un-insured service for which they charged a fee had the potential to create a two-tier system.

B.4. Increasing Efficiency in the Family Practice Setting

- It was noted that innovation was key in identifying opportunities to consolidating practices (virtually or geographically) to create efficiencies

B.5. Improving Quality in Primary Care

- Some participants noted that a portion of payments to primary care providers should be based on performance against quality or access measures.
- It was noted that it is important to begin measurement as quickly as possible as this would drive improvement in data quality. There were some challenges in relation to disease specific interventions and it

was important that data measurement was accurate and that a baseline was developed. One participant noted that within Toronto Central LHIN, the sharing of performance data amongst hospital CEOs on a number of measures had had a positive effect on performance.

- The separation of quality improvement from accountability was raised by a few participants. The *Excellent Care for All Act* however was discussed as a model for creating accountability for quality.
- There were some discussions around effectiveness and design of financial incentives. Regular review and evaluation of the effectiveness incentives was discussed. As well, it was suggested that incentives should reward best practices and move away from rewarding individual primary care providers to team.

C. Overview of Deliberations Regarding the Draft Integrated Report

The following outlines a summary of discussions by meeting participants which related to the integrated report.

- Some Co-Chairs noted that a few pieces of important context from the WG reports were not reflected in the draft integrated report and it was decided that there would be opportunity for Co-Chairs to provide feedback on the next version of the draft.
- The focus of the *Excellent Care for All* strategy to enhance provision of quality health services *for all* was discussed as critical to ensure that everyone regardless of geography, demography or other barriers receives high quality primary care.
- Going beyond EMRs to have EHRs was raised as essential for health system integration. Some participants noted that one barrier to implementing EHR was the lack of inter-operability of existing IT systems and identified regional planning as key to implementation of EHRs.
- Some participants noted that a key role, used in other countries is missing from Ontario's primary care: the primary care manager. These professionals provide management expertise and help to ensure efficient and appropriate running of primary care practices and might be a key role required in primary care in Ontario.
- There was a large degree of consensus around the establishment of a primary care secretariat for detailed design and implementation of the recommendations.
- Based on feedback from meeting participants, the overarching themes as outlined in the report were re-categorized.

D. Summary of Round Table Deliberations on Enablers, Barriers and Priorities for Implementation.

Participants were asked to work with their table to identify the highest priorities for implementation and the most significant enablers and barriers to implementation.

D.1. Priorities:

The priorities identified by roundtable discussions fell into the following categories:

1. Establishment of a Primary Care Secretariat with administrative and leadership capacity to implement recommendations
2. Development and communication of a vision
3. Establishment of a regionalized governance model aligned with an accountability framework
4. Electronic Health Records and principles for their optimal use

D.2. Enablers:

The enablers identified by roundtable discussions fell into the following categories:

1. Engaged leadership with a large degree of consensus and eager for transformation
2. The quality agenda as a unifying vision
3. Enhanced scope of practice for IHPs

D.3. Barriers:

The barriers identified by roundtable discussions fell into the following categories:

1. Buy-in from frontline providers
2. Difficulties in engaging a fragmented system
3. Limits in existing IT infrastructure

APPENDICES

Appendix 1: Glossary of Acronyms

AA	Accountability Agreement
ACO	Accountable Care Organization
AHAC	Aboriginal Health Access Centres
AHRQ	Agency for Healthcare Research and Quality
AOHC	Association of Ontario Health Centres
BSM	Blended Salary Model
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CCAC	Community Care Access Centre
CCM	Comprehensive Care Model
CHC	Community Health Centre
CHF	Congestive Heart Failure
CHQI	Centre for Healthcare Quality Improvement
CIHR	Canadian Institute for Health Research
COPD	Chronic Obstructive Pulmonary Disease
CPOE	Computerized Physician Order Entry
CQI	Continuous Quality Improvement
DFLE	Disability Free Life Expectancy
DGP	Divisions of General Practice
DHB	District Health Boards
ECFAA	Excellent Care for All Act
ED	Emergency Department
EHR	Electronic Health Record
EMR	Electronic Medical Record
FFS	Fee for Service
FHG	Family Health Group
FHN	Family Health Network
FHO	Family Health Organization
FHT	Family Health Teams
FP	Family Physician
GDP	Gross Domestic Product
GP	General Practitioners (GP consortia)
HALE	Health Adjusted Life Expectancy
HCC	Health Council of Canada
HLE	Healthy Life Expectancy
HQO	Health Quality Ontario
HRA	Health Risk Appraisal
HSP	Health Service Provider
ICES	Institute for Clinical and Evaluative Sciences
IHI	Institute for Health Information
IHP	Interdisciplinary Health Provider
IOM	Institute of Medicine
KT	Knowledge Transfer
LDL	Low-Density Lipoprotein
LHIN	Local Health Integration Network
MAS	Medical Advisory Secretariat
MOHLTC	Ministry of Health and Long-Term Care

MSAA	Master Service Accountability Agreements
NHS	National Health Service
NP	Nurse Practitioner
NPLC	Nurse Practitioner-Led Clinic
OECD	Organization for Economic Cooperation and Development
OHQC	Ontario Health Quality Council
OHTAC	Ontario Health Technology Advisory Committee
OMA	Ontario Medical Association
OTN	Ontario Telemedicine Network
P4P	Pay for Performance
PA	Physician Assistant
primary care	Primary Care
PDSA	Plan-Do-Study-Act
PEM	Patient Enrolment Model
primary healthcare	Primary Health Care
PHO	Primary Health Organization
PHPG	Primary Healthcare Planning Group
PHU	Public Health Unit
Pprimary careCN	Provincial Primary Care and Cancer Network
PSC	Physician Services Committee
QA	Quality Assurance
QI	Quality Improvement
QIIP	Quality Improvement and Innovation Partnership
QIP	Quality Improvement Plan
RN	Registered Nurse
RNPGA	Rural Northern Physician Group Agreement
THAS	Telephone Health Advisory Service
TQ	Total Quality
TQM	Total Quality Management
WG	Working Group

Appendix 2: Membership of the Primary Health Care Planning Group and Five Working Groups

Primary Healthcare Planning Group (PHPG)

Chair:

Susan Fitzpatrick, Ministry of Health and Long-Term Care

Members:

Doris Grinspun, Registered Nurses' Association of Ontario
Adrianna Tetley, Association of Ontario Health Centres
Janet Kasperski, Ontario College of Family Physicians
Michael Goodwin, Ontario Medical Association

Project Manager:

Azi Boloorch, Ministry of Health and Long-Term Care

Working Group 1: Quality in Primary Care

Co-Chairs:

Brian Hutchison, Health Quality Ontario
Suzanne Strasberg, Ontario Medical Association

Members:

Angela Carol, College of Physicians and Surgeons of Ontario
Alba DiCenso, School of Nursing, McMaster University
Michelle Greiver, North York Family Health Team
Jennie Humbert, Nurse Practitioner, West Nipissing Community Health Centre
Anjali Misra, Association of Ontario Health Centres
Margie Sills-Maerov, Ministry of Health and Long-Term Care
John Stronks, Ontario College of Family Physicians
Lynn Wilson, Department of Family and Community Medicine, University of Toronto

Working Group Lead:

Monica Aggarwal, Health Quality Ontario

Working Group 2: Strengthening Primary Care Access

Co-Chairs:

Doris Grinspun, Registered Nurses' Association of Ontario
Adrianna Tetley, Association of Ontario Health Centres

Members:

Beth Cowper-Fung, Registered Nurses' Association of Ontario/NPAO
Tannice Fletcher-Stackhouse, Registered Nurses' Association of Ontario/NPAO
Rick Glazier, Institute for Clinical Evaluative Sciences
Joyce Helmer, Indigenous Health Knowledge Centre
Angie Heydon, Association of Family Health Teams of Ontario

Paul Huras, South East Local Health Integration Network
Camille Orridge, Toronto Central Local Health Integration Network
Roger Strasser, Northern Ontario School of Medicine
Wendy Talbot, NorthWest Community Health Centres
Ruta Valaitis, Registered Nurses' Association of Ontario
Valerie Milburn, Ministry of Health and Long-Term Care

Working Group Lead:

Alex Goddard, Ministry of Health and Long-Term Care

Working Group 3: Increasing Efficiency in the Family Practice Setting**Co-Chairs:**

David Price, Department of Family Medicine, McMaster University
Michael Goodwin, Ontario Medical Association

Members:

Trish O'Brien, Health Quality Ontario
Dr. William Hogg, Élisabeth Bruyère Research Institute
Dr. Chris Jyu, Ontario Medical Association
Cathy Hamilton, Ministry of Health and Long-Term Care
Jocelyn Maxwell, Centre de santé Communautaire du Temiskaming
Dr. Laura Muldoon, Association of Ontario Health Centres
Luise Wood, Registered Nurses' Association of Ontario/NPAO
Judith Manson, Registered Nurses' Association of Ontario/Ontario Family Practice Nurses

Working Group Lead:

Peter Brown, Ontario Medical Association

Working Group 4: Improving Accountability in Primary Care**Co-Chairs:**

Scott Wooder, Ontario Medical Association
Ruth Wilson, Department of Family Medicine, Queen's University

Members:

Rick Glazier, Institute for Clinical Evaluative Sciences
Andreas Laupacis, Michael's Hospital
John McDonald, Association of Family Health Teams of Ontario
Shirlee O'Connor, Registered Nurses' Association of Ontario/NPAO

Working Group Lead:

Phil Graham, Ministry of Health and Long-Term Care

Working Group 5: Strengthening Primary Care Organization and Governance**Co-Chairs:**

Brian Golden, Rotman School of Management, University of Toronto
Janet Kasperski, Ontario College of Family Physicians

Members:

Adalsteinn Brown, University of Toronto
Dr. Glenn Brown, Queen's University
Paula Carere, Nurse Practitioners' Association of Ontario
Stacey Daub, Toronto Central Community Care Access Centre
Sheree Davis, Ministry of Health and Long-Term Care
Raisa Deber, University of Toronto
Linda Dietrich, Dietitians of Canada
William Falk, University of Toronto
Angie Heydon, Association of Family Health Teams of Ontario
William Hogg, Department of Family Medicine, University of Ottawa
Paul Huras, South East Local Health Integration Network
David Klein, Li KaShing Knowledge Institute
Lydia Lee, University Health Network
Jacques Lemelin, Department of Family Medicine, University of Ottawa
Cheryl Levitt, Department of Family Medicine, McMaster University
Ross Male, Section of General and Family Practice, Ontario Medical Association
Robert Milling, Registered Nurses' Association of Ontario
Kate Power, Ontario Association of Social Workers
Thérèse Stukel, Institute for Clinical and Evaluative Sciences
Adrianna Tetley, Association of Ontario Health Centres

Working Group Leads:

Azi Bolorchi, Ministry of Health and Long-Term Care
Rosemary Hannam, Rotman School of Management, University of Toronto

Appendix 3: Consolidated List of Recommendations of Each Working Group

Working Group 1: Quality in Primary Care

Performance Measurement

Recommendation #1

Primary healthcare performance measurement at the practice, local, regional and provincial levels should be based on the Triple Aim Framework (improved population health outcomes, enhanced patient experience and reduction/control of per capita costs) and the Health Quality Ontario attributes of a high performing health system (safety, efficiency, effectiveness, person centredness, timeliness, equity, integration, population health focus, appropriately resourced).

Recommendation #2

Capacity to measure primary healthcare performance at all levels needs to be developed, drawing on EMR/EHR, administrative and patient survey data.

Recommendation #3

Performance measurement data should be disseminated widely to drive change and inform decisions at the local and system level.

Performance Targets

Recommendation #4

Performance priorities and targets should be set mainly at the practice and community levels taking into consideration regional/provincial/national targets if available.

Recommendation #5

Provincial targets need to be carefully selected through a process of consultation with key stakeholders and should be based on short and long term health system goals, available capacity, evidence of potential for improvement and high quality data.

Electronic Medical Records/Electronic Health Records

Recommendation #6

High quality primary healthcare requires EMR functionality recommended by the Agency for Healthcare Research and Quality and the Institute for Healthcare Improvement. The following attributes were identified as being critical elements of a highly functioning EMR.

- Proactive Patient Based
 - All involved in quality improvement should be able to query the data
 - The system should support instant access to query results
 - The querying system should allow the user to ask any question
 - Users should be able to construct and run queries without technical assistance
 - Users should be able to specify the inclusion of any data elements in queries
 - The system should support “drill down” into data
 - Users should be able to save queries for re-use and/or refinement
 - The system should support the sharing of queries
 - The types of action taken on the lists of patients in a query should be flexible
 - The action taken on the list should incorporate and use patient data to further segment the action (e.g., HbA1c follow up)
 - The system should automate the actions whenever possible
- Planned Care for Individual Patients

- The “whole patient” should:
 - be displayed in one place
 - be dynamic
 - be used for planning, treatment and follow up
 - support care across all conditions and health issues, not just the complaint associated with a particular encounter
 - be the central location for other views of patient data, such as run charts of laboratory results and vitals
 - incorporate evidence-based prompts and reminders;
 - provide a portal for the patient for both input and viewing data, giving the patient some control over his/her record
- Measurement
 - The measurement module should allow the user to customize any report by adding or changing a filter
 - The query and filter structures for measurement and reporting should be identical to those used for the population-based care tool and for reminders and prompts
- Other
 - Ability to customize the data presented
 - Ease of use
 - Interoperability
 - Data available across the continuum of care (including the social determinants of health)
 - Appropriate data structures provide information that supports improvement
 - Automation

Recommendation # 7

Common data standards, capacity for data sharing, and appropriate training and support for providers in meaningful use of EMRs need to be developed and implemented.

Primary Healthcare Teams

Recommendation #8

Continue expanding the number of collaborative interprofessional primary healthcare teams. Teams should vary in size, composition and organizational structure to meet local community needs.

Recommendation #9

Interprofessional collaborative practice opportunities that are consistent with the needs of the population being served be made available to all primary healthcare models regardless of funding or provider payment methods.

Recommendation #10

Support coordination, collaboration and/or integration of primary healthcare teams/practices with other community health and social services to allow for effective and efficient patient navigation through the healthcare system.

Recommendation #11

To achieve efficiencies and improved outcomes, team members should function at their level of competency, focusing on the patient’s needs and recognizing the importance of continuity in building trusting provider-patient relationships.

Patient Enrolment

Recommendation #12

Formal patient enrolment re-enforces patient-provider relationships and responsibilities and is foundational to pro-active, population-based preventive care and chronic disease management and to systematic practice level performance measurement and quality improvement. Ontario should continue the spread of Patient Enrolment Models.

Patient Engagement**Recommendation #13**

Patient engagement in the form of both patient self-management and patient involvement in services design and planning is widely believed to be a critical driver of quality improvement in primary healthcare. More information from evaluative studies on the best approaches to engaging patients is required.

Research and Evaluation**Recommendation #14**

A continuing flow of research and evaluation to inform primary healthcare policy and practice is an essential underpinning of a high-performing primary healthcare system and needs to be supported by adequate funding of research, evaluation and research training.

Recommendation #15

Specific areas requiring focused evaluation include: Approaches to patient engagement; Approaches to quality Improvement training and support; Costs and benefits of primary care accreditation; team-based incentives as opposed to physician ones.

Recommendation #16

Promising but untried quality-related innovations should be implemented and evaluated on a small scale prior to system-wide implementation.

Financial Incentives**Recommendation #17**

Given the ambiguity of current evidence and the potential for perverse effects of pay-for-performance (P4P) in primary healthcare, primary care P4P incentives should be pursued with caution and be carefully evaluated.

Training and Support**Recommendation #18**

QI training and support should be made available over time to all primary care providers and organizations.

Recommendation #19

QI training should be embedded in all healthcare professional training programs.

Public Reporting**Recommendation #20**

Public reporting of primary healthcare performance at the regional and provincial levels should track changes over time and include comparison across regions, taking differences in population characteristics into account.

Recommendation #21

Mandatory public reporting of performance is not recommended for primary care practices and/or organizations.

Accreditation**Recommendation #22**

Primary healthcare accreditation is a potential driver of quality. However, evidence of lasting impact is required before a definitive recommendation can be made. A synthesis of international experience with primary healthcare accreditation and the evidence regarding its impact is currently underway under the auspices of the Canadian Health Services Research Foundation and should inform future decision making.

Primary Healthcare Organization/Governance**Recommendation #23**

Local primary healthcare provider networks that engage patients and the public could play a key role in promoting, supporting and coordinating quality improvement initiatives and in sharing quality improvement expertise and experience among local providers

Leadership Development**Recommendation #24**

Create programs to support the development of quality improvement leadership capacity among primary healthcare clinicians and administrative staff.

Working Group 2: Strengthening Primary Care Access**Equitable****Recommendation #1**

That MOHLTC in partnership with the LHINs adopt a population needs-based, equity-oriented planning approach to primary care under the principles of primary health care for all Ontarians
That MOHLTC and LHINs conduct a needs-based analysis by sub-LHIN or via postal codes in order to capture unique attributes of neighbourhoods and communities
That this data be mapped against current providers and their patients
That the gaps be determined
That any needs-based population planning approach take into consideration existing assets including current HHR

Recommendation #2

That this needs-based planning approach apply to the entire population, but with a focus on strategies pertaining to five sub-populations:

- Aboriginal
- Francophone
- Northern and remote
- Southern rural
- Urban with a focus on racialized communities and new immigrants

Recommendation #3

That all strategies take into consideration the unique challenges of:

- Chronic disease prevention and management
- Complex mental health, addictions and co-morbidities
- Patients with disabilities
- People living in poverty
- LGBTQ issues

Recommendation #4

That future resource allocation be informed by the population needs-based, equity-oriented planning approach

Recommendation #5

That a strategy be developed to identify and focus on patients with complex co-morbidities and determine appropriate resource level for optimal return on investment

Recommendation #6

That complex vulnerable populations receive acceptable care that results in equitable health outcomes and reduced usage of ED and ALC

Complete a complexity of care and socio-demographic profile study to determine adjusted panel (physician/NP) size and resource levels for mix of patients served

Recommendation #7

That a patient-focused approach be embodied in all primary care access policy and planning

Recommendation #8

That *OntarioMD* specification for future EMR certification require the mandatory collection of socio-demographic data for planning purposes while respecting patient rights under prevailing privacy legislation

Recommendation #9

That mechanisms be established to enable tracking of all patient's addresses for planning purposes

Immediately make a mandatory requirement in all *OntarioMD* certified EMRs

In medium term reinstate the mandate to ensure all Ontarians have individual OHIP cards which track current addresses

Recommendation #10

That a central repository for primary care data be created with mandatory requirements by primary care models to provide data as appropriate and as abides by relevant privacy legislation currently in effect

Timely

Recommendation #11

That all primary care models be required to:

Immediately provide 3 hours of after hours care per physician and NP per week

Providers assisted to work in collaboration with other providers in the community to furnish 24/7 coverage to meet primary care needs or as appropriate EDs by March 2015. ED use may be appropriate in northern and remote communities when it is agreed to as part of the after hours plan for the community

Recommendation #12

That the "Access bonus" be reviewed to better enable collaboration across primary care models to reduce barriers to patients for using other primary care models, especially for after hours care

Recommendation #13

That all patients have access to their primary care provider within 48 hours through advanced access, assisted by expanding *Quality Improvement and Innovation Partnership* (QIIP) to all relevant providers with a focus on office efficiency

Continuous

Recommendation #14

That the use of walk-in clinics* be phased out as soon as is realistic:

Develop common standards, definitions, and codes for walk-in clinics, urgent care and after hours care so that usage rates can be monitored

Recommendation #15

That mechanisms be established to foster shared after hours care across primary care models

Patients to sign an agreement to enable providers in the shared after hours care services to inform their primary care provider of the reason for visits and treatments

Shared after hours care services be required to immediately inform primary care providers if their patient had a visit to an after hours care service, the purpose of visit and treatment received

That the *OntarioMD* specifications include viewing and input by other providers for the purpose of shared after hours care

* The access working group's definition of walk-in clinics pertains to stand-alone clinics which are not connected to any primary care model, and does not include after hours urgent care centres.

Recommendation #16

That system navigators and case managers^ϕ be leveraged so that all patients have better access to seamless and coordinated care as they move across the continuum of care
Primary care models with high-utilization patients be required to track and follow these patients as they access care across the health care system
Family practice nurses and other primary care professionals such as mental health workers be used to their full scope of practice, including system navigator and case manager roles
In some settings it may also be appropriate for community members to be trained as case managers and system navigators and be incorporated into health care teams

Comprehensive**Recommendation #17**

That all Ontarians are attached to IP primary care models including AHACs, CHCs, FHTs and NPLCs. It is not recommended to develop new delivery models
In the short-term to continue to attach all Ontarians to primary care providers and to immediately expand HCC to include NPs
In the medium term to develop a strategy to transfer patients to IP teams as physicians move, retire, or change their scope of practice
Formulate a transition strategy which incorporates current assets including human resources, programs and community services

Recommendation #18

That all IP Teams are fully functional
That standards be defined and established for IP teams
That ongoing quality improvement is ensured for IP team work processes
That IP training is provided at all health professional colleges and universities
That research is conducted to examine health outcomes associated with IP models of care

Recommendation #19

That all IP teams provide a full basket of services including at a minimum the Provincial Co-ordinating Committee on Community and Academic Health Science Centre Relations (primary careCCAR) Basket of Services, which includes:
Health assessment
Clinical evidence-based illness prevention and health promotion
Appropriate interventions for episodic illness and injury
Primary reproductive care
Early detection, as well as initial and ongoing treatment of chronic illnesses
Care for the majority of illnesses (with specialists as needed)
Education and supports for self-care
Support for hospital care and care provided in-home and in long-term care facilities
Arrangements for 24/7 response
Service coordination and referral
Maintenance of comprehensive patient health record
Advocacy
Primary mental health care including psycho-social counselling
Coordination and access to rehabilitation
Support for the terminally ill

Recommendation #20

That each member of the IP team works to their full scope of practice with an initial focus on NPs and family practice nurses.

Recommendation #21

^ϕ For definitions please refer to <http://www.ontla.on.ca/library/repository/mon/24002/299238.pdf>.

That each IP Team has an appropriate mix of professionals and that a study be conducted to determine an appropriate mix of professionals for IP teams working at full scope based on population needs (e.g. seniors vs. new immigrants vs. complex mental health may need a different mix of providers)

Recommendation #22

That Northern and remote care models be assisted to recruit and retain optimal level of IP Teams
To develop meaningful HHR strategy for the north including:
Review incentive programs (e.g. 1 year of service = 1 year of tuition)
Review criteria for “Grow your own NP” and expand program to other professionals
To increase the capacity of education facilities in Northern Ontario

Recommendation #23

That *OntarioMD* specification for future EMR certification standards continuously be improved to enable all members of IP team to have access to patient records as per appropriate security profiles

Recommendation #24

That alternative methods of delivery be utilized as appropriate:
Increased use of mobile clinics and telemedicine, especially in northern and rural Ontario
Explore more primary care provision in homes including long term care facilities (e.g. LTC facilities being allowed to provide IV antibiotics, palliative care at home)

Recommendation #25

That an information database about community and social services be developed such as 211 to enable primary care models to better refer patients to appropriate services as required

Evidence-informed

Recommendation #26

That all aspects of primary care access, where available, be guided by sound research and evidence
To foster broad adoption of the RNAO’s internationally recognized *Nursing Best Practice Guidelines*[†]
To require all primary care providers with EMRs to use the alerts and other evidenced-based tools (pathways for chronic disease etc.) already incorporated in the software
To continuously review the *OntarioMD* specifications for EMR software development with the view to incorporate evidence-based information in the products
To review relevant literature, including leveraging best practice guidelines from international jurisdictions, to determine the evidenced-based information related to access that is currently available and make recommendations on its implementation
To conduct research where evidence is currently lacking

Recommendation #27

That evidenced-informed primary care requires input from patients, families and communities
To conduct regular quantitative and qualitative research methodologies to identify patient and population needs and assets to guide programs and services planning and evaluation
To strongly encourage participatory evaluation approaches
To ensure active community engagement in the development of programs and services so as to better meet population needs
To leverage the current LHIN engagement processes as one opportunity for input
To ensure all forms of engagement be conducted in a culturally safe environment, with appropriate languages as required by the patient, their family and the community

Recommendation #28

That all primary care models be required to have accountability agreements with their funders and appropriate authorities that link to performance as per evidence-based access guidelines
To immediately develop relevant performance indicators for primary care access

[†] Registered Nurses’ Association of Ontario. *Nursing Best Practice Guidelines*. Canada: Registered Nurses’ Association of Ontario.

In the mid-term to link funding to process measures with long-term goal of linking funding to outcomes

Culturally Safe

Recommendation #29

That all Ontarians have access to culturally safe care that is culturally competent and addresses the inequities to health care, with a focus on Aboriginal Ontarians, Francophones, new immigrants and racialized communities, as well as LGBTQ Ontarians and Ontarians with disabilities. That culturally safe care also extends to Ontarians living in poverty

Recommendation #30

That all health care providers be required to develop necessary proficiencies and competencies to deliver culturally safe care to accommodate the unique needs of Ontario's diverse populations

Recommendation #31

That health care professional educational institutions be encouraged and supported to provide education on culturally safe primary care integrated throughout the core curriculum

Recommendation #32

That primary care models be resourced to have IP teams including translation services, community workers, primary care providers who are representative of the cultural community being served, and all staff with familiarity with the predominant cultural groups they are serving

Recommendation #33

That an HR plan be developed that includes supporting and training members from these communities to be trained as primary health care providers

Recommendation #34

That primary care access indicators be developed to depict the provision of culturally safe care (e.g. Pap rates for racialized women, colorectal and breast cancer screening amongst Aboriginal populations, etc.)

Additional Recommendations pertaining to foci of other Working Groups

Recommendation #35

That primary care be the next priority for implementation under the *Excellent Care for All Act* (ECFAA)

Recommendation #36

That all primary care models be required to sign accountability agreements with performance indicators and targets with their funders or appropriate authorities

Recommendation #37

That a primary care secretariat/council be established with the responsibility to oversee the strategic planning and transitioning to a more robust primary care system in Ontario, informed by the principles of primary health care, including but not limited to developing a comprehensive HHR strategy for culturally safe, comprehensive IP teams, and strengthening patient and community-focused care and engagement

Recommendation #38

That the role of the LHINs be integral and formally linked in the planning of primary care to enable accountability and linkages with the continuum of care

Recommendation #39

That primary care models in communities be supported in working together so as to better ensure comprehensive services are available to all patients (e.g. one FHT may specialize in diabetes education while another CHC or NPLC in the same community may specialize in mental health)

Recommendation #40

That timely implementation of advanced access in all primary care practices be available as soon possible

Recommendation #41

That all primary care models be required to implement certified EMRs as soon as possible

Working Group 3: Increasing Efficiency in the Family Practice Setting**Information Technology****Recommendation #1**

The Ontario government should work with healthcare providers and other stakeholders to design and implement information technology resources that effectively integrate care between providers, while enabling access to best practice tools and resources.

Recommendation #2

The Ministry, in collaboration with Health Quality Ontario, OntarioMD, primary care providers and their associations and Colleges, and patients, should establish EMR data entry standards that enhance quality of data collection without increasing administrative burden on providers.

Recommendation #3

Primary care providers should consult with their patients around the adoption of technology to assist in communicating directly with patients.

Access**Recommendation #4**

The Ministry should work with primary care providers to determine the necessary resources and support required to allow all primary care providers to adopt 'Advanced Access' principles, making timely access to appropriate care more widely available.

Recommendation #5

The Ministry should work with primary care providers and their associations to ascertain the costs to practice, with a goal of assisting providers with reducing both waste and the cost to practice in Ontario.

Recommendation #6

The Ministry and Health Quality Ontario should work with primary care providers to promote, encourage and resource the tracking of each provider's time to Third Next Available Appointment.

Office Practice Design/Workflow**Recommendation #7**

The Ministry should work with primary care providers and their associations and Colleges to establish resources and supports to enable primary care practice development and redesign that consider workflow and patient interaction.

Recommendation #8

The Ministry and Health Quality Ontario should work with primary care providers to promote and support providers' understanding of patient cycle time within their practice, and the face-to-face time spent with patients.

Recommendation #9

The Ministry and Health Quality Ontario should work with primary care providers to understand how to incorporate the administrative needs of the family practice setting into clinical planning and decision-making.

Quality**Recommendation #10**

The Ministry and Health Quality Ontario should work with primary care providers and their associations and Colleges to develop an incentive to apply quality improvement methodology into their practice.

Recommendation #11

The Ministry and Health Quality Ontario should work with primary care providers to identify and adopt a common set of data elements for measurement within the family practice setting.

Recommendation #12

The Ministry and Health Quality Ontario should work with primary care providers and interested stakeholders to establish data management training, support and implementation standards that enhance quality without increasing administrative burden on providers.

Recommendation #13

The Ministry should take care to consider impacts on all aspects of patient care when establishing priorities for quality improvement in Ontario.

Team Care**Recommendation #14**

The Ministry and E-Health Ontario should support the delivery of interdisciplinary team care both internally and externally through information technology funding targeted at enhancing transitions of care and provider communication.

Recommendation #15

The Ministry, primary care providers and their associations and Colleges, patients, and other interested stakeholders should design and develop resources to assist primary care providers in understanding the expanded and enhanced roles of service providers within the patient's team.

Working Group 4: Improving Accountability in Primary Care**Recommendation #1**

A structure is put in place to act on these recommendations and the recommendations from other working groups.

Recommendation #2

Develop clear and measurable objectives for which Ontario's primary care sector is to be held to account, including such elements as access to care, patient satisfaction, relationships with other parts of the system and resource utilizations.

Recommendation #3

Design and implement a simplified and efficient primary care measurement and monitoring strategy to assess how the primary care system is performing, relative to measurable objectives, on an on-going basis. The strategy, at a minimum, is to include patient feedback and regular public reporting.

Recommendation #4

Explore alternative units of analysis to support the measurement and monitoring strategy, consistent with the principles of the Multispecialty Provider Network approach developed by ICES.

Recommendation #5

Immediately review current physician incentives and premiums related to preventative care, after hours, chronic disease management, patient enrolment and others incentives related to access.

Recommendation #6

Develop a policy of series of policies to guide corrective actions/remediation in circumstances where accountability requirements are not being met and ensure that funders are also subject to the policy(ies).

Recommendation #7

Finalize a policy or program to formally track and analyze the activities of Interdisciplinary Health providers in primary care.

Recommendation #8

Review and report on the current way in which access to after hours primary care is measured and the degree to which it is/is not being provided.

Recommendation #9

Develop and implement a comprehensive strategy for advanced access to enable greater access to primary care.

Recommendation #10

Identify, track and measure evidence-based best practices for use at the practice level to promote more cost effective resource utilization.

Working Group 5: Strengthening Primary Care Organization and Governance

It is the position of the Working Group on Primary Care Organization and Governance that, if implemented, the following reforms and recommendations will help to strengthen primary care and health system governance and need to be addressed regardless of the chosen governance model:

Recommendation #1

The Ministry, with reference to the *Excellent Care for All Act, 2010*, announces its commitment to improving Accountability, Access, Efficiency and Quality in Primary Care. The achievement of this directly depends on an effective governance function.

Recommendation #2

The Ministry communicates to providers and Ontarians the view that good governance involves: (1) Planning and resource allocation, (2) Monitoring and (3) Holding accountable with subsequent rewarding contingent on performance.

Recommendation #3

The Ministry pursues the implementation of Option A (Governance based on a LHIN Regional Structure), B (Governance based on Integrated Health System), or Option C (Hybrid Model). Importantly, Options A and C can still be effectively pursued should current health region structures and systems (i.e. LHINs) be modified in the future.

Recommendation #4

The Ministry, whether it supports Option A or Option B or Option C, be willing to provide sufficient resourcing and funding authority to these regional structures so that their governance activities are not impeded.

Recommendation #5

The regional governance structures establish MOUs between themselves and "Primary Care Councils" based on provincial standards.

Recommendation #6

The regional governance structures provide support and infrastructure for primary care planning “tables” (e.g., Primary Care Councils and Sub-Councils) so that communities of providers can meet their individual and collective accountabilities and meaningfully contribute to local and regional planning.

Recommendation #7

The regional governance structures be given authority to write and enforce accountability agreements between themselves and all health services provider organizations in their jurisdiction including primary care providers. This implies the transfer of current accountability agreements with the Ministry (e.g., those between FHTs, NP-Led Clinics and the Ministry).

Recommendation #8

The Ministry continues to enhance e-Health Ontario and IT initiatives to support regional governance structures so that regional governance structures have reliable and timely data to support the three elements of health system governance. Primary care, through EMRs/EHRs, requires a robust capacity for quality improvement capabilities and system-wide interconnectivity.

Recommendation # 9

Recognizing that many primary care providers, regardless of their funding model, will be initially challenged to meet accountability requirements under our proposed plan, the Ministry move to incent and support effectively all family practice models to strengthen their ability to function as true group practices capable of delivering comprehensive care. Since solo practice physicians may be especially challenged to meet accountability requirements under our proposed plan, the Ministry further support these physicians to practice in multi-physician/virtual group models.

Recommendation #10

Because Governance and Accountability are so inextricably linked, our Working Group also wishes to show support for the following four recommendations by the Working Group on Accountability.

(Accountability Working Group Recommendation #1)

To ensure the work of the Primary Health Care Planning Group and its constituent working groups continues, the Ministry should create a time-limited Primary Health Care Secretariat tasked with implementing the recommendations of this initiative. At a minimum, the mandate of the Secretariat should include the following:

- Prioritize the recommendations of the working groups and develop an implementation plan for action;
- Work with professional associations and other primary care stakeholders to develop and contribute to the implementation plan;
- Assign resources to support implementation activities;
- Adapt and amend the recommendations to reflect changes in the environment, such as regulatory/legal changes, fiscal changes, etc.
- Track progress with respect to the implementation of key recommendations.

(Accountability Working Group Recommendation #2)

The Ministry, in consultation with professional associations, patient groups and other stakeholders in primary care, should develop a clear and measurable statement of goals and objectives for which the primary care system is to be held to account. At a minimum, these goals and objectives should include:

- timely access to care (including after hours)
- relationships with other parts of the health system
- patient satisfaction
- provider satisfaction
- appropriate resource utilization
- patient outcomes (e.g. immunization rates, prevent care rates)
- attraction and retention, distribution of health human resources in primary care.

(Accountability Working Group Recommendation #3)

The Ministry, in partnership with Health Quality Ontario and others, should develop and implement measurement and monitoring strategy to identify how the primary care system is performing in reference to its goals and objectives. Attributes of the measurement and monitoring strategy should include:

- On-going, proactive measurement and monitoring
- Inclusion of patient feedback as an indicator of performance
- Development of benchmarks
- Regular reporting to stakeholders, providers and the public

(Accountability Working Group Recommendation #4)

The Ministry, in consultation with professional associations representing Interdisciplinary Health Providers, should develop a formal mechanism to track and analyze the activities of Interdisciplinary Health Providers to better understand the impact they are having in primary care, including in CHCs and NP-led Clinics.