PRIMARY CARE 2025

Capitalizing on rapid change to improve Ontario's primary healthcare system

About Primary Care 2025

Primary Care 2025 is an independent, not-for-profit group of Ontario primary care clinicians, leaders, and researchers. Biographies of contributors are available in Appendix 1. While we are affiliated with primary care leadership and governance groups, we are not representing any specific organizations for the purpose of this paper.

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TABLE OF CONTENTS

This report is the beginning of a conversation. Share your thoughts and feedback with us.

EXECUTIVE SUMMARY

The COVID-19 pandemic in Spring 2020 has resulted in rapid adaptive shifts in healthcare design and delivery. The crisis highlighted many fractures and weaknesses within our system, creating chasms in care delivery.

Innovative solutions to emerging challenges were implemented, capitalizing on existing strengths. Galvanized by a cultural shift away from many embedded assumptions and laboured decision-making processes, the pandemic accelerated the momentum towards integrated care and exacerbated the challenges where care is more fragmented.

The objective of this report is to **ensure that reforms either implemented during or revoked after the COVID-19 pandemic are aligned with the changes necessary to achieve sustainable high quality care across the province,** with a specific focus on the role of primary care. In committing to improving the provincial health system, it is important to reflect on the gains that rapid change has afforded us, without losing sight of the essential foundational elements required for a high functioning healthcare system.

As a group of primary care leaders, we wish to catalyze this important conversation in order to highlight key areas for change in the immediate future. As we continue to deal with COVID-19 through response, recovery and stabilization, we must remain mindful of medium and long-term goals for establishing the highest level of population health in our province into the future.

Our vision is built on the guiding principles of the Patient Medical Home and Patient Medical Neighborhood – concepts rooted in the understanding that high performing healthcare systems around the world all have strong high-functioning primary healthcare systems. These guiding concepts are inclusive of a holistic model of wellness preservation and illness management that addresses the social determinants of health. We understand leadership of primary care teams to come from any provider in that group, including family physicians and nurse practitioners. This care should be socially accountable, community-responsive and built around a robust ethical framework for population health planning and care delivery.

Overall, our recommendations build on a priority of **creating interprofessional, team-based, primary care hubs which have responsibility for the well-being of all people within a geographically defined population**

and are aligned with work done to date to establish Ontario Health Teams. We organize our recommendations in accordance with the 10 pillars of the patient medical home.

This report represents the beginning of a conversation. While it was created by a group with professional, geographical, and population diversity, more voices are needed. Further engagement with patients and the broader primary care community is necessary. For the full report, please see www.primarycare2025.com

Recommendation 1
ADMINISTRATION AND FUNDING

Short-term: Open up Patient Enrollment Models (PEM) and enrollment/registering to all physicians and nurse practitioners through primary care hubs. These hubs would service all patients within a dedicated geography, and would oversee accountability to the PEM contract. The intent of these hubs would be to allow for organizational continuity and coverage and ensure timely access to care.

Long-term: New risk adjusted (beyond age and gender) funding formulas would be established to promote population healthcare delivery, and incent care to socially and medically complex patients.

Every primary care provider will have access to team-based care aligned with their patients' needs in the primary care hubs to support holistic care inclusive of social determinants of health for wellness, prevention and management.

See full recommendation on page 12

Recommendation 2
APPROPRIATE INFRASTRUCTURE

Short-term: Establish networks of primary care providers (family physicians, nurse practitioners and others) in primary care hubs, which will connect into the surrounding health and social ecosystem, inclusive of hospital infrastructure anchors. These networks will together resolve current issues of personal protective equipment procurement and distribution, IPAC implementation and support, virtual care optimization and other necessary steps for the COVID-19 response and recovery.

Long-Term: Networks will evolve into the full Ontario Health Team model, and primary care hubs will make up part of the anchor infrastructure. Primary care leadership in the network will be an equal voice in prioritization, strategic planning and funding decisions.

See full recommendation on page 13

Recommendation 3
CONNECTED CARE

Short-term: Build on the movement from sector silos to connected systems, inclusive of public health for data mining, analysis and dashboard creations to support needs-based system planning, delivery and evaluation.

Information sharing as a single network for better predictive planning of the health system response to future pandemic surges, and enabling rapid learning analysis of current strategies in the network.

Use of digital technologies will allow better care at any location of delivery for of healthcare services, while minimizing the needs for patient transitions between, for example home, emergency, hospital, long-term care, assessment centre.

Long-term: Creation of an integrated digital platform, inclusive of home care, acute care, mental health and community support services to support a single, easy communication system for all primary care providers in the network integrated into primary care EMRs.

See full recommendation on page 14

Recommendation 4
ACCESSIBLE CARE

Short-term: Develop or define a primary hub in each geographic area that will be accountable to delivery of care to residents in that area.

Redefine "access to care" beyond same day availability to "flexible convenient scheduling that responds to urgency of need and considers patient preferences for modalities and locations of care".

Long-term: Include access to interprofessional care providers, community agencies and specialists. Creation of a central intake referral process for services outside of primary care hubs. Consolidate into a single system navigation solution for social determinants of health and specialized care services.

See full recommendation on page 15

Recommendation 5
COMMUNITY ADAPTIVENESS AND SOCIAL ACCOUNTABILITY

Short-term: Proactively address the backlog of care and future COVID-19 waves through a standards of care and prioritization guideline using an ethical framework and focusing on safety and population healthcare delivery. This must be inclusive of primary care and other sectors supporting social prescribing and supports for determinants of health.

Long-term: Look beyond the physician to all community programs and assets (provincial, regional and municipal) to enable social prescribing, patient activation and wellness resiliency building.

See full recommendation on page 15

Recommendation 6
COMPREHENSIVE TEAM-BASED CARE WITH PRIMARY CARE PHYSICIAN/NURSE PRACTITIONER LEADERSHIP

Short-term: Identify, fund and support primary care leadership development to accelerate primary care hub and network development and to allow every patient who needs it, access to team-based care through their physician's hub.

Long-term: Modify funding structures and resources to allow the delivery of primary care and team-based care for all providers and all patients, ideally in patients' preferred place of care (home, office, long-term care) and through the means best suited to the needs of the situation (virtual, in-person).

See full recommendation on page 16

Recommendation 7
CONTINUITY OF CARE

Short-term: Declare the value and complexity of generalist medicine. Elevate the role of primary care and ensure remuneration that acknowledges the complexity of primary care services at "top of scope" for complex diagnosis and management.

Understand the value-based benefits of continuity of care. De-incentivize/de-prioritize options that place convenience over continuity (virtual walk-in clinics) and care that should be provided by other members of the primary care team.

Long-term: Make generalist medicine a highly desired career choice for medical school graduates. Support areas of expertise within comprehensive primary care, such that they can serve as content experts to each other within networks and be appropriately remunerated. This allows for specialist demand to be reserved for the highly complex and uncommon medical conditions.

Ensure a primary care provider human resource management planning process is in place in all OHTs and succession planning addresses the issue of physician retirement/leaves to ensure patients have continuity of primary care.

See full recommendation on page 17

Recommendation 8
PATIENT AND FAMILY PARTNERED CARE

Short-term: Include patients and families in evaluation of the current COVID response, and in aspects of forward planning for future pandemic surges. Recognize the value of informal caregivers in home care and long-term care, ensuring forward planning is inclusive of this group.

Long-term: Embed patient and family experience and impact evaluations in the rapid learning system.

Develop federal and provincial policies to support wage subsidies for informal caregivers, as done in the UK.

Established a shared accountability framework and declaration of responsibility for system planning and resource utilization between the system providers and residents.

See full recommendation on page 17

Recommendation 9
MEASUREMENT, CONTINUOUS QUALITY IMPROVEMENT AND RESEARCH

Short-term: Embed safety in primary care as a key quality metric, and develop training in (for example) IPAC and QI for all primary care providers. Primary care hubs will require support to implement safety procedures, including a model of IPAC and QI.

Long-term: Establish a culture of continuous learning, accountability and quality improvement in primary care, through funding of education and leadership.

Support practice change management and implementation through business optimization/ practice facilitation teams shared within the network for quality standards.

See full recommendation on page 18

Recommendation 10
TRAINING, EDUCATION AND CONTINUING PROFESSIONAL DEVELOPMENT

Short-term: Identify primary care leaders in each network and support through skills development, mentoring and remuneration to focus on COVID response and recovery planning and change implementation.

Long-term: Establish primary care leadership recruitment, development, and succession planning in every network, with appropriate infrastructure and funding.

See full recommendation on page 19

ACCOUNTABILITY

We recognize that a healthy system requires optimization of commitment and performance by all: patients, primary care, specialists, hospitals, community agencies, home care, public health. Clear accountabilities need to be established at all levels from policy makers and funders to system operators, front line workers and citizens.

BARRIERS TO CHANGE

We acknowledge there are barriers to change, and offer some solutions to consider as we move ahead in this dialogue toward implementation of long-standing change. Some of these barriers are:

Loss of autonomy: The decisions we make as we move toward need to be governed by a broader ethical framework, inclusive of a philosophy that supports both professional autonomy and network solidarity, one that balances equity and accountability to deliver the highest level of care possible to the population we serve.

Power dynamics: The Canada Health Act established rights to care that entrenched dominance toward acute care sectors and physician providers. Moving forward, design and decision making need to allow for strength-based leadership, such that the network capitalizes on the expertise and experience of each group respectfully. For example, hospital infrastructure for operational efficiency of short-term immediate needs is combined with the ability for complex and complicated patient-centred decision making in primary care.

Long-term change is short-term planning cycles: Complex change requires consistency and unwavering commitment to a long-term vision. New Zealand and the UK, both identified as high performing health systems, boldly identify 10 year reform strategies for primary care. De-coupling healthcare decision making and prioritization from a 4 year election cycle will be important. Empowering an agency of the government, like Ontario Health, to stay the course on the long-term vision for healthcare reform will be important.

Despite the challenges that the pandemic has brought, COVID has taught us that integrated, rapid change is possible. Now is the time to continue our momentum forward toward change while not losing sight of the fundamental primary care direction needed to make Ontario a world class, high-performing healthcare system.

INTRODUCTION

The COVID-19 pandemic revealed the need for a high-functioning primary care system and suggested important areas for improvement.

The COVID-19 pandemic in the spring of 2020 has been a crisis. It is one that we cannot let go to waste by missing the opportunities to learn and improve. In regions where the local primary care system was high functioning and nimble, the health and well-being needs of Ontarians were met through both routine and crisis events. In regions where the local primary care system was unorganized and disconnected, we saw confusion for patients, reduced access to care, and frustration from primary care providers as they tried to maintain their ability to deliver care.[1] Accordingly, COVID-19 has revealed in new ways the value of primary care to the health system. As the pandemic abates and our health system and society look ahead, we must ensure that what we have learned during the pandemic is not lost.

COVID-19 HAS REVEALED THE VALUE OF A HIGH FUNCTIONING PRIMARY CARE SYSTEM, AND GALVANIZED RAPID CHANGE. WE MUST ENSURE THAT WHAT WE HAVE LEARNED DURING THE PANDEMIC IS NOT LOST.

The following report offers guidance to Ontario policy-makers on how to strengthen the value of primary care as the foundation of the healthcare system. The objective of this report is to ensure that reforms implemented or revoked after the COVID-19 pandemic are aligned with the changes necessary to achieve high quality care across the province.

This report was created with the guidance of a diverse group of primary care stakeholders. Our group includes family physicians, nurse practitioners, health researchers and administrators working across the province. We work and lead in a variety of geographical locations, care settings, and care models. We are affiliated with primary care leadership and governance groups but are not representing any specific organization for the purpose of this paper. The names and biographies of contributing members are available as Appendix 1. At this preliminary stage, our group did not include physicians working in a fee-for-service model, nor patient or community stakeholders, although we believe that as our recommendations move forward, their input about operationalization will be essential.

THE PROBLEM

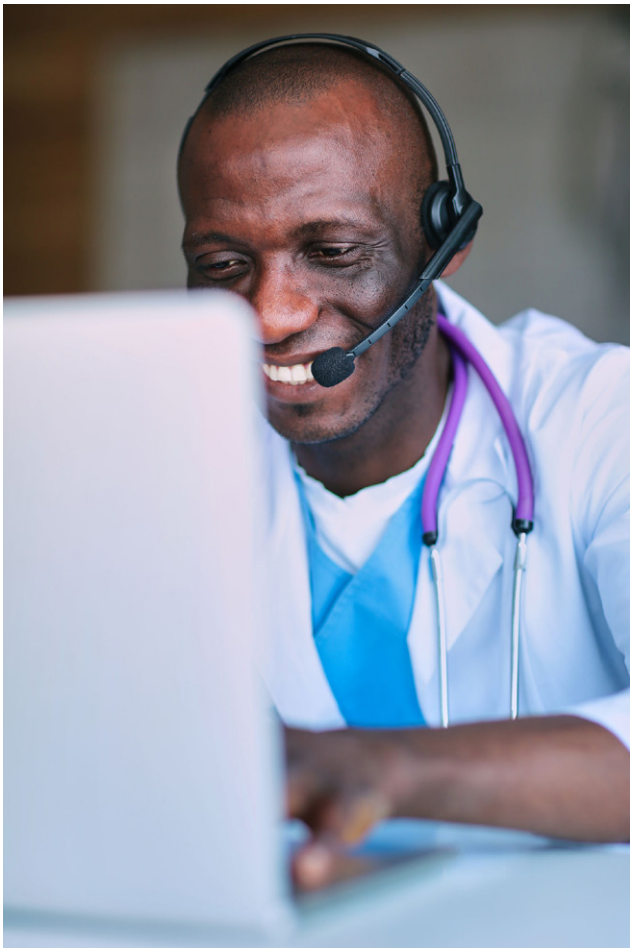
Ontario has failed to establish a consistent and high-performing primary care system, which is necessary for the provision of high quality healthcare

Canada, like many other high-income nations, has seen significant primary care reforms over the past several decades, recognizing the importance of a well-functioning primary care system to the efficiency and effectiveness of the overall health system. [2-4] Despite these efforts at reform, Canadian primary care outcomes remain poor, both compared to primary care outcomes in other countries and secondary care outcomes within Canada. [5, 6] For example, while we are one of the highest spenders on healthcare in the OECD, we rank relatively poorly in access to care. [6, 7]

A high functioning primary care system is essential for population health. For most Ontarians, their primary care provider is their point of entry into the healthcare system, becoming their most frequent contact and acting as a gatekeeper to other services.[8] Primary care providers serve patients living in the community and typically continue to remain the main point of co-ordination and contact when they move to hospital, long term care, or hospice settings. In this way, the primary care provider provides longitudinal care, focusing on care planning in line with the values and needs of the person rather than considering the current disease in isolation. The ongoing relationship allows for early detection of disease, and interventions to change the course progress of disease and improve health outcomes. A trusting relationship with one's primary care provider is a great influence in patient understanding of illness and care, decision making on resource utilization and treatment follow up. Primary care embedded in a community can also play an important role in addressing health inequities. A strong primary care system is essential to ensuring the health of Ontarians. In fact, international evidence demonstrates that Health System performance is improved through policy emphasis on Quality Improvement, Information Technology and Primary Care. [9] When all Ontarians have timely access to the appropriate services, primary care can lower the costs of care and improve population health outcomes and inequities. [4, 10, 11]

Now, after a period of rapid disruption, there is an opportunity to capitalize on the collaborative momentum and appetite for change.

NOW, AFTER A PERIOD OF RAPID DISRUPTION, THERE IS AN OPPORTUNITY TO CAPITALIZE ON THE COLLABORATIVE MOMENTUM AND APPETITE FOR CHANGE.



THE OPPORTUNITY

COVID-19 disrupted the healthcare system and resulted in rapid change

The COVID-19 pandemic has catalyzed rapid change, increasing the focus of healthcare resources and leadership on identifying and addressing the health needs of the community, rather than on the professional interests of different stakeholder groups. The pandemic escalated the adoption of a population needs-based approach in places where it was already underway and catalyzed it anew in other regions. COVID-19 provided an urgent common goal; health systems stakeholders worked together on a common outcome and were not sidetracked by a focus on the means of the change. The priorities of COVID-19 helped prioritize and guide our decisions about which reforms to move forward. Responding to these priorities provoked collaboration and innovation to optimize the value of care for patients, improve health outcomes, and responsibly mobilize human workforce capital. The disruption of the pandemic galvanized a cultural shift away from many embedded assumptions about how different elements of the healthcare system should work.

For instance, small town COVID-19 Assessment Centres have been staffed by specialist physicians from orthopods to gynecologists, who experienced a decrease in typical workflow and willingly stepped up to address needs identified by the local healthcare community. Family physicians and nurse practitioners closed gaps in the healthcare system by staffing local assessment centres, and supporting long term care and other congregate housing centres by providing resident care and setting up and managing wide scale COVID-19 testing of residents and staff. Primary care groups across the province have initiated innovative ways to provide care for the anticipated effects of interrupted care on chronic diseases. Examples include virtual patient support groups, mobile primary care units, attaching primary care to vulnerable populations in supportive housing, and wellness calls to patients identified as vulnerable and high risk. Community based situation tables emerged that have brought together partners in prevention - from EMS to shelter workers, to public health and church groups and industry - all with a shared focus on protecting staff, patients and the wider community from COVID-19.

In Ontario we have seen many sectors of the healthcare system rise to meet significant challenges. Now is the time to create a shared vision for the primary care system of the future, to capitalize on this disruption to effect long-term positive change within the healthcare system rather than returning to status quo. In this recommendation, we carry forward the call of Ontario's 2014 Expert Advisory Committee on Strengthening Primary Healthcare in Ontario. [12]

NOW WE MUST CHOOSE WHICH RAPIDLY IMPLEMENTED CHANGES TO KEEP, WHICH TRADITIONAL WAYS OF WORKING ARE STILL WORTHWHILE, AND WHICH NEW WAYS OF WORKING NEED TO BE FOSTERED.

In the following sections of this report, we provide our recommendations for capitalizing on the rapid change forced by COVID-19 adaptations to make improvements to Ontario's primary care system in the near (6 months) and medium (5 year) future.

THE VISION FOR CHANGE

Ontario's primary care system should strive to ensure that every patient has a medical home that is well integrated within a patient-centered medical neighbourhood

We have built our vision on the guiding concepts of the Patient Medical Home (PMH) and Patient Medical Neighborhood (PMN). While PMH is explicitly a medical model, we understand not all people seeking primary care would consider themselves "patients" and that teams may be led by any type of health professional. However, we retain the PMH language because it is familiar to many. The PMH model does not suggest a particular model of practice; rather, it is a set of principles that should guide the development and implementation of local strategies to primary care. In our recommendations, we outline the way that a capitated payment model would be particularly helpful in the PMH model. Reforms guided by these principles have already demonstrated success in multiple sectors. [13, 14] In PMH, primary care is accessible, continuous, comprehensive, person-centered, coordinated, compassionate and strives to meet the needs not just of individual patients but of the population. This care should be socially accountable and community-responsive, seeking to assess and intervene into the social determinants of health.[14]

WHILE THE PMH IS EXPLICITLY A MEDICAL MODEL, WE UNDERSTAND THAT NOT ALL PEOPLE SEEKING PRIMARY CARE MAY CONSIDER THEMSELVES "PATIENTS" AND THAT TEAMS MAY BE LED BY ANY TYPE OF HEALTH PROFESSIONAL.

The Patient's Medical Neighbourhood (PMN) is an extension of the PMH concept , bringing the concept beyond individual patients and their primary care practices by emphasizing the importance of community health and collaboration across sectors. [15] The PMN recognizes the need for structures which encourage collaboration between the medical home and other service providers both within and outside of the healthcare system.[16] In the PMN, the patient is at the center, with the PMH as the central point of contact for the patient. Other key actors include local and provincial public health agencies, acute and post-acute care providers, ambulatory care providers, diagnostic services, pharmacy and community and social services.[15]All of these services are connected to, and are supportive of the PMH, and information flows between them, mediated by the PMH as necessary (see Figure 1).

The PMH and PMN ensure that effective primary care is the foundation of an integrated healthcare system, and all patients are well-connected to a comprehensive range of health services in the community. [17]

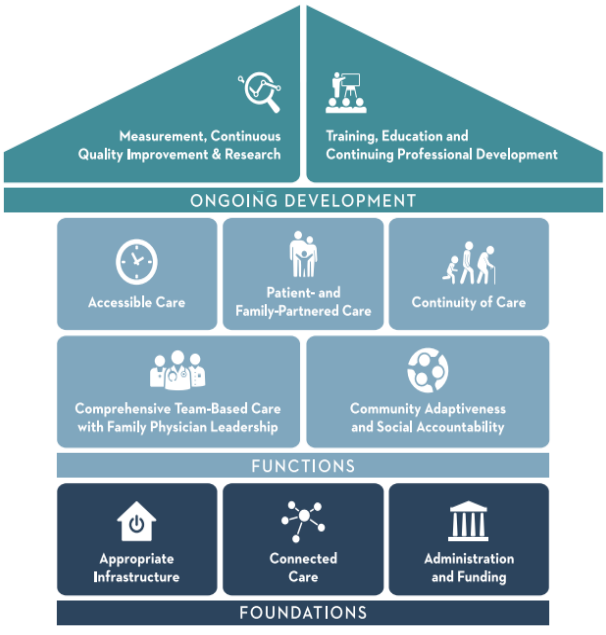


Figure 1: College of Family Physicians of Canada's vision of the Patient Medical Home. We recognize that Nurse Practitioners are also most responsible providers.

RECOMMENDATIONS

From Pre-Pandemic to Post-Pandemic

The vision for primary care emerging prior to the pandemic was that of the Patient Medical Home. [17] In parallel, a movement toward integrated systems of care to support whole populations was emerging through Ontario Health Teams. Many of the principles underlying these two concepts will continue to hold value moving into a renewed future in healthcare in Ontario, and there is value in examining the pre-pandemic reality and the post-pandemic possibilities through the lenses of these important concepts. Accordingly, we have organized our recommendations according to the pillars of the Patient Medical Home as outlined in 2019 by the CFPC and endorsed by organizations such as Canada Health Infoway, Canadian Association of Social Workers, Canadian Family Practice Nurses Association, Canadian Home Care Association, Canadian Medical Association, Canadian Nurses Association, Canadian Public Health Association, Royal College of Physicians and Surgeons of Canada, Working for Change (Table 1).[14]

THESE RECOMMENDATIONS BUILD ON A PRIORITY OF CREATING PRIMARY CARE HUBS WHICH WILL BE RESPONSIBLE FOR THE CARE OF A GEOGRAPHICALLY DEFINED POPULATION.

Overall, these recommendations build on a priority of creating primary care hubs which have responsibility for 100% enrollment of a geographically defined population. This goal of 100% enrollment will be facilitated through blended capitation payment models with complexity modifiers for any physicians willing to work in this way, which will be matched with resources to establish and maintain a high-functioning team of interprofessional care providers. As salaried primary care providers, Nurse Practitioners will be involved in enrollment of patients but do not participate in capitation payment models. Each primary care hub will be partnered to a hospital to provide infection prevention and control equipment, advice, and support. Communication across sectors of the healthcare system (primary, acute, community, public health) will be facilitated by the establishment of an inter-operable electronic medical record.

Table 1: Recommendations for Primary Care Reform in the near and medium future

FOUNDATIONS	
Administration and funding	Use payment model to incentivize 100% enrollment by geographic area Provide financial support for primary care leadership Increase patient access to inter professional care by expanding team-based care and funding more IHPs
Appropriate infrastructure	Establish networks of primary care practices, each partnered with a hospital in a regional hub responsible for all the healthcare needs of the community.
Connected care	Work towards inter-operable EMR accessible to primary, acute, community care providers and public health Secure intersectoral instant messaging system between healthcare providers, particularly those who work in primary care and home care Leverage the modernization of home and community care by ensure relevant supports are embedded in primary care Make possible secure patient- provider communication, access to shared patient records
FUNCTIONS	
Accessible care	Ensure all Ontario patients who desire are attached to a primary care provider Incentivize providers and also hold them accountable for providing timely care for attached patients Establish centralized intake and navigation system in each regional hub for access to specialist care
Community adaptiveness and social accountability	Anticipate the costs of deferred care and support primary care providers to “scale back up” to meet the needs of their communities Adopt a commitment to community and population health at a provider and system level Enable social prescribing and address social determinants of health within each medical neighbourhood, potentially through inclusion of social work and system navigator team members
Comprehensive team-based care with family physician or nurse practitioner leadership	Support regional primary care leadership with training and resources, recognizing that well-organized inter-professional primary care networks are best suited to meet the needs of the community.
Continuity of care	Encourage comprehensive, generalist practices by primary care providers serving a defined community in order to optimize continuity of team-based care for all patients. Ensure that any future virtual care options is based on the principles of continuity and not convenience
Patient and family-partnered care	Embed as a quality improvement process regular patient and family input on the design of service and experience of care.

ONGOING DEVELOPMENT	
Measurement, continuous quality improvement, and research	Develop and publicly report on patient-directed outcomes of care Encourage and support a culture of continuous quality improvement through funding, training, and accountability (through practice facilitation/change management support)
Training, education, and continuing professional development	Recognize the necessity of clinical leaders in the primary care system. Support the development and maintenance of local clinician leadership in each regional primary care hub

FOUNDATIONS

Administration and funding

Pandemic learning: In 2017/18, nearly three quarters of primary care physicians in Ontario were funded through some sort of patient enrollment model, with 41% of Ontario's primary care physicians choosing a capitated model. 25 % of family physicians remained in a fee for service model.[18] These fee-for-service physicians experienced significant challenges in being able to manage their practices and sustain care through the pandemic because of the directive to cease non-essential services. This left these practices with no income. In contrast, physicians remunerated through patient enrollment models continued to receive payment for their practice population and were not at risk of needing to close their clinics because of lack of funding. Nurse Practitioners practising in these models continued to provide care to patients through onsite and virtual means. Accordingly, patients enrolled in team-based care received extra support through proactive wellness checks. If issues were identified, the interprofessional team was able to step in. Interprofessional team-based models, in many sites, were able to collaborate for communication, IPAC planning, and community based initiatives in ways that were not possible for physicians not working in team-based models. Because these teams were not constrained by FFS billing, they were able to continue to provide care to patients through onsite visits and rapid integration of virtual options for care delivery. Due to decreased demand for primary care services at the beginning of the pandemic, staff could be redeployed to assessment centres; this means that special funding systems did not need to be set up as there was already a mechanism in place to pay and support staff. As the pandemic abated in many communities and the demand for deferred primary care rose, it was seamless to bring staff back to work in their traditional setting.

There is a 10-fold variation across Ontario in access to team-based care. Even in a large urban centre such as Toronto there is a 6-fold variation in access to team-based care. There is also evidence that access to team-based care does not match patient need.[19] FHO/FHT patients are less likely to live in low-income neighbourhoods and be new immigrants, and capitation payments which adjust for age and sex serve to incentivize team-based care of people who are healthier. Said another way, the patients least likely to be enrolled in a primary care team are those who are poor, new immigrants, and medically complex. All across the province, in both rural and urban areas, low income medically complex patients struggle to access team-based care. This is a problem because the disparity in access to team-based care typically means a disparity in access to the services of interprofessional healthcare providers.[20] In urban areas, this may be related to the ubiquity of the relationship between urban FHO/FHT and an academic centre which is not located in these neighbourhoods. This is not to say that FHTs do not or can not serve low-income patients or newcomers; there are several examples of inner city urban FHTs that successfully serve these populations, who benefit from the extra interprofessional resources of team-based care. In particular, social workers and primary mental health workers may help address social determinants of health.

Post Pandemic goal: Sustainability of practices for patients and communities should not depend on the funding model that physicians and nurse practitioners can access. Within 6 months, we recommend that patient-enrollment models are opened to new graduates, and team-based resources are expanded to those OHTs which are currently poorly resourced. Payment models have become highly politicized in Ontario and even within our group there is little appetite to make a single recommendation. We do agree that payment models should be used to incentivize accountability in the form of 100% patient enrollment and transparent reporting of measures. We agree on the importance of this accountability being shared amongst a collection of healthcare professionals who work together to decide how to

INTERPROFESSIONAL TEAMS ARE WELL-SUITED TO ADDRESSING SOCIAL DETERMINANTS OF HEALTH, BUT ACCESS IS UNEVEN AND MANY OF THE MOST MEDICALLY COMPLEX PATIENTS ARE NOT ENROLLED IN TEAM-BASED CARE.

offer the best care possible to a particular group of patients in their community. We differ on what payment model would work best to do this. One option is expanded capitation funding for any physician who desires to work within this model, and adjusted capitation models with age-sex-complexity modifiers for others. Regardless of what model is chosen, it should be accompanied by an increase in resources for other members of the healthcare team, and could be operationalized in a way which could support regional primary care on-call sharing to meet the after-hours care needs of the population. A blended capitation model would promote proactive care, and enable team members to use any modality of service (e.g. email, messaging, phone, video) with patients without having to worry about whether they would be reimbursed for their time.

Rather than enrolling a patient to a specific physician, patients should be enrolled to a "most responsible organization" which will foster team care from a group of health professionals working in a model of shared care. This would foster effective use of the expertise and resources of each member of the healthcare professional team, and help the team move away from protecting professional turf. The Ontario structure of negation of payment when a patient seeks care outside of where they are enrolled would need to be adjusted to fit this new model.

PATIENTS SHOULD BE ENROLLED TO A "MOST RESPONSIBLE ORGANIZATION" TO FOSTER TEAM CARE FROM A GROUP OF INTERDISCIPLINARY HEALTH PROFESSIONALS WORKING IN A MODEL OF SHARED CARE.

APPROPRIATE INFRASTRUCTURE

Pandemic learning: The lack of consistent infrastructure in primary care pre-pandemic might be best illustrated through the challenge of personal protective equipment (PPE). Many, and probably most, practices in Ontario found themselves without PPE supply sufficient to be able to see patients safely in person, even many weeks into the pandemic. Primary care was the lowest in the priority for receiving pandemic or emergency supplies from government stores. The Ministry of Health initially contended that community clinics were responsible for their own PPE, which meant that practices relied largely on medical supply companies to access PPE, and most commercial entities had no surgical masks available for distribution.

This basic infrastructure deficit in primary care made it very difficult for many practices to ramp up their services when the time came to do so. After unified appeals from the primary care community, the Ministry of Health began to make PPE available to primary care providers.

Post pandemic goals: The lack of PPE is just one illustration of the need for networking and infrastructure support for primary care providers within geographical areas. Primary care practices should be networked, with each network recognized as an important partner within their Ontario Health team. Collectively, the regional network would have responsibility for providing PPE and Infection Prevention and Control advice and support, mental health and addictions care, community and home care, and all other health needs of the community. These networks require a coordinated approach, potentially facilitated by Ontario Health regional tables. By 2025, these networked hubs of primary care should have identified and funded leadership structures, and the responsibility to communicate information out from the Ministry of Health, gathering information about hotspots, challenges etc. to communicate back. In addition, Ontario should establish a centralized stock of full PPE for primary care providers, supplemented by a clear regional distribution network that will ensure quick response for the next pandemic.

CONNECTED CARE

Pandemic learning: Prior to the pandemic, Public Health, Home and Community care, Long Term Care, the acute care sector, mental health and addictions and Primary Care existed in silos of care. Of particular importance from a pandemic learning standpoint was the challenge of data access, and lack of shared EMR to manage a population.

One consistent feature of countries which rank highly on effective and coordinated care is the presence of information technology and "meaningful use" of electronic medical records.[7] While adoption of electronic medical records in Ontario ranges, many physicians are still using EMRs in the same fashion in which they used paper records: as a standalone patient record accessible only to the family physician in that practice. There are many reasons to work towards an EMR which can enable information to be shared outside of the practice. For example, robust cross-platform referral management modules would help coordinate referrals to eliminate costs or delays to care while helping to coordinate diagnostic workups to avoid repetitive and unnecessary testing. [21, 22] A shared database enables communication among providers as well as supporting systematic sharing of best practices. The economies of scale can be significant.

Post pandemic goal: Inter-operable EMRs that permit rapid sharing of information and more rapid identification of infectious disease outbreaks. The ability to share EMR data across sectors of the

health and social care system in Ontario would also provide more seamless care for patients who require care by multiple sectors, facilitating collaboration between the primary care provider and providers working in home, community, mental health and addictions care.

A particular point of difficulty that must be rectified is the separation of public health labs from primary care EMRs so that primary care has to "pull" results. The inability to understand risk for a whole population for which primary care has a shared responsibility is a challenge that must be overcome in a post pandemic era. This is one example of the need to strengthen the connection between primary care and public health. Provincial consistency between public health units is essential. Even though there will be regional variation in disease prevalence, there should be more consistency in access to testing and reporting.

A ROBUST CROSS-PLATFORM REFERRAL MANAGEMENT MODULE IN AN ELECTRONIC MEDICAL RECORD WOULD HELP COORDINATE REFERRALS AND DIAGNOSTIC WORKUPS TO ELIMINATE REDUNDANT COSTS AND DELAYS TO CARE.

Consistent clear messaging about contact tracing and case clearance needs to come from Public Health Ontario and be communicated consistently across regions.

There are some examples that have emerged to show how a secure instant messaging platform between family physicians and hospital specialists in a region has improved transitions in care. Instant messaging allows each provider to reach the other. This communication platform should be expanded to include homecare providers. While a single EMR will rectify some of the challenges of siloed care, by 2025 there should be more movement to integrating

home and community care within the patient's medical neighbourhood, both through digital connectedness but also through pooled funding at the OHT level.

FUNCTIONS

Accessible care

Pandemic learning: Accessible care requires both attachment to a primary care provider and timely access to that provider when care is needed. 90% of Ontarians have access to a primary care provider, which means that 1.5M Ontarians have not achieved the first level of access to the primary care system.[23] Having a primary care provider is only the first level of access; most Ontarians will wait for an appointment with their care provider, regardless of the acuteness of their illness. In the pre-pandemic era, most Ontarians did not have access to virtual care via phone or video appointment. Only small numbers of Ontario patients were able to communicate via email with their primary care team.

Post pandemic goals: All citizens in Ontario will be assigned to a most responsible provider for their care delivery, from which they can reliably expect timely access to safe, high quality care, and through which they can expect their care to be coordinated. Attachment of patients to primary care providers will be realized by the creation of primary care hubs in each region; each hub will be responsible for a particular geographic population.

Regarding timely access, we encourage the use of multiple measures of access that are patient informed, as research has shown patients do not always prefer the "same day or next day" metric of access commonly used by news media and politicians. [24] For example, patients may conceptualize access as the ability to schedule appointments that accommodate work commitments or childcare obligations. One clinic improved patient perceptions of access to redesigning after-hours advertisement and communication materials and providing this information in multiple formats. Understanding how to access after-hours of care

THE METRIC OF "SAME DAY OR NEXT DAY" ACCESS TO CARE DOES NOT ADEQUATELY REFLECT PATIENT PREFERENCES FOR CONVENIENT SCHEDULING AND CHOICE OF MODALITY OF VISIT.

demonstrated a significant increase in perceptions of access and use of after-hours service, even when the actual availability of care did not change. [25] While many capitated models have an explicit goal of

improving access to care, evidence on their success has been mixed, suggesting a need for careful policy implementation supplemented with accountability measures.[26] The current access bonus has been shown to be ineffective in improving access. [27] When appropriate for the patient's problem and circumstances, virtual care may also improve access, although like other after-hours access, it should be available within a patient's medical home to ensure continuity of care.

By 2025, each regional hub will have a centralized intake and navigation system to coordinate care with specialists.

Community adaptiveness and social accountability

Pandemic learning: The pandemic laid bare the importance of the social determinants of health, and the vulnerabilities that many of our patients face related to employment, housing, transportation, race, and racism. Before the pandemic, there was limited provision of resources to address the health implications of the social determinants of health. Data clearly demonstrate that individuals with a low income and racialized groups have been disproportionately hit by COVID-19. Primary care that is better integrated with public health can play a role in addressing these inequities, for example, using a data-driven approach to reach out to neighbourhoods and populations that are more affected.

During the pandemic, the primary care provider's "duty to care" was unclear since many primary care providers were not able to continue working without support in the form of PPE and access to ongoing funding to support adapted ways of providing care. Accordingly, primary care providers were unable to adapt to the needs of their communities. Anecdotally, those primary care providers who are part of team-based models of care seem to

have been better equipped to quickly adapt to the needs of their communities during the pandemic, continuing to provide regular care and also providing COVID assessment.

Post-pandemic goals: First, all practices must receive the support they need to scale back up to meet the needs of their patient populations. The consequences of deferred care during the pandemic and the new needs that will arise because of isolation and loss of employment directly related to the pandemic require swift attention. Within the next 6 months, we recommend that we normalize the notion of social accountability for primary care practices, clarify the "duty of care", and provide the supports needed to enable the duty of care to be fulfilled.

THE PANDEMIC ILLUSTRATED THE IMPORTANCE OF SOCIAL DETERMINANTS OF HEALTH AND DEMONSTRATES THE NEED FOR BETTER INTEGRATION WITH PRIMARY CARE, PUBLIC HEALTH AND COMMUNITIES IN ORDER TO IMPROVE ACCESS TO HEALTH AND SOCIAL SERVICES.

By 2025, a commitment to community and population health will guide all primary care providers and will be fully supported by a healthcare system that links municipalities and community organizations to enable social prescribing and address the social determinants of health. Embedding primary care, social and health services in a medical neighbourhood will also encourage the delivery of trauma-informed culturally safe care and begin to address some of the structural determinants of health such as racism. Some international models have successfully employed the role of community health ambassadors serving defined registries of their highest risk clients both for chronic disease management as well as targeted outreach during the pandemic and could be integrated into this vision. In Ontario, access to system navigators, social workers, and social prescribing strategies must expand.

TO ADDRESS THE SOCIAL DETERMINANTS OF HEALTH, ACCESS TO SYSTEM NAVIGATORS, SOCIAL WORKERS, AND SOCIAL PRESCRIBING STRATEGIES MUST EXPAND.

Comprehensive team-based care with family physician and nurse practitioner leadership

Pandemic learning: There exists significant inequity in access to team-based care across the province. In areas where there was leadership by primary care, the response to the pandemic was more effective, with family physicians and nurse practitioners better able to pivot their care to the changing realities.

An emerging issue identified during the first wave of the pandemic is the tremendous challenge that exists in long term care settings. As we move forward, it is anticipated that there will be a significant drop in frail seniors applying to long term care settings and these seniors will need much more robust care in the community. Access to long term care may also contract as rooms with four beds are reduced to double occupancy. This will likely result in more frail seniors requiring care in the community. While some services will be delivered through Home and Community care, these services require a "quarterback" and a team to support complex needs.

Post-pandemic goals: By 2025, all patients should have access to team-based care that is appropriate to their needs, no matter what setting they live in. Primary care leadership of these teams is essential. The intimate knowledge that primary care providers have of their patients' lives and local challenges informs relevant and effective changes. If primary care clinicians are called upon to provide oversight to long term care facilities, they should be remunerated for their time in a way which permits them to have overall direction, accountability, and authority to effect changes. Fee-for-service care to individual patients does not allow this.

As more care for seniors will be required in the community the need to coordinate their care through the patient medical home will increase. As affirmed by the Connecting Care Act, Home and community care will need to evolve to be a part of the team in primary care with care delivery led by the patients primary physician or NP. [28]

Continuity of care

Pandemic learning: Before the pandemic, we were seeing decreasing numbers of medical students choosing comprehensive, generalist primary care as their career of choice. Family Medicine residents are increasingly choosing to do walk-in clinic work and are pursuing additional training in focused areas of practice in increasing numbers. Recent evidence across Canada shows that new graduates primarily choose focused practice for personal reasons: interest, work-life balance, increased remuneration. While focused practice by family physicians can be leveraged to meet community needs, it must be associated with continuity of care. For example, Family Physicians with enhanced skills working in rural and remote areas will facilitate patients in those areas to receive the care they need in their own communities from their own care team. Ensuring that enhanced skill practitioners work in a way which furthers continuity of care requires policy intervention. [29] As more primary care providers choose to work in models which do not support continuity of care for patients (e.g. walk-in clinics), the relationship-based nature of primary care will suffer.

The current models of care are also failing to effectively use Nurse Practitioners to expand access to continuous, generalist care in an effective way. The College of Nurses of Ontario reports that only 51% of NPs were employed full-time in 2019, down from 61% in 2015.

Post-pandemic goals: We recommend establishing the 2025 goal of record numbers of medical students choosing comprehensive, generalist primary care as a career choice. Specifically, we are not targeting Family Medicine residency as a choice, but the choice to pursue comprehensive generalist care after graduation. For both family physicians and nurse practitioners, developing enthusiasm about a career providing generalist, relationship-based care will require proper resourcing of primary care and competitive remuneration for this type of work. Policy incentives will be needed to encourage family physicians to combine their area of focused practice with a generalist practice or with strong collaboration with generalists, rather than a retreat into a very small clinical area with limited community relevance and connection. For example, this could be accomplished by requiring every family physician to work within a networked group of other family physicians. That group can decide whether they require the enhanced skill holder to also maintain a generalist practice, or whether the focused practice is sufficiently valuable to the group that the group is able to provide generalist care to the patient population without the enhanced skill physician maintaining their own roster of patients. Stable, consistent, and innovative funding options must also be developed to ensure that the nurse practitioner profession remains an attractive option for experienced registered nurses to return to school and join the primary care workforce. Without this support, we will continue to experience a decline in the availability of primary care providers.

IT IS LIKELY THAT THE COVID-19 PANDEMIC WILL INCREASE THE NUMBER OF FRAIL SENIORS REQUIRING CARE IN THE COMMUNITY, WHICH WILL INCREASE THE NEED FOR INTEGRATED HOME AND COMMUNITY CARE COORDINATED THROUGH THE PRIMARY CARE TEAM.

Patient and family-partnered care

Pandemic learning: After significant improvements in patient and family-partnered care over the last decade, including strong shifts to co-designed care in many places, the perspectives of patients and families were largely excluded from COVID-catalyzed changes to the healthcare system. For example, visiting policies in Long Term Care homes were created without input from family caregivers and patients in many places, disrupting relationships and causing significant distress. The mental health impact on both patients and their families will be tremendous after months spent without seeing their loved ones.

Post-pandemic goals: Immediately, the importance of engaging in meaningful patient partnership should be recognized. By 2025, measurement and improvement of patient experience data should become routine. Patients will have input into how

their Medical Home is organized, and be on all boards of their Medical Neighbourhood. The key in this goal is to formally partner with informal caregivers and family members to better support patients living in their homes. In other jurisdictions (e.g. United Kingdom) family caregivers receive a wage for caring for frail elderly who would otherwise need to be in long-term care. Recognizing the important role of family caregivers is a meaningful form of patient partnership.

PATIENT AND FAMILY INPUT IS REQUIRED FOR ANY HEALTH SYSTEM REFORM; MEANINGFUL ENGAGEMENT WITH THESE GROUPS IS THE NEXT STEP IN THE CONVERSATION.

Both providers and patients must share accountability. It may be easier to go to a walk-in clinic to refill a prescription than waiting for an appointment with one's own care provider. Providers must improve accessibility and patients must commit to working with a particular team of healthcare providers to get the comprehensive and complete care they won't receive through episodic visits with walk-in providers.

ONGOING DEVELOPMENT

Measurement, continuous quality improvement, and research

Pandemic learning: As we learned very quickly, there has been a lack of attention to the feature of "safety" as part of quality. Pandemic planning and infection control in the primary care office has not been widely taken up or supported, despite its inclusion in a number of different resources. As a result, when the pandemic began, it was clear that many practices were not prepared to address infection control related issues such as office cleaning, patient flow, understanding of PPE for droplet and airborne illness.

Post-pandemic goals: Family Medicine and Nurse Practitioner curriculums should embed infection control content. Core education should be developed for practices. Safety and infection control should be built into the next iteration of Quality Improvement Practices. By 2025, all residents and NP trainees should complete infection control training, all QIPs should feature safety as core to QIP work. All OHTs should be mandated to ensure that affiliated practices have good infection control measures in place and adequate PPE for managing droplet and airborne illness.

Support for clinician-led QI initiatives would include funding for leadership and accountability through measures driven by both patients and clinicians. Governance is essential for the improvement of patient safety. High quality governance practices include safety dashboards, reporting of near misses and adverse events, and the proactive reduction of higher risk activity. Each primary care network should identify a skills-based safety Board which will drive the culture of safety within the network. This board should include community members and patients to inform priorities and measures.

All QI initiatives should consider the social determinants of health, and collect data in order to ensure that programs and services developed in a community are reflective of that community.

Training, education, and continuing professional development

Pandemic learning: Prior to the pandemic, there was no funded leadership education for clinicians in primary care. Funded continuing education was removed from the Family Health Team model. Physician consulting dollars remain, but many teams have pivoted away from using those funds for the intended purposes of supporting program development and consultation to support honoraria for non-affiliated physicians to participate in OHT initiatives. Family physicians in independent

practice who identify a community need and want to pursue additional clinical training to serve their patient population face immense financial and patient-coverage barriers to doing this.[29] Supporting the continuing education and leadership of primary care clinicians is important; groups with strong leadership have been able to effectively move elements of the PMH and PMN models forward effectively. Teams who have come together to provide salary support and patient coverage have been able to expand the clinical services available to their patients by supporting a clinician member to seek enhanced skills training.

Post-pandemic goals: Leadership training will be important to implement, maintain, and continuously improve the reforms recommended in this report. Each primary care network will require leaders with expertise in primary care, health systems, and change management. The development of these leaders can be supported through leadership and education programs as well as support to build leadership capacity to influence and promote adaptability at the front lines. This will enable networks of primary care providers to adapt and evolve to emergent crises, such as future pandemics.

ROLES AND ACCOUNTABILITIES

FOR THE PRIMARY CARE SYSTEM, PATIENTS, PUBLIC HEALTH, HOME AND COMMUNITY CARE STAKEHOLDERS

As demonstrated during the COVID-19 pandemic, patients rely on their primary care, home and community care providers and any reform must consider the multiple directions of accountability between these groups. Here we suggest some starting points for establishing a system of accountability:

- The **primary care team,** including the Family Physician and Nurse Practitioners as well as the rest of the interprofessional team should be the key and first point of contact for healthcare issues, house the complete patient care plan and be a central source for resources throughout the health and social services sector
- The **patient's** responsibility is to maintain consistency with a primary care team, hold responsibility for their health questions and identifying barriers and concerns to reach their goals
- Local **Public Health** departments bear a responsibility for policy development that promotes healthy communities and allows the healthy choice to be the easy choice, detection, prevention of diseases in the population, system planning and monitoring within the community. Public Health data and patient information must connect seamlessly to primary care EMRs.
- **Home Care organizations** should be intimately linked to the primary care team in order to provide timely supports to augment and support care in the patient's home, regular assessments and early detection of changes in patient's care needs.

- **Community Care providers** should also be well connected to the primary care team. They must be agile and responsive to the needs of the community that they serve, adapt models of care, access and programing based on the population needs of the community, maintain dynamic relationship with primary care to together plan and respond to the needs of the person and the population
- **Hospitals** must support primary care with access to resources and supports that enable them to maximize the care they provide in the community, collective care planning with patients as they move through their care needs
- **Community specialists** will provide access, support and education to the primary care team for patient needs that require specialist level diagnostics or management. They will commit to coordinated handover to primary care for maintenance of chronic conditions in stable patients.

BARRIERS TO REFORM

PHYSICIAN RESISTANCE TO SYSTEM REFORM BASED ON RELUCTANCE TO LOSE AUTONOMY

The changes we propose in this report are likely to result in a loss of professional autonomy for Family Physicians. When we refer to "professional autonomy", we mean the autonomy to arrange and organize one's practice. We are not referring to the autonomy to exercise clinical judgment. Physician leadership within the healthcare system has resulted in a series of policy legacies which maintain the "physician as business owner" model, wherein physicians own and operate their own practices to earn public fee-for-service revenue. [5] As a result, physicians may choose to practice in a way where they have few formal obligations or connections to other providers in the sector, creating a fragmented primary care system. [30] Given the investment these individuals have made into a particular way of practicing, many are reluctant to change course and engage in structures which intend to bring greater coordination at the cost of reduced professional autonomy.[31] This can result in practices organized to serve the interests of the physician rather than the interests of the patient or community. For instance, Ontario has long tried to increase after-hours access to primary care, which many physicians have resisted because they do not wish to work in the evenings or overnight. There are few policy mechanisms which the government can use to compel the provision of after-hours services. Without a need to change or assistance to make the change, some primary care providers will not be motivated to work in a way which enables after hours access. This lack of motivation may come from a fear of being accountable for unreasonable expectations of access from patients. Consequently we believe that the system will be improved if physicians trade some of their individual autonomy for meso-level administrative and back-office support. [32] Connection between family physicians who currently work in fee-for-service silos will help move the culture away from "physician as business owner" and towards "physician as an accountable coordinator of care".

POWER DYNAMICS BETWEEN PRIMARY CARE AND ACUTE CARE

Policy is made within the political arena and health policy is not an exception. Historically, the Canada Health Act has entrenched physician and hospital dominance. Acute care systems are funded and resourced as the defining focus of healthcare in Ontario. This is both historical, but also in many ways intuitive. Problems in acute care are obvious, visible and often time-sensitive, requiring immediate intervention. The funding and associated power follows the problem. Acute care has a structure which appeals to the simplification of a complex problem, incentivizing reactive rather than proactive approaches. For example, COVID response focused on hospitals for the provision of PPE, expansion of critical care capacity, and identification and amelioration of drug shortages. The issues faced in other parts of the system were de-prioritized until we started seeing acute issues devastate Long Term Care and other sectors.

Primary care providers work longitudinally, often on complex chronic issues affected by social determinants. They should be considered equal partners within the healthcare system, and not just a source of referrals and labour for appointment bookings, follow-up, and coordination of diagnostic tests. Historical policies entrench this power dynamic, with specialists billing higher fees when seeing the patient for the same stable issues the primary care provider is already seeing and monitoring. Ending "Hallway Medicine" cannot happen without an investment in primary community care. Preventing admissions to hospitals and enhancing effective discharges and transitions is the robust solution needed to solve this issue. In this way, we can re-direct health resources away from the "repair shop" of the acute care hospital and towards the consequences of not attending to the social determinants of health responsible for most of our health status.[33]

LONG TERM PLANNING IS DISRUPTED BY 4 YEAR ELECTION CYCLE AND GOVERNMENTAL RENEWAL

Primary care reform takes significant planning and investment, on a scale which is at odds with Ontario's 4 year election cycle of governmental renewal. New Zealand provides a cautionary tale of the difficulty with implementing significant reforms through political mechanisms. Over the past several decades, significant primary care reforms focusing on de-centralization have been made, rescinded, and then re-introduced.[34] These patterns have closely followed the three-year electoral cycle and

two-party political system, which create an incentive for radical change to be enacted very quickly.[35] While many health policy analysts emphasize the importance of institutions in driving policy reform, New Zealand illustrates that buy-in and support from other stakeholders is essential, both in designing the reform as well as in operationalizing it, in order to ensure that commitment to the reform is maintained beyond the four year election cycle.

We hope that one value Ontario Health will bring is to move change outside of the political cycle, enabling longer-term planning and implementation. If primary care is not in the purview of OH, this will represent a significant barrier.

CONCLUSION

Despite significant barriers, we are at a unique place in time where collaborative momentum across sectors of the healthcare system have come together to enact change very quickly in response to the COVID-19 pandemic. Before sliding back into our established ways of thinking about the arrangement of the healthcare system, we should seize the opportunity to sustain the changes which are beneficial, and align the “return to normal” with practices that will support an integrated primary care system well situated to provide high quality care to all Ontarians. While the cost of change may be painful, it will be nothing compared to the cost of not changing. We learned during COVID-19 that all across the health, community, and social care systems that we are in this together. Primary care is most effective when integrated and now is the time to move forward to that future.

This report is the beginning of a conversation.
Share your thoughts and feedback with us at **https://forms.gle/HAfTHx6nAuaJ6G9x7**

APPENDIX 1: GROUP CONTRIBUTORS

Rob Annis MD CCFP	Rob Annis has been a general practitioner in Listowel, Ontario for the last 26 years, working in association with the North Perth Family Health Team. He is currently on the Section of General and Family Practice Executive, and the Association of Family Health Teams Board. He has held a number of leadership positions, including: Board Member for the Ontario Telemedicine Network, the SW LHIN Clinical Quality Lead, SW LHIN Primary Care Lead, the Primary Care Lead for the SW Regional Cancer Program, and the Chief of Staff of the Listowel Memorial Hospital.
Mira Backo-Shannon BSc, MD, CCFP, MHSc	Mira Backo-Shannon has been a practising family physician for 20 years. She has held numerous leadership positions in hospitals, primary care, and provincial work. She is currently the VP, Clinical, Health System Strategy, Planning and Integration for Ontario Health Central Region. She also supports the Mississauga OHT as Executive Lead. Mira also holds teaching positions with the University of Toronto and McMaster University. She is committed to furthering healthcare system design and policy development for improved health and wellness delivery for all.
Jocelyn Charles MD, CCFP(COE), FCFP, MScCh	Jocelyn Charles is a family physician in the Sunnybrook Academic Family Health Team, the Primary Care Clinical Co-Lead for North Toronto and the Medical Director of the Veterans Program at Sunnybrook Health Sciences Centre. She helped to establish and currently leads the Provincial Primary Care Council, a community of practice for Ontario Health Team Primary Care Leads. She is an Associate Professor in the Department of Family and Community Medicine at the University of Toronto. Her clinical and academic work has been focused developing patient-centred models of care to meet the needs of patients with complex needs both in the community and in long term care. She was recently recognized by the College of Family Physicians of Canada as the Family Physician of the Year for Ontario.
Leanne Clarke	Leanne is the Chief Executive Officer of the Ontario College of Family Physicians (OCFP). She joined the organization in 2013 to lead the OCFP's 2014-2018 Strategic Plan, oversaw the OCFP's policy portfolio, and became CEO in 2017. Prior to this she launched a pan-Canadian roadmap for a palliative approach to care, The Way Forward, supported by one-time funding from the Government of Canada. From 2007-2012, she was inaugural Vice President, Strategy, Performance Measures and Communications at the Canadian Partnership Against Cancer (CPAC). She was responsible for measuring the impact of the cancer control strategy and for the portfolios of person-centred care, adolescents and young adults, First Nations, Inuit and Métis cancer control, and patient and public engagement. Leanne has worked in the non-profit, charitable and private sectors over the past 30 years.

Beth Cowper-Fung NP-PHC, MN	Beth Cowper-Fung is a Primary Healthcare NP and Clinic Director at the Georgina Nurse Practitioner-Led Clinic in Sutton Ontario. She has over 10 years experience providing full scope, primary healthcare to residents of all ages. Beth has also spent 9 years managing the clinical team as well as providing strategic and operational oversight and at the clinic. She is currently the Past President of the Association of Family Health Teams of Ontario and is a past President of the Nurse Practitioners' Association of Ontario (NPAO). She has served on multiple provincial committees including the Clinician Digital Health Council, Primary Care Sub-Committee informing the Premier's Council on Improving Healthcare and is a member of the Primary Care Quality Advisory Committee.
Geordie Fallis MD, CCFP, FCFP	Geordie's first leadership position was President of the Junior Red Cross of his Grade V class in 1960. Since then, it has been pretty much downhill. He has been a practicing Family Physician since 1977; a former Chief of Family Medicine at Michael Garron Hospital; and a former Clinical Lead for the Subregion of East Toronto in the Toronto Central LHIN. He believes that lasting healthcare transformation will occur when Primary Care is truly the focal point for change.
David M. Kaplan MD, MSc, CCFP, FCFP	David M. Kaplan is the Chief, Clinical Quality at Ontario Health (Quality). Additionally, he chairs the Primary Care Quality Advisory Committee, a group of leaders in Ontario that advises on the direction of Ontario Health's primary care strategy. This includes establishing a comprehensive approach to supporting and motivating quality improvement in primary care, leveraging existing networks and key foundations already established within the sector. David is a family physician who practices comprehensive family medicine at the North York Family Health Team. He is the Vice-Chair of the Medical Advisory Committee at North York General and an Associate Professor at the University of Toronto.
Tara Kiran MD, MSc, CCFP, FCFP	Tara Kiran has been practicing family medicine for over 15 years. She has held numerous leadership roles including Primary Care Physician Advisor for the Toronto Central Local Health Integration Network, Provincial Clinical Lead for the Ontario Diabetes Strategy, and Board Chair for the St. Michael's Hospital Academic Family Health Team where she has practiced for the last ten years. She is a clinician scientist and leads a program of research to improve quality in primary care. She is currently the Fidani Chair of Improvement and Innovation at the University of Toronto and Vice Chair for Quality and Innovation in the Department of Family and Community Medicine at the University of Toronto.
Claudia Mariano MSc, NP-PHC	Claudia Mariano is a Primary Healthcare NP with 20+ years experience working with patients across the lifespan. She is a past President of the Nurse Practitioners' Association of Ontario (NPAO), past Board member of the Association of Family Health Teams of Ontario, and Adjunct Lecturer at the University of Toronto Lawrence S. Bloomberg Faculty of Nursing. She is currently the Manager of Practice and Policy at the NPAO.

Kavita Mehta RN, BScN, MBA	Kavita Mehta is the Chief Executive Officer of the Association of Family Health Teams of Ontario (AFHTO). Prior to AFHTO, she was the Executive Director of the South East Toronto Family Health Team (SETFHT) for 9 years, a leading academic FHT that was awarded the Ontario College of Family Physicians Family Practice of the Year in 2012 and a recipient of a 20 Faces of Change in 2015. She started her work in primary care as a Senior Program Consultant at the Ministry of Health and Long-Term Care Primary Healthcare Team where she participated in the policy and program development work for family health teams and primary care renewal. Kavita also served on the Change Foundation Board of Directors for the last five years and has been proud of the work they continue to do in pushing the patient co-designed integrated healthcare system needed in each local community.
Sarah Newbery MD FCFP FRRMS	Sarah Newbery has been a rural physician in comprehensive community practice in Marathon since 1996 and is currently Chief of Staff of the North of Superior Healthcare Group She is a past President of the OCFP, past VP clinical of the Northwest LHIN and is currently Assistant Dean of Physician Workforce Strategy for the Northern Ontario School of Medicine. She has been involved in several provincial primary care related committees and is passionate about equitable access to primary care as the foundation of an integrated healthcare system.
Harry O'Halloran MD	Harry O'Halloran has been in General/Family Practice in Collingwood since 1986, and on staff at the Collingwood General and Marine Hospital throughout that time. He has held numerous leadership roles in Primary care including Chief of Family Practice at Collingwood General and Marine Hospital, Lead Physician of the Georgian Bay Family Health Organization, and Primary Care Physician LHIN Lead for NSM LHIN. He has been involved in multiple regional and provincial primary care initiatives and currently sits on the executive of the Section of General and Family Practice of the Ontario Medical Association.
Penny Paucha MA	Penny Paucha is the founder and principal of Instincts at Work, a neuroscience based leadership coaching and consulting firm transforming healthcare by evolving people's thinking to meet the demands of complex systems. Penny facilitates the integration of primary care by engaging providers to create seamless systems of caring for patients. She is a trained mental health counsellor, an accredited coach with the Neuroleadership Institute and a faculty member with the Ontario College of Family Physicians and the Dorothy Wylie Health Leaders Institute.
Thuy-Nga (Tia) Pham MD, MSc, CCFP, FCFP	Thuy-Nga (Tia) Pham is an Associate Professor in the Department of Family and Community Medicine at the University of Toronto, teaches on Physician Leadership at the medical school and is strongly involved in Quality Improvement and Patient Safety within the residency program. She is a passionate advocate for frail older adults and has published on the need for a system's approach to providing integrated homebased primary care. Dr Pham has been an invited lecturer internationally, promoting team-based primary care. She is heavily involved presently in driving forward her East Toronto Family Practice Network and the important role of family physicians in designing effective integrated health systems within the Ontario Health Teams.

David Price MD, CCFP, FCFP	David Price is a Family Physician who over the last 30 years, has practiced in both rural and urban settings. He has a particular interest in models of Primary Care and has advised Governments both in Canada and Internationally. He chairs Ontario's Primary Care Advisory Table and is currently Professor and Chair of the Department of Family Medicine at McMaster University.
David Schieck MD, CCFP	David Schieck has practiced comprehensive general family practice and long term care in Guelph since 2003. He has held various roles in primary care including Chief of the Department of Family Medicine at Guelph General Hospital and Guelph-Puslinch Subregion Clinical Lead Waterloo Wellington LHIN. He currently serves on the executive of the OMA Section on General and Family Practice.
Rebecca Van Iersel MD, CCFP	Rebecca Van Iersel has worked as a family physician in the Orillia area since 2007. She is currently the Chief of Family Medicine at Orillia Soldiers' Memorial Hospital (OSMH). She has previously served as the North Simcoe Muskoka (NSM) LHIN Vice-President Clinical, NSM HQO Regional Clinical Quality Lead, NSM Primary Care Lead, NSM Emergency Lead and a member of the Ontario Quality Standards Council.
Meredith Vanstone PhD	Meredith Vanstone is an Associate Professor in the Department of Family Medicine and a member of the Centre for Health Economics and Policy Analysis at McMaster University in Hamilton, Ontario. Her research addresses policy implications of health professional education and primary care practice.
Jennifer Young MD, FCFP-EM	Jennifer Young practices comprehensive family medicine in Collingwood since 1999 that includes part time Emergency Medicine, low risk obstetrics and hospitalist care. She has been in local leadership roles including Chief of Family Practice, Chief of Emergency and Quality Improvement Lead for our FHT. Jennifer has practiced in the developing world and in the Netherlands. She is the current President of the Ontario College of Family Physicians having been on its Board since 2011.

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