

An Action Plan for Patients First: Report of a Stakeholder Dialogue on Bill 41 in Ontario

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PREPARED FOR:

Ontario Ministry of Health and Long-Term Care

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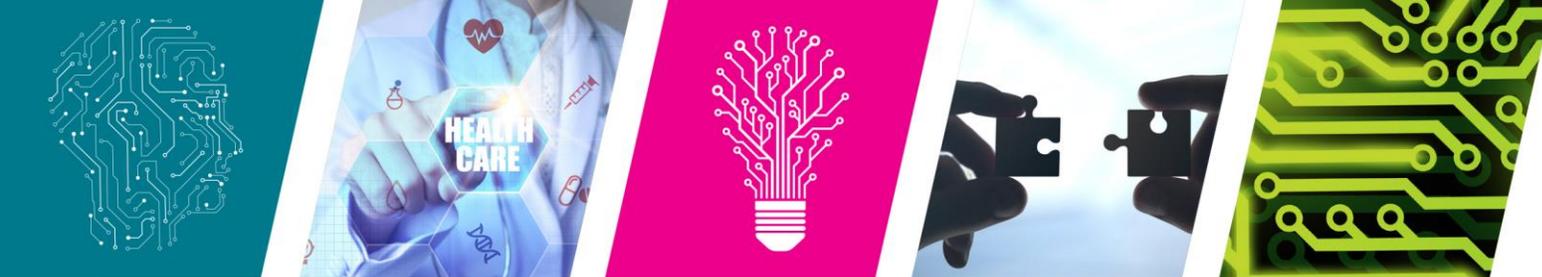
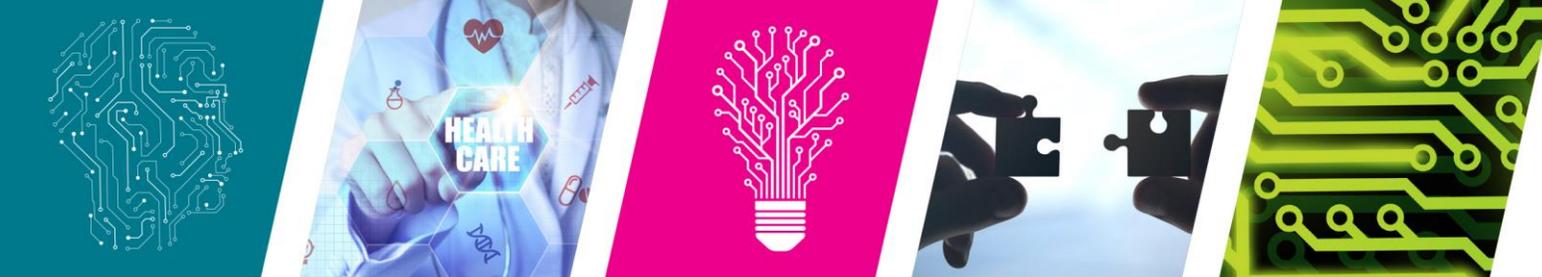


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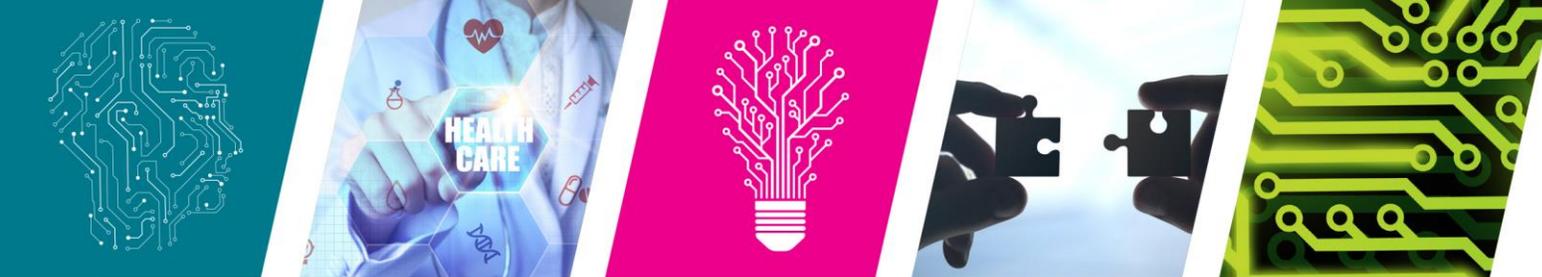
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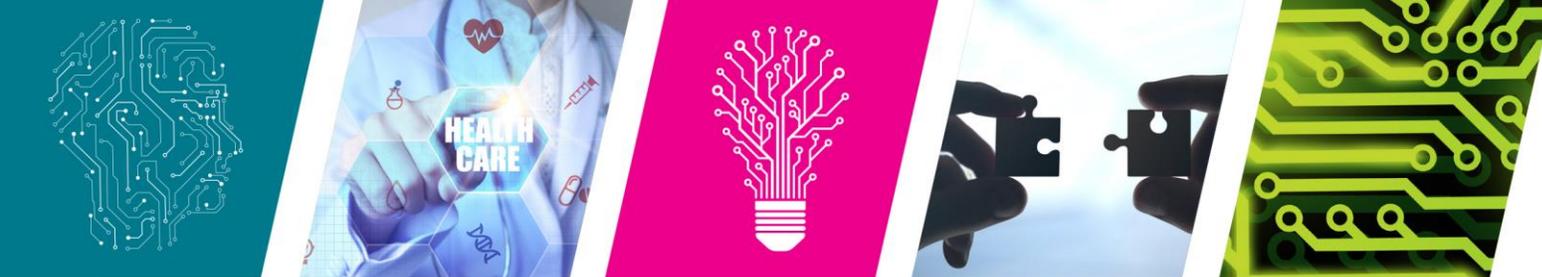


EXECUTIVE SUMMARY

The Government of Ontario has laid the groundwork for a more patient-centred health care system through the recent passage of *Bill 41: An Act to amend various Acts in the interest of patient-centred care*. This policy, which passed through its early implementation phase during the spring and summer of 2017, is intended to improve the coordination and integration of health care at the local level. By bringing the activities of the Community Care Access Centres (CCACs) into the Local Health Integration Networks (LHINs), and by creating LHIN sub-regions responsible for local planning (simply referred to as “sub-regions” in this report), Bill 41 provides a platform in which patients, caregivers, health care providers, and organizational leaders can work together to achieve meaningful local improvements in care.

However, the ultimate success of Bill 41 depends on the coordinated action of this wide range of health system stakeholders, in collaboration with LHINs and the Ministry of Health and Long Term Care. Understanding the responsibilities, opportunities, and perspectives of these various stakeholder groups is essential as Bill 41 is operationalized in the months and years ahead.

In an effort to engage representatives of these stakeholder groups in the development of a strategy for implementing Bill 41, the Women’s College Hospital Institute for Health System Solutions and Virtual Care (WHV) co-hosted a stakeholder dialogue symposium, along with VHA Home Health Care and the North American Observatory on Health Systems and Policies. The symposium took place on March 23rd, 2017, and included structured presentations from representatives of each of these groups, and breakout sessions focused on brainstorming related to key topics addressed in Bill 41. Following the symposium, the dialogue was analyzed to identify a series of action items that will help to ensure the implementation of Bill 41 is successful. These action items are as follows:



Recommendation #1: Enhance approaches to governance and accountability at the LHIN and sub-region levels to promote a more integrated patient experience of the health care system

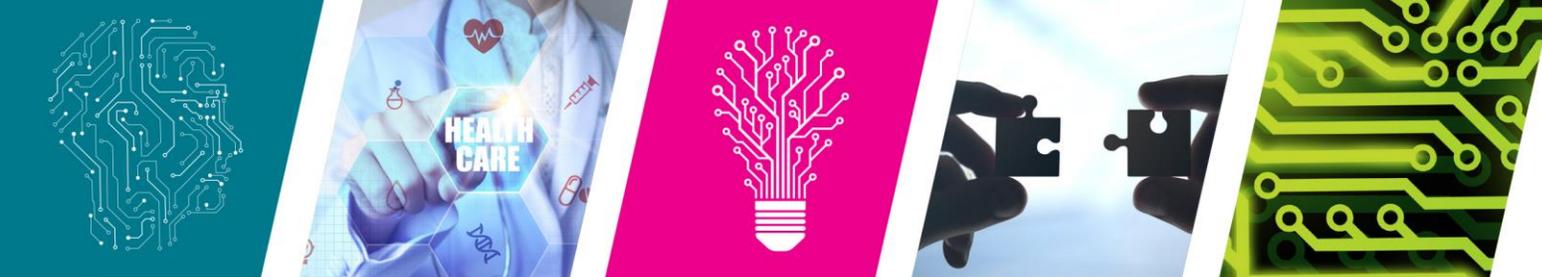
Many stakeholders in the health system acknowledge that silos exist at multiple levels. The following recommendations relate to strategies for governance and accountability that can help to promote a more integrated health system that focuses on the needs and wishes of patients and families. The development of these strategies is the responsibility of the Ministry of Health and Long Term Care (MOHLTC), LHINs, and health care delivery organizations.

- **1.1** Encourage shared accountability arrangements between health care delivery organizations wherever possible, in order to enable more integrated patient experiences of the health care system.
- **1.2** Establish clinician-level accountability mechanisms for more integrated care.
- **1.3** Develop incentives to build collaborative relationships with non-health system stakeholders, in order to connect patients with all the services they need.

Recommendation #2: Establish metrics and measurement strategies that provide a clear picture of quality across the continuum of care, and reflect the perspective of patients, families and providers

Effective quality improvement and health system change relies on the availability and use of accurate data relevant at the sub-region level. The following recommendations relate to identifying relevant metrics in ways that can leverage the knowledge available within the health system. Developing and communicating the importance of these metrics is the responsibility of the MOHLTC.

- **2.1** Patients and caregivers should be systematically engaged to help co-design priority metrics that can be used to guide the implementation of Patients First.
- **2.2** Build health care providers perspectives and experiences into the evaluation of Patients First.
- **2.3** Enable provider and manager access to performance data relevant to their local level of care delivery.



Recommendation #3: Leverage the sub-regions to enable health care providers to develop, scale and spread innovative strategies of care delivery

Innovating in Ontario's health care system will depend on those people who work in it every day. The following key points relate to strategies to leverage the creativity and interests of health care providers to enable the innovation sought through Bill 41. These strategies are the responsibility of the MOHLTC, LHINs and clinicians.

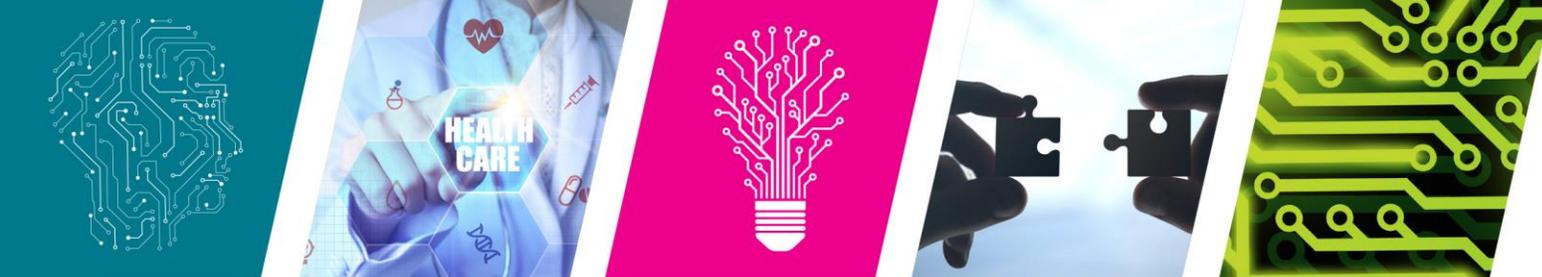
- **3.1** Identify and share best practices for engaging health care providers in the local development of innovative initiatives, including care coordinators.
- **3.2** Build clinical leadership at the sub-region level.
- **3.3** Streamline administrative functions to make innovation easier.
- **3.4** Build on innovative funding models that promote innovation, and particularly those in the areas of digital and mobile health.
- **3.5** Develop a provincial communications plan that emphasizes provider opportunities for innovation.

Recommendation #4: Continue to engage patients and caregivers as central partners in health system planning

The last recommendation, but arguably one of the most important, is a continued commitment to patient and caregiver engagement in all of the above processes. The following action items represent key elements of a strategy to achieve true engagement for the implementation of Bill 41. Patient engagement is the responsibility of the MOHLTC, LHINs, and organizations responsible for planning and delivering health care.

- **4.1** Continue to enable patient and caregiver engagement at the level of the LHINs and sub-regions.
- **4.2** Support training and capacity development of patients and caregivers.
- **4.3** Develop a communications strategy specifically directed to patients and the public that tells the story of how the health care system is changing, why, and what will be different for them as users of the system.

In addition to these key points, the stakeholders identified a number of topics that require further work in order to promote the best outcomes for the Patients First policy.

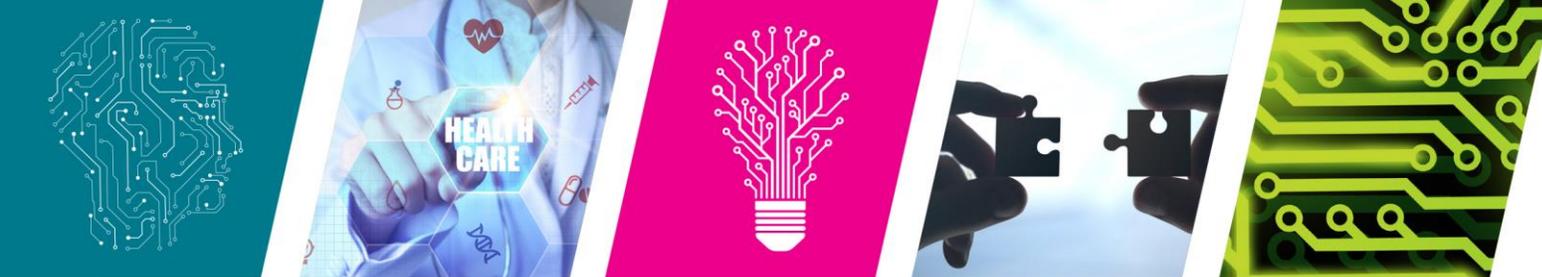


These included (a) *Establishing standards versus standardizing practice*, (b) *Sharing accountability across organizations and providers*, (c) *Getting data to those who need it*, and (d) *Health human resources and labour force planning*. We believe these warrant sustained attention in the coming months/years in order to provide guidance for the broader health care community regarding the implications of Bill 41.

INTRODUCTION

A person-centred health care system represents the ultimate goal for health system stakeholders in Canada, in which the needs and wishes of patients and their unpaid caregivers are the primary focus of health care encounters. Such a system not only applies the most up-to-date, innovative strategies for delivering care, but also supports and enables healthy living for the entire population. Through these approaches to focusing the system's attention on peoples' needs and wishes, health care systems are best positioned to achieve the goals of the Triple Aim: improving population health, enhancing patient and family experiences, and controlling health system costs. Recent progress toward achieving these goals in Ontario is represented by progress on Bill 41, *An Act to amend various Acts in the interests of patient-centred care*.

Bill 41 represents the Ministry's approach to addressing a number of health system challenges faced by all advanced economies. These challenges include identifying the best ways to bring health care providers together across sectors of the health system, strategies for better supporting how patients and their caregivers manage complex needs in the community, and building a platform to promote local innovations in care delivery. Continuing to build on successes across the Province in better integrating patients into both regional and local health system planning is a central part of addressing these challenges. The Patients First policy recognizes this important point, and provides a framework for building a



system of locally integrated care where patients' needs and wishes are central to health care decision-making.

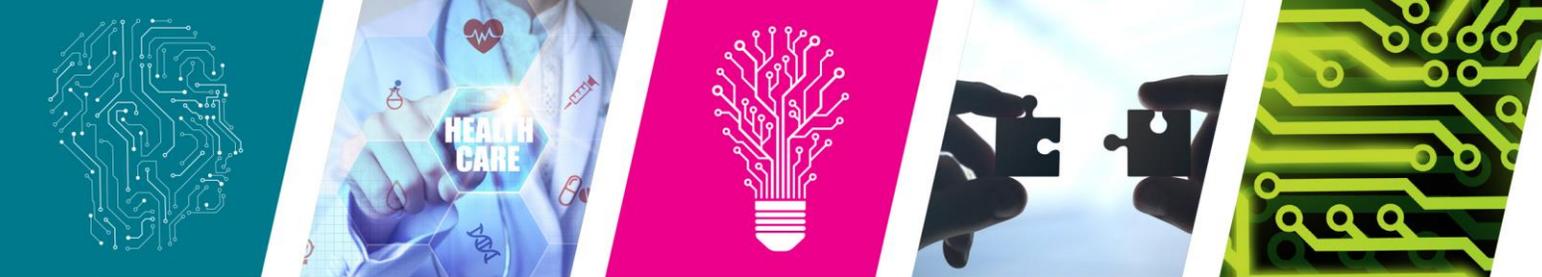
BACKGROUND

In the Ministry of Health and Long-Term Care (MOHLTC)'s 2015 Patients First: Discussion Paper, five critical areas for work were outlined that represent key health system priorities:

1. Expanding the role of LHINs
2. Facilitating timely access to primary care
3. Providing more consistent and accessible home and community care
4. Strengthening the links to population and public health
5. More prominently including Indigenous voices in health care planning

In 2016, in response to this discussion paper, the MOHLTC proposed Bill 41, An Act to amend various Acts in the interests of patient-centred care. Central features of the Bill include the transfer of functions of Community Care Access Centres (CCACs) to the Local Health Integration Networks, and the development of more localized Local Health Integration Network (LHIN) "sub-regions" as a basis for more integrated care. These key elements of the Bill represent the intention to achieve better integration across the health care continuum, and especially between primary care and home and community care settings. Although there are many components to Bill 41, the focus of this paper is on the views of key stakeholders regarding the elements that are of the highest priority to ensure that Bill 41 is implemented successfully.

One of the overarching objectives of these health system changes is that they will address unwarranted variation in care that occurs across the province and individual LHIN regions. Unwarranted variation refers not only to varied access to services and experiences of the health care system, but also to health outcomes – such as rates of surgical



amputation.¹ These issues may be the products of differences in resource availability and utilization, clinician practice patterns, and patient demand for services.²

Sub-regions present an opportunity to gain further insight into Provincial variations in care, and take a step toward possible solutions that are based in evidence but adaptable and relevant at the local level. While LHIN regions collect large volumes of data, sub-regions will have the opportunity to engage with smaller volumes of data and extract meaningful information about their populations. At the sub-region level, primary care and homecare stakeholders will have greater opportunity to address treatment of these disparities in health outcomes and access issues that exist at the neighbourhood level through integrated, inter-sectorial action.

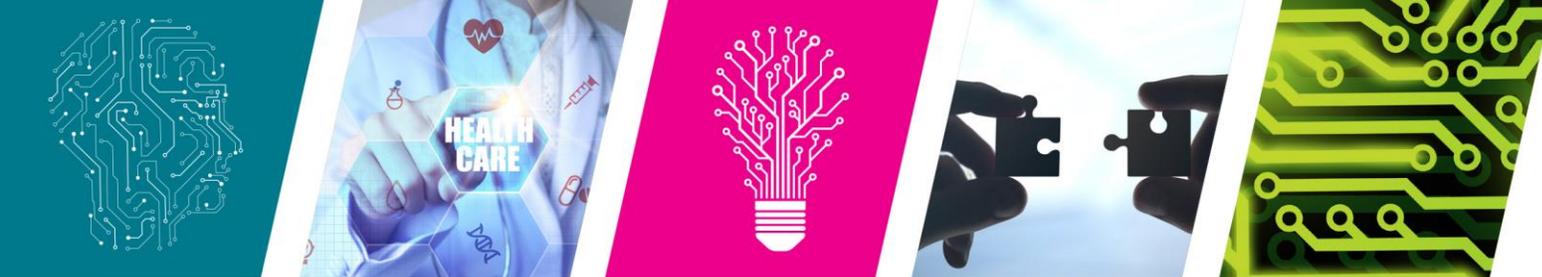
Promoting integrated, patient-centred primary care is a challenging task for health policy stakeholders around the world. The actual content of policy for integrated, patient-centred care needs to be highly context-specific, as it must incorporate features of health systems that have developed out of particular histories of health and health care.³ As Ontario navigates the implementation of Bill 41, it will be important to draw from best practices and lessons learned, and will be critical to address specific issues that have already been identified. This especially includes paying close attention to the perspectives and opinions of the individuals who will ultimately be affected once the policy is implemented: health care providers, patients, and caregivers.

Acknowledging the need to bring together best available research evidence with stakeholder views and opinions, the Women's College Hospital Institute for Health System Solutions and Virtual Care (WIHV) co-hosted a stakeholder dialogue symposium on Bill 41 with VHA Home Health Care and the North American Observatory on Health Systems and

¹John-Michael Gamble and Sonia Butalia, "Medical Practice Variations in Diabetes Mellitus," *Medical Practice Variations*, ed. Ana Johnson and Therese Stukel (New York: Springer US, 2016), 323-359.

²BW Holcomb, AP Wheeler and EW Ely, "New ways to reduce unnecessary variation and improve outcomes in the intensive care unit," *Current Opinion in Critical Care* 7, 4. (2001):304-311.

³Gregory Marchildon and Brian Hutchinson, "Primary care in Ontario, Canada: New proposals after 15 years of reform," *Health Policy* 120, 7. (2016): 723-738.



Policies. This report outlines a series of themes and recommendations that arose during symposium discussion regarding the implementation of this Bill.

CONTEXT FOR PATIENTS FIRST

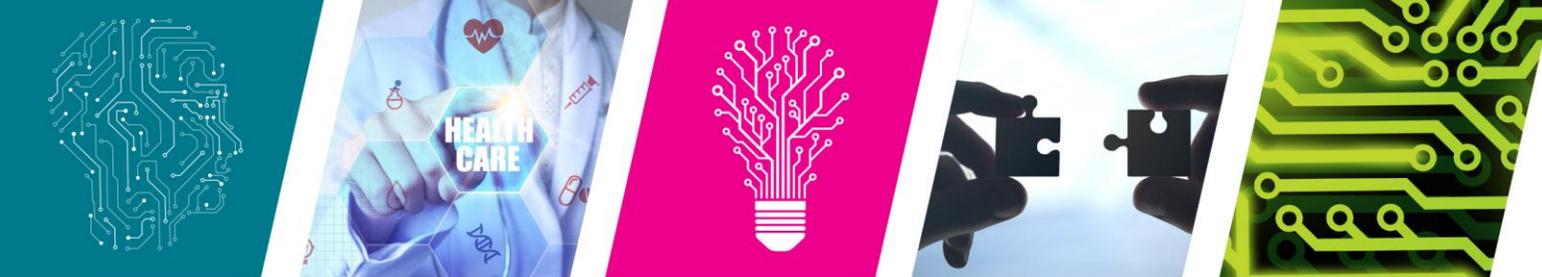
Efforts to improve integrated care here in Ontario have been informed by lessons learned from international initiatives that have leveraged integrated care as a tool to address health care system fragmentation. A study by Wodchis et al (2015) compared case studies from Australia, New Zealand, Sweden, the US, the UK and Quebec, which have implemented community-based, multi-disciplinary teams or service delivery networks⁴ with the goal of achieving the triple aim.

Recognizing that there is no single ‘best approach’, and that positive outcomes can be achieved through a variety of strategies, these case studies indicate some key insights for Patients First. Integrated care goals can be set by national and sub-national governments through high-level visioning, priorities, and financial incentives, but integration generally occurs at a more local level. Achieving such local integration is facilitated by partnerships, relationships and trust building at the clinical and managerial levels. Additionally, technological supports remove barriers to sharing information and care.

Local level innovation and integrated care networks offer valuable opportunities for achieving high performing health systems. However, these case studies offered that at the local level, improving the engagement of both patients and providers throughout the process was still a critical area that needs strengthening. Across all of these case studies, several key mechanisms for service providers and policy makers regarding implementing integrated care were identified. They are listed in Box 1.⁵

⁴Walter Wodchis, Anna Dixon, Geoff Anderson, and Nick Goodwin, “Integrating care for older people with complex needs: key insights and lessons from a seven-country cross-case analysis,” *International Journal of Integrated Care* 15, 21. (2015).

⁵Ibid.



Box 1. Mechanisms for Integrated Care

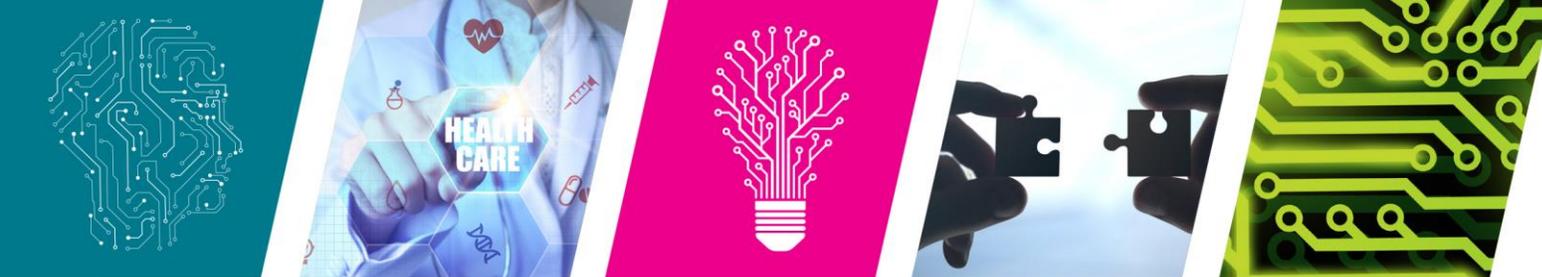
1. Focus on clinical integration rather than organizational or structural integration
2. Foster good communication and relationships among those receiving care and the professionals and managers involved in delivering care
3. Employ multidisciplinary teams with well-defined roles and joint responsibility for care
4. Recognize the importance of addressing the agenda of integrated care for complex populations
5. Provide stimulus through funding or other means to support the development of local initiatives to improve care
6. Balance top-down policy goals with strategies to promote local engagement
7. Remove barriers that make it more difficult for providers to integrate care, such as differences in financing and eligibility of patients for needed care

SETTING THE STAGE FOR PATIENTS FIRST

Drawing on recent international best practices, Patients First is a timely approach to transforming the way that care is integrated and coordinated throughout the province. The Patients First symposium offered several key insights and recommendations that will inform Ontario's implementation of the Bill, and many of these lessons draw on insights learned from the international best practice case studies just summarized.

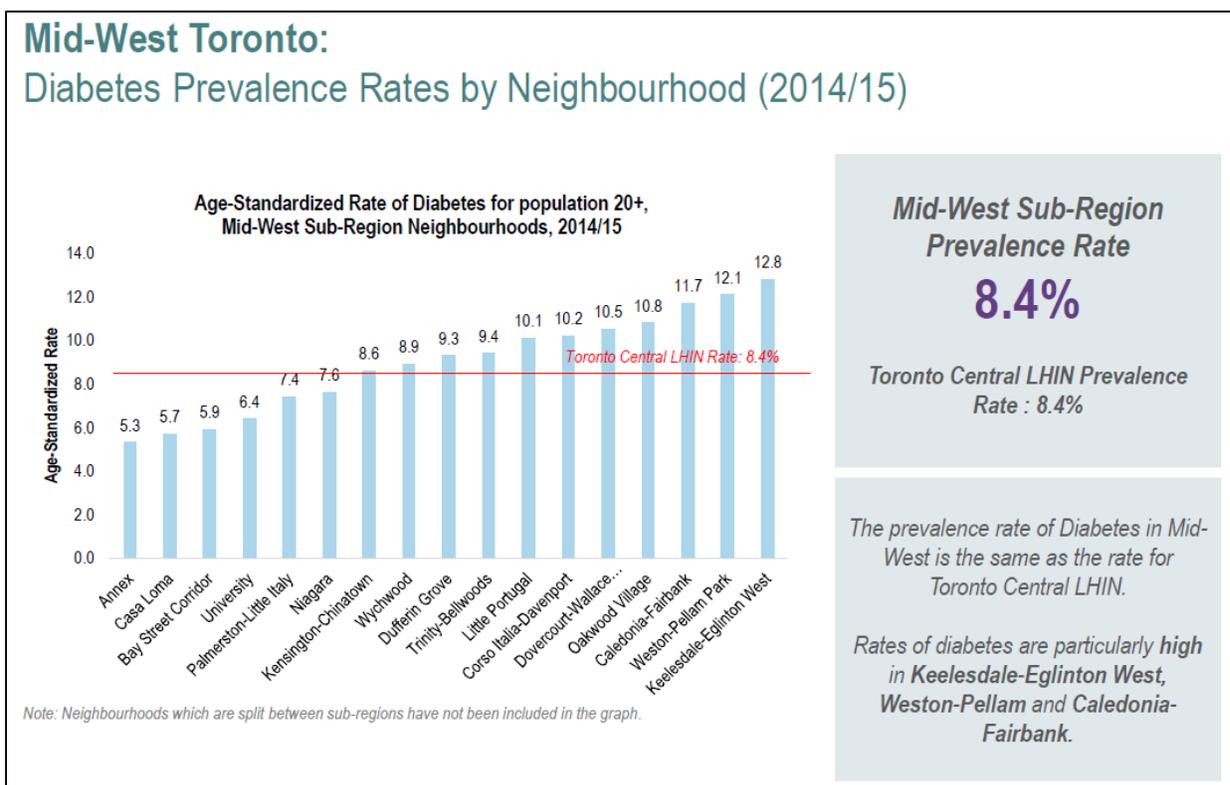
Historically, the LHIN model has provided the capacity for regional planning and delivery of care. However, this model may not allow for the tailored local-level approach that is needed to address issues of appropriateness of care, unwarranted variation, and to deliver equitable care to marginalized populations based on disparities caused by the social determinants of health. The introduction of sub-regions will ideally create smaller-scale platforms for improvement and innovation throughout the system.

Ontario's 76 sub-regions will have on average 153 physicians per region; proportionate to the size and needs of the sub-regions. Based on this flexibility, patients, caregivers, care coordinators and physicians in sub-regions will have the opportunity to build trust and partnerships that will support local-level co-designing and innovation during

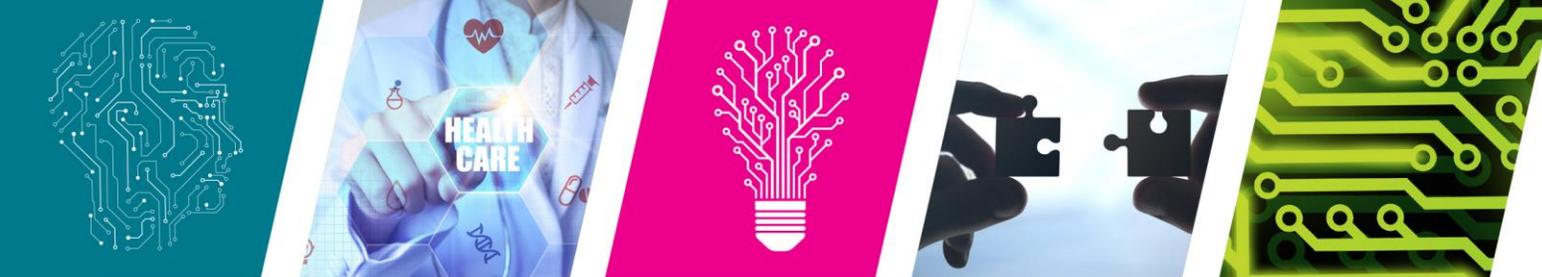


planning and implementation of how best to integrate care. Sub-regions also provide the opportunity to draw insights from local-level data. For example, the Toronto Central LHIN has already analyzed data related to population health needs in sub-regions, presented in publicly available infographics such as that available in Figure 1.

Figure 1. Diabetes Prevalence in Mid-West Toronto (Toronto Central LHIN sub-region)



The development of sub-regions also raises the importance of care coordinators as a professional group. With a clearly defined role and stronger presence of care coordinators in primary care, as well as home and community care, this important professional group will be critical in assisting patients with navigating the health care system across *all* sectors.



Building on existing professional networks and referral patterns, care coordinators will also play a role in ensuring that the establishment of sub-regions does not disrupt current health care delivery for patients. In the next section, we describe the structure of the symposium and provide an overview of the day’s discussion.

THE SYMPOSIUM: STRUCTURE AND DIALOGUE

The stakeholder dialogue symposium was a day-long event on March 23, 2017 which engaged a diverse group of key stakeholders including patients and caregiver representatives, physicians, leadership from the MOHLTC, LHIN and hospital executives, representatives from the City of Toronto, and representatives from the Premier of Ontario’s office. There were 45 attendees in total. The symposium was conducted under Chatham House Rules, meaning that the identities of the symposium participants were not linked to particular statements in order to promote honest, productive dialogue. The symposium agenda is provided in Appendix A.

The symposium was intended to engage a diverse range of stakeholders in discussion about the promises and challenges of Bill 41, developing recommendations collaboratively to foster positive impact across Ontario. Prior to the symposium, participants completed a survey of the key issues to be addressed related to Bill 41 (25 responses were received). Issues ranged from the role and location of care coordinators to the development of an evaluation plan, and were used to structure the discussion during the symposium. Figure 2 shows participant responses before the symposium regarding what became a central topic of discussion: promoting integration between primary care and home care (respondents were prompted to “select all that apply”).

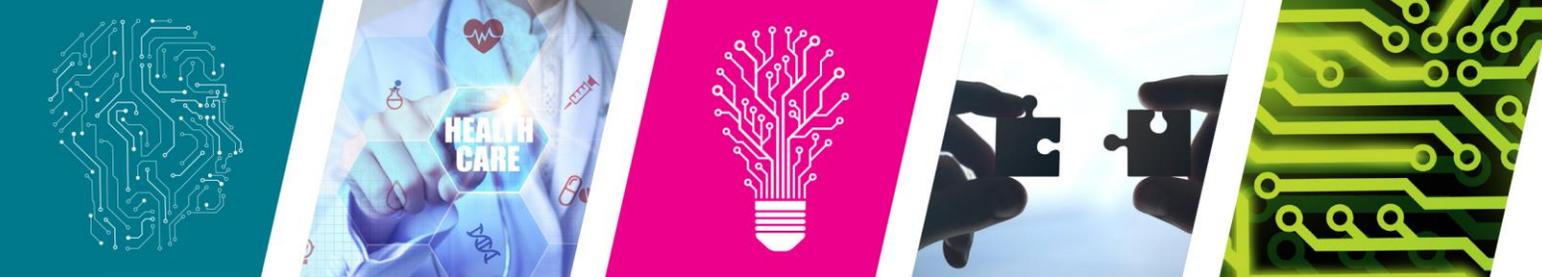
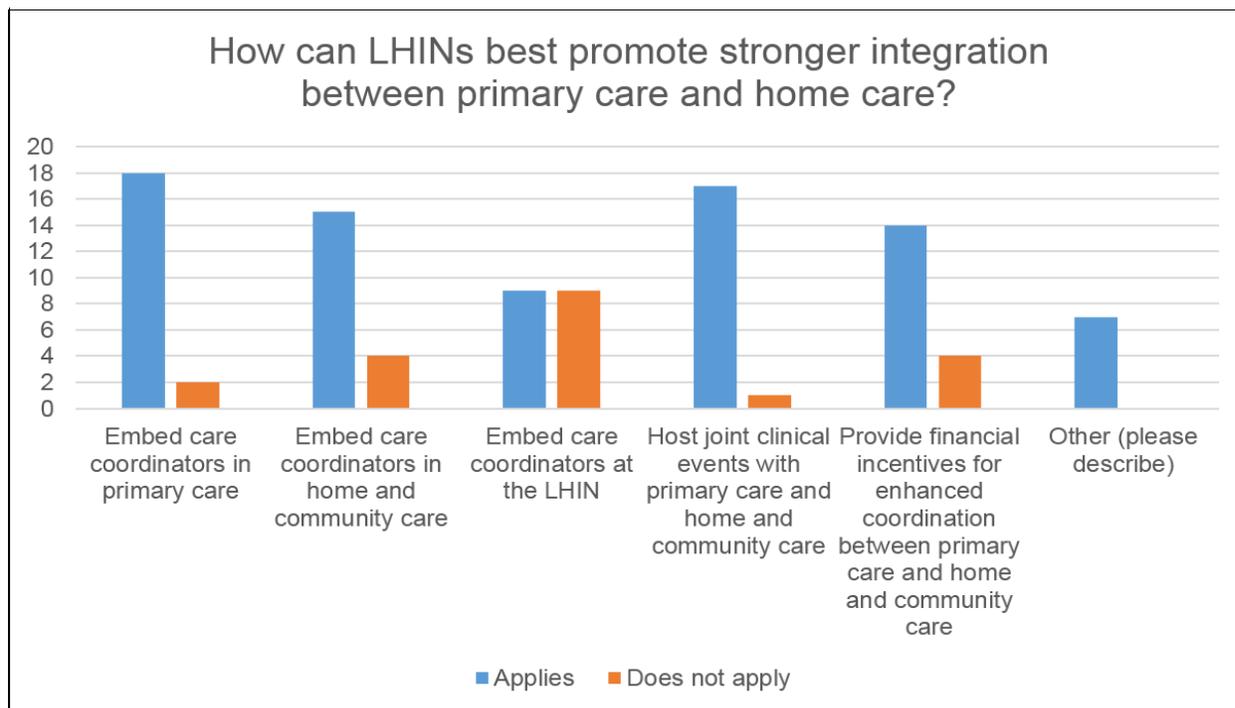
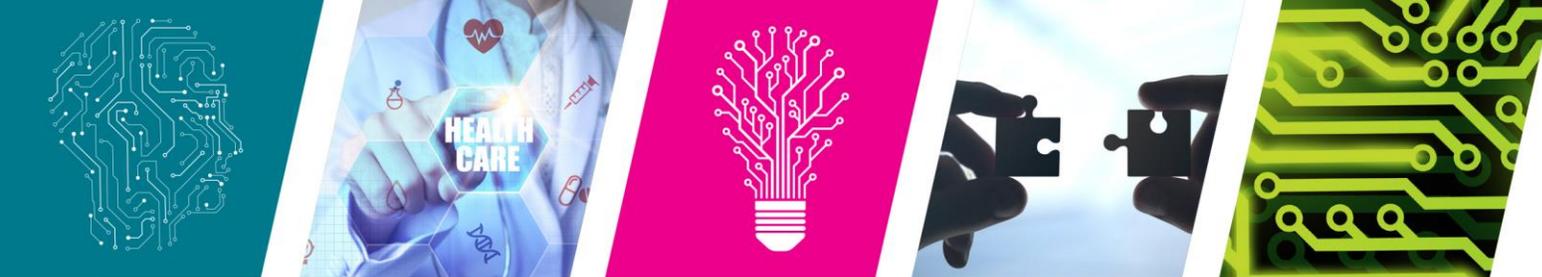


Figure 2. How LHINs can promote integration



The morning sessions at the symposium engaged attendees in four interactive panels, focusing discussion on (1) patient and caregiver perspectives on care coordination, (2) international lessons learned on integrated care, (3) the perspectives of primary care physicians on the way forward with Bill 41, and (4) the perspectives of health care organizational leaders on facilitating meaningful change. Breakout sessions on clinician engagement, governance and accountability, and mechanisms for success were held in the afternoon with participants self-selecting which breakout session to attend. The day concluded with a final group discussion to summarize and synthesize the key themes and priorities of the day.

Following the symposium, a follow-up survey was completed by participants to determine whether the summary of key themes arising from the discussion resonated with



their experiences (14 responses were received). The following action plan summarizes both the symposium discussion and the post-symposium survey results.

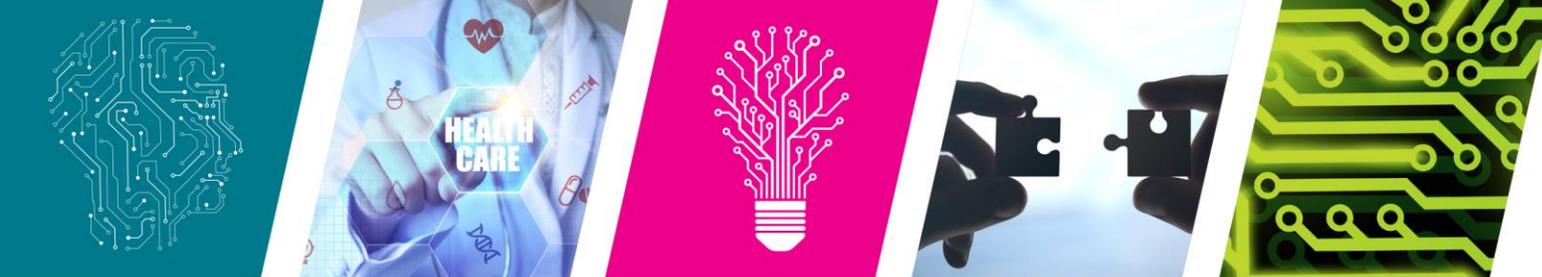
AN ACTION PLAN FOR ACHIEVING THE GOALS OF PATIENTS FIRST

Over the course of the symposium, participants engaged in discussion related to care coordination, integrated care, silos in health care, patient engagement, and other issues pertinent to the successful implementation of Patients First. Several key priority areas emerged which warrant consideration, and have been used to structure this discussion paper. The action plan is presented below as a series recommendations followed by concrete action items that symposium participants agreed most need attention moving forward.

Recommendation #1: Enhance approaches to governance and accountability at the LHIN and sub-region levels to promote a more integrated patient experience of the health care system

- **1.1 Encourage shared accountability arrangements between health care delivery organizations wherever possible, in order to enable more integrated patient experiences of the health care system.**

Many organizations in the current health care landscape in Ontario report to independent Boards of Directors, based on activities identified as strategically important at the organizational level. However, effective integration of care in Ontario requires the coordinated efforts of organizations working toward the same goal. To accomplish this, organizations must be held accountable for goals that require collaboration to achieve, such as population-level metrics at the sub-region level (e.g., reducing the frequency of hospitalization caused by exacerbations of certain chronic diseases).

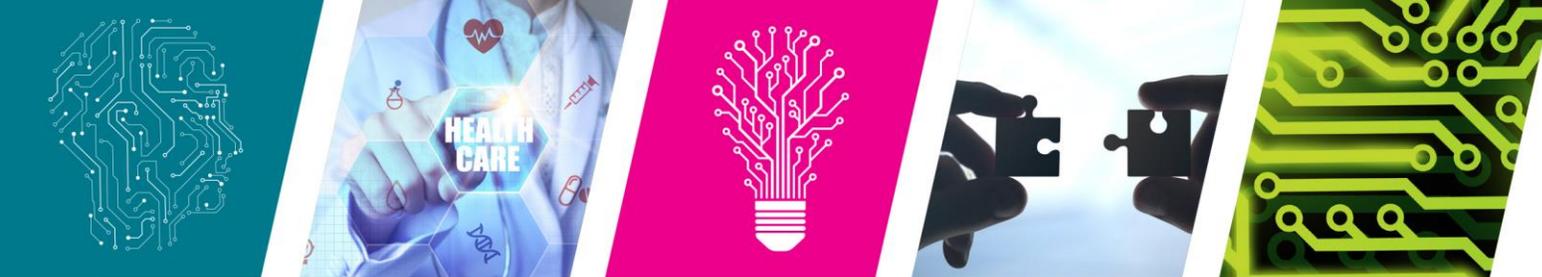


The success of accountability mechanisms intended to promote collaboration depend on trust and take time to develop. Where pre-existing trust and interest in shared accountability exist, collaborations between organizations could be formalized with mechanisms such as “accords” or memoranda of understanding to represent the shared commitment to collaborative local health care provision. These organizations can then share their learnings with others in the province to promote the broader adoption of such strategies. *Enacting this recommendation will require the coordinated effort of the Ministry (to endorse such an approach), LHINs to lead their development, and health care delivery organizations to spearhead and support the process.*

- **1.2 Establish clinician-level accountability mechanisms for more integrated care.**

Strategies to hold health care providers accountable, based on clear governance structures, will also be important. For many health care providers, organizational mechanisms exist to promote accountability related to their employment status. For others, such as independent contractors in the home care sector and physicians across sectors, alternative accountability strategies are necessary. As a starting point, it is important to take stock of the many accountability mechanisms currently in place for different health care provider groups. Only then can the Ministry, LHINs, and health care organizations leverage the means at their disposal to ensure that health care providers adopt more integrated strategies of care delivery.

- **1.3 Develop incentives to build collaborative relationships with non-health system stakeholders, in order to connect patients with all the services they need.** This means actively creating links with the many groups working on the broader social determinants of health, including housing, education, community mental health services, and the shelter system. Although the development of

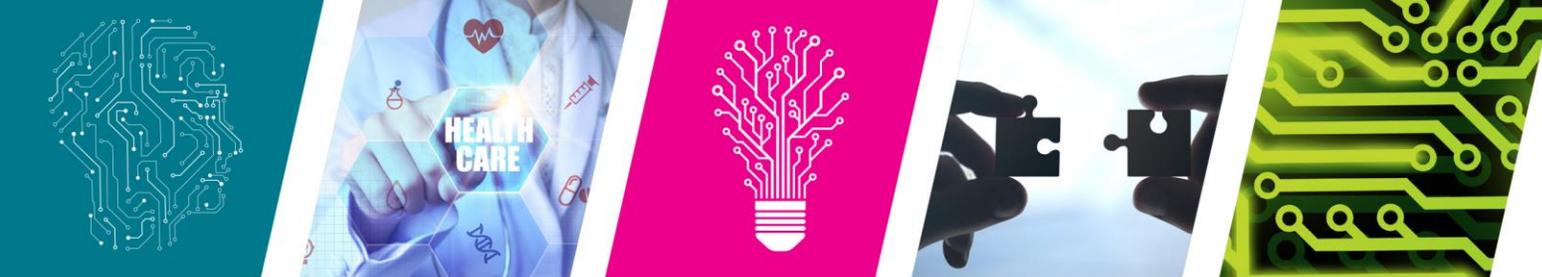


collaborations can be supported by provincial systems, collaborative relationships across sectors must fundamentally be driven at the local level. The important work already accomplished with the Health Links model of care provides a starting point for inter-sectorial approaches to improving population health and health care. However, the role of Health Links in the sub-regions remains unclear to the broader health care community. The MOHLTC should clarify how the Health Links will interface with sub-regions, and encourage LHINs and sub-regions to build upon the important work already completed by Health Links in their geographic areas. Ultimately, the work of building relationship between health system stakeholders and those outside the system, such as housing services, will require focused attention from LHINs at the sub-region level.

Recommendation #2: Establish metrics and measurement strategies that provide a clear picture of quality across the continuum of care, and reflect the perspective of patients, families and providers

Incorporating patient- and caregiver-focused metrics as primary indicators of success will help to drive the Patients First policy forward. These metrics exist in isolated instances across the province, but are not yet in widespread use for evaluating the quality of care. Furthermore, access to real-time data across the continuum of care is limited, which makes it difficult to follow patients through the system to identify quality across the continuum of care. In the absence of real-time patient data, existing datasets and metrics should be coordinated and leveraged to develop clear, measurable targets.

Furthermore, this data can be compared against existing datasets (e.g., Commonwealth Fund, OECD) to develop clear objectives for improvement across the health system. Fundamentally, developing and disseminating this data infrastructure is the responsibility of the MOHLTC.

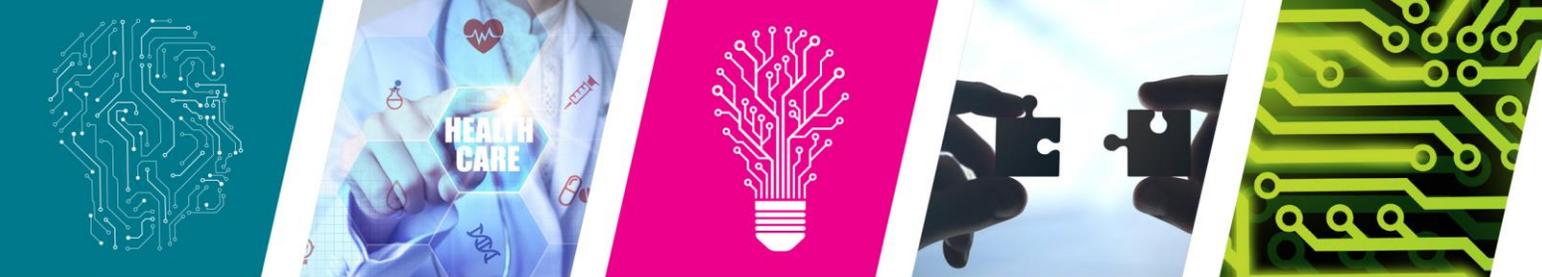


- **2.1 Patients and caregivers should be systematically engaged to help co-design priority metrics that can be used to guide the implementation of Patients First.** Patients and caregivers must be engaged to help inform the ways in which both the process and outcomes of achieving integrated care in sub-regions are understood. These metrics can then be leveraged to create clear targets for providers to which they can be held accountable to, and to improve the overall quality of care.

The processes of engaging these stakeholders must be conducted with acknowledgement of and respect for the diverse perspectives and narratives of patients and caregivers from different cultural and geographic locations. Although the MOHLTC will set an example for the ways in which patients and caregivers can be engaged in health system planning, the *LHINs must also play a substantial role in ensuring patients and caregivers are involved in the implementation of sub-regions.*

- **2.2 Build health care providers perspectives and experiences into the evaluation of Patients First.** The system of metrics built for Patients First should also incorporate health care provider experiences. Health care providers represent the engine of health care, and the extent to which they are satisfied with their work is a key consideration in the provision of high quality health care. The inclusion of health care provider experience, in addition to metrics co-designed by patients and caregivers, will contribute to solutions that work for everyone across the health care spectrum.

The fourth tenet of “the quadruple aim” incorporates health care provider experience as a metric of health system quality (in addition to patient experience, population health, and health care costs). Based on this “fourth aim”, Patients First can support innovation by explicitly incorporating a focus on the capacity of health care providers to apply their creativity and compassion to providing better care. This



will enable a better understanding of how health care providers are responding to and engaging with the Patients First agenda.

- **2.3 Enable provider and manager access to performance data relevant to their local level of care delivery.** Understanding how to improve care at the local level requires access to local level insights. This means the availability of information to help understand current challenges at the sub-region level. One important step forward will be enabling health care providers and managers to have access to data about their performance (as individual clinicians and as organizations), and the performance of their local area, that can be used to drive improvement activities forward.

Recommendation #3: Leverage the sub-regions to enable health care providers to develop, scale and spread innovative strategies of care delivery

In partnership with patients and communities, Ontario’s health care providers represent the innovative potential that will drive the future of the health system. Efforts to innovate in health care build on these individuals, as health care providers work to establish new models of care, technologies, and other best practices that stand to improve individual and population health. However, more work needs to be done to support the innovative potential of Ontario’s health care providers. Table 1 provides concrete examples as a starting point for the ways in which different stakeholders might promote the development, scale and spread of innovations across the province.

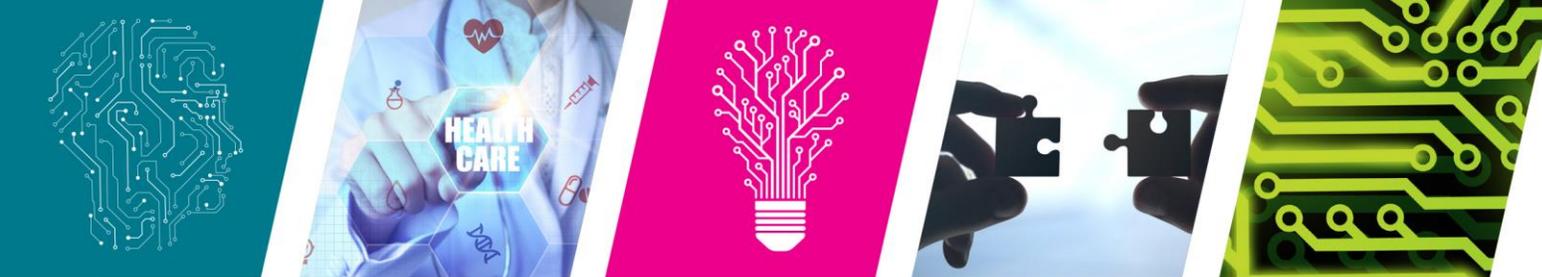
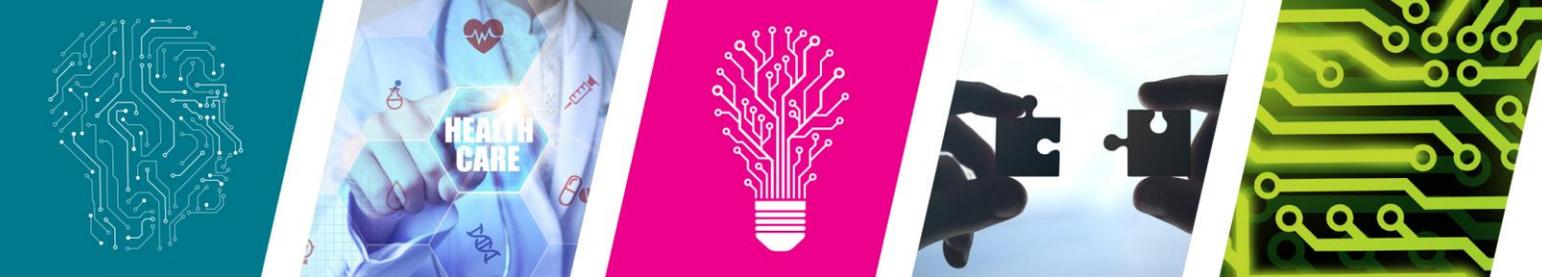


Table 1. Strategies to Operationalize Innovation in Patients First

LHINs	Health Care Delivery Organizations	Health Care Providers
<p>Standardize administrative and office procedures.</p> <p>Support the development of data sharing agreements.</p>	<p>Integrate supply chains across the continuum of care.</p> <p>Develop data sharing agreements with other organizations.</p> <p>Establish shared accountability agreements with organizations along the continuum of care.</p> <p>Partner with research and innovation organizations to support clinician engagement.</p>	<p>Disseminate successful models of care in Provincial fora.</p>

Recommendation #3 entails the largest number of specific recommendations. We believe this domain of the action plan is essential, and will require leadership from the MOHLTC along with commitment by each LHIN to support and enable innovation. In addition, the capabilities of health care organizations and commitment of health care providers will be fundamental to ensuring this recommendation comes to fruition.

- 3.1 Identify and share best practices for engaging health care providers in the local development of innovative initiatives.** In cases where local areas have been successful with innovative initiatives, what were the conditions in which those initiatives thrived? Sharing the answer to this question, along with key processes and strategies followed to engage health care providers in innovative activities, will be essential to ensuring that best practices spread across the province instead of remaining only at the local level. For example, symposium participants

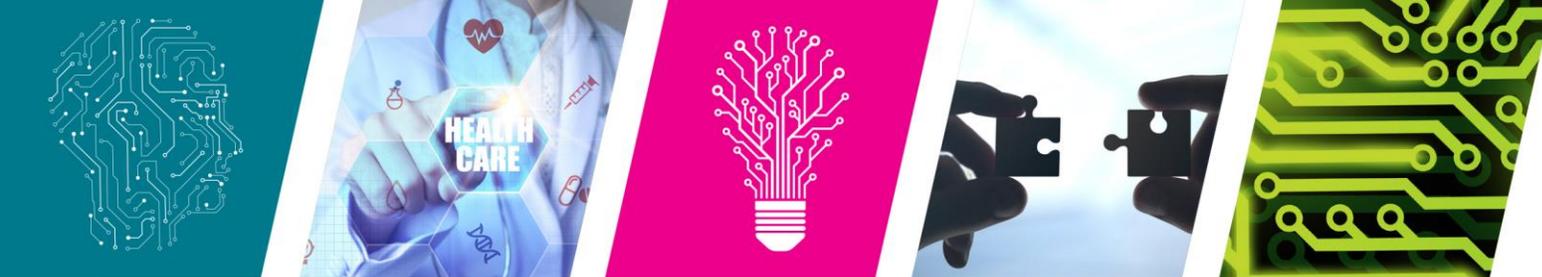


acknowledged that health care providers “commit to what they create”, and so the early engagement of providers in service innovation and change is essential. Sharing strategies to support such engagement will help to enable the spread of innovative activities across the province.

One important group of health care providers to promoting innovation for the Patients First agenda is care coordinators. These professionals have a diverse role that is focused on helping patients navigate the health system (beyond simply assigning resources for home health care services). Their broad scope includes navigation to link primary care, home care, acute care, and other sectors of social support systems.

In order to boost the role and success of care coordination in the health system, the existing group of care coordinators need to be supported to innovate in patient-centred ways. This means supporting **communities of practice** in which care coordinators can discuss practice issues, share best practices, and collaborate to bring those best practices to the point of care in sub-regions. Drawing on the extensive expertise that already exists in this important area, the implementation of Patients First can further support care coordinators to clearly define their role, and clearly state their responsibilities in sub-regions. *This effort will need to be provincially relevant, and therefore should be led by the MOHLTC. Leaders in the field of care coordination will need to be engaged to develop a community of practice for care coordinators.*

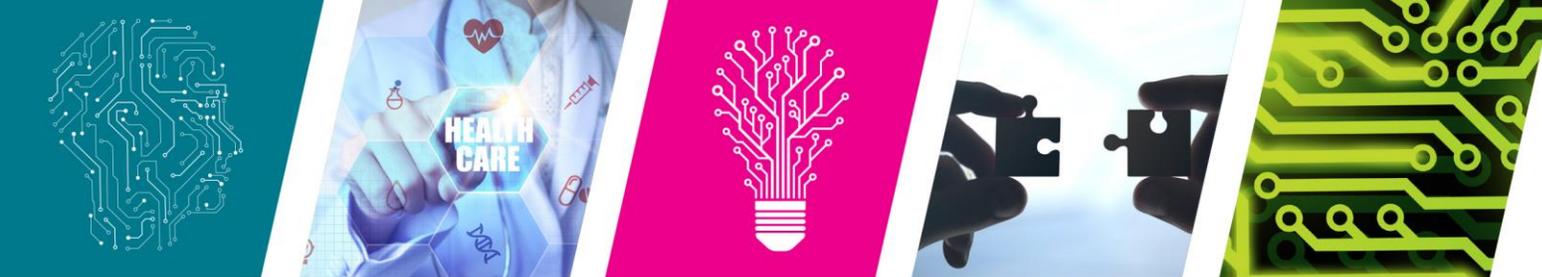
- **3.2 Build clinical leadership at the sub-region level.** Based on the approach already seen in the development of many sub-regions, local clinical leadership is essential. Such leadership motivates the development and adoption of innovation in practice, and enables the rallying of support for the spread of innovations to new local areas. Although the work of developing clinical leaders will begin with physicians, leaders from the home care sector and community mental health will also



be necessary to achieve meaningful integrated care. *The LHINs should take a prominent role in identifying and supporting clinical champions who have high potential to act as leaders in local communities.*

- **3.3 Streamline administrative functions to make innovation easier.** Although the capacity to promote and encourage innovation has become an important leadership capability and has become a part of the broader health system conversation, administrative barriers to innovative practice remain. These barriers often relate to the risk aversion of mid-level managers and health care providers, who hesitate to try new processes of care delivery due to perceived or actual policy barriers. This risk averse mindset is also prevalent across individual organizations and clinicians based on service or program contracts, or funding rules and restrictions.

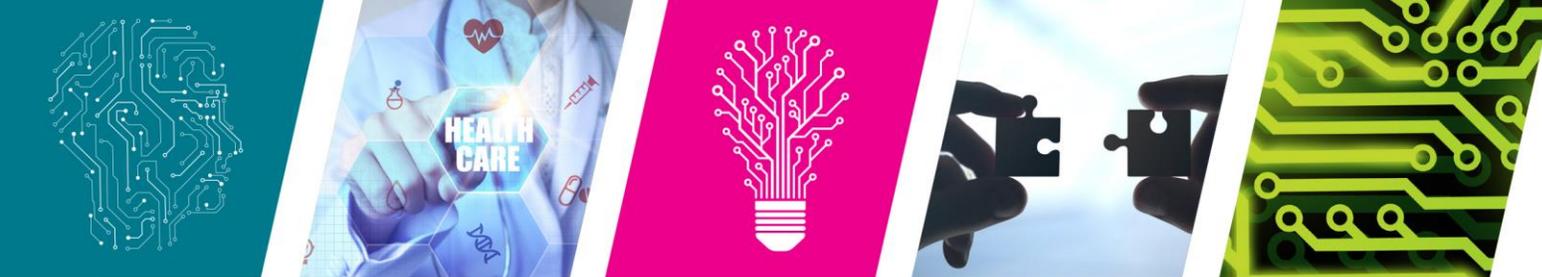
One specific action item may help to streamline administrative processes in order to better promote innovation: LHINs could encourage the innovation-focused review of policy and administration procedures at the LHIN and sub-region level to identify possible barriers and enablers of innovation. This review could take place from a design-focused perspective, examining the ways in which collaborative activity could be further enabled through user-centred administrative design. Successful minimization of administrative burden could lead to streamlining approvals for information technology, procurement processes, and other innovation-oriented activities. One example of an administrative burden that could be solved quite simply is the need for home health care agencies to seek out approval from the Community Care Access Centre to recruit their patients into research – removing this barrier would enable a stronger scientific presence in home care, supporting innovation in clinical practice.



- **3.4 Build on innovative funding models that promote innovation, and particularly those in the areas of digital and mobile health.** These efforts also require reevaluating existing funding silos, in order to adequately fund providers and models of care that require support to engage providers in local level innovation. The MOHLTC should closely examine the ways in which current health system funding projects interface with the activities of sub-regions, identifying opportunities for re-aligning financial incentives to promote stronger integration.
- **3.5 Develop a communications plan that emphasizes provider opportunities for innovation.** A number of challenges unrelated to the Patients First policy have posed barriers to engaging a wide range of health care providers in its successful implementation. To address this concern, a new communications plan targeted specifically at health care providers could emphasize the opportunities for involvement, leadership, and innovation at the local level, represented by sub-regions. This new communications plan could focus on the positive elements of this opportunity, and feature health care providers in positive ways – for example, by highlighting existing innovations already taking place at the sub-region level.

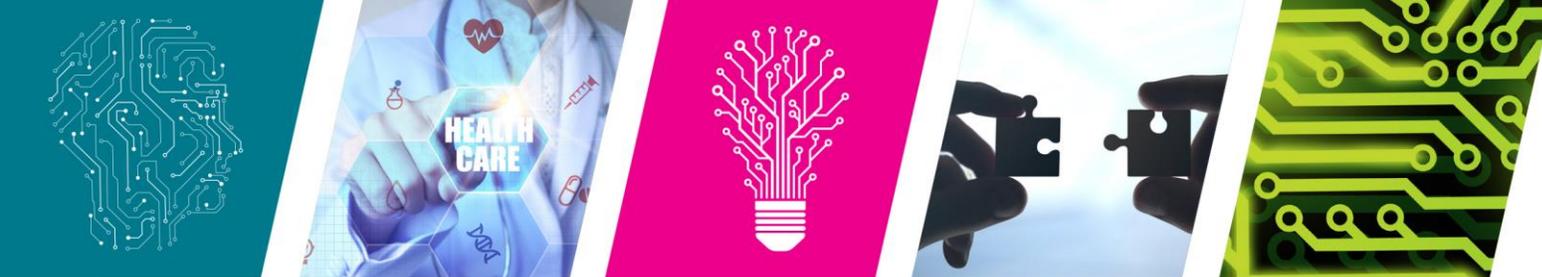
Recommendation #4: Continue to engage patients and caregivers as central partners in health system planning

The last recommendation, but arguably one of the most important, is a continued and deepened commitment to patient and caregiver engagement in all of the above processes. While patient advisory committees are being increasingly engaged as key stakeholders in health care planning and are routinely consulted throughout the health care system, gaps in patient engagement are still being identified. Patient advocates report that many patients and their unpaid caregivers continue to struggle with the need to navigate the health care system on their own.



One of the goals of localizing care in the sub-regions is to leverage local-level relationships between patients and providers, and to enhance the capacity of sub-regions to be responsive to needs as they arise. Sub-regions also represent the opportunity to engage representatives of local communities for their knowledge of the community itself, as opposed to their experience with the health system. In this way, health care organizations can better incorporate understandings of people as they live their everyday lives, as opposed to simply the ways in which they interact with health care. Achieving these goals will require leadership from both LHINs and health care delivery organizations, attending to community representatives at the sub-region level.

- **4.1 Continue to enable patient and caregiver engagement at the level of the LHINs and sub-regions.** This will help to incorporate patient and caregiver perspectives more strongly into planning and organization of sub-regions. Caregivers also have a specialized understanding of the health care system and can therefore provide nuanced observations and advocacy regarding patients' barriers to health system navigation. However, moving beyond a narrow focus on the health system, these efforts can extend to other members of the community with a better understanding of daily population health. LHINs should lead the development of partnerships at the LHIN and sub-region levels, focused on better understanding community needs.
- **4.2 Support training and capacity development of patients and caregivers.** Developing a comprehensive approach to enhancing capacity among patients and caregivers would help to boost local patient engagement in the planning process. This support would also encourage and reaffirm the work of patients and caregivers to show them that their input is valued and meaningful. Examples of strategies to support the capacity of patients and caregivers to contribute to health system planning include one-time, online educational courses about the health system, in-



person and online communities (like patient councils), as well as the appointment of patients to ongoing governance roles.

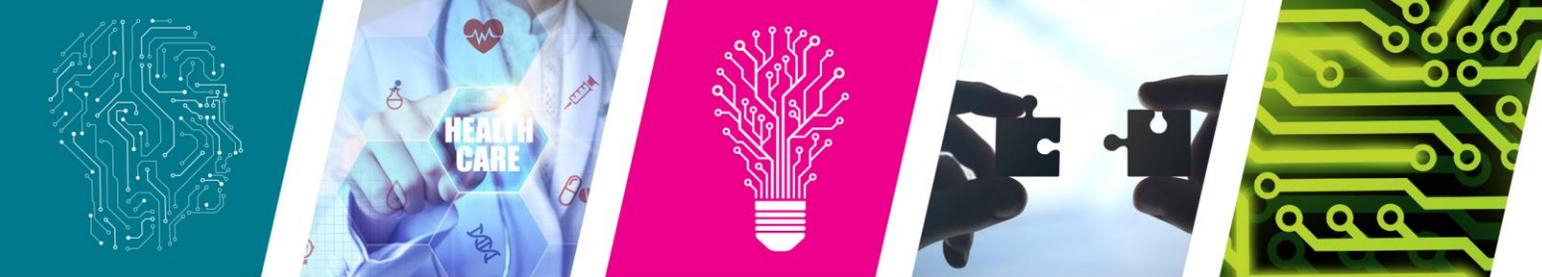
- **4.3 Develop a communications strategy specifically directed to patients and the public that tells the story of how the health care system is changing, why, and what will be different for them as users of the system.** Such a communications plan would focus on what this policy means for them, and could help to clarify the overarching purpose of Bill 41 for the broader public. Emphasizing the local-level nature of health system planning that arises from the policy, this plan could assist in communicating the implications of Patients First for patients in local areas.

DISCUSSION: TOPICS FOR FURTHER WORK

Despite the broad agreement on the action items reported here, a number of complex issues were also raised through symposium discussion which warrant further attention. These issues represent ongoing debates and challenges in the health system. *We acknowledge that these topics for discussion transcend the work of implementing Bill 41, but are nonetheless directly relevant for the Patients First policy agenda.* In this brief discussion, we summarize these points that need attention and encourage the broader health care community to commit to further work addressing these topics as Bill 41 is implemented across Ontario.

Establishing standards versus standardizing practice.

The persistence of unwarranted variation in access to care, experience of care, and health outcomes indicates that standardization across Ontario is a continual challenge. Our symposium discussion suggested that certain things, such as administrative procedures, should be standardized while others should not, such as collaborative models of care



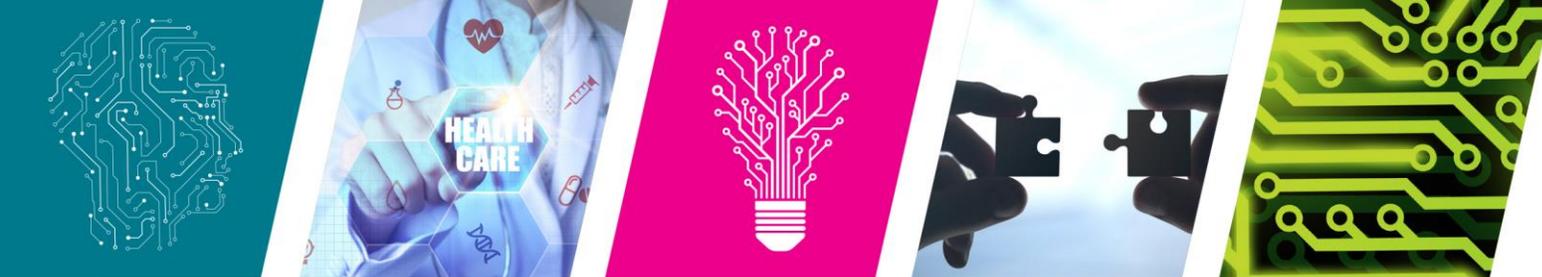
delivery and the organization of some specialized services. Activities such as developing new models of care delivery are fundamentally local endeavors; they depend on the resources available in particular communities. However, office and administrative procedures represent activities that could be standardized to promote simpler collaborations across local areas, which would also help to facilitate efforts to spread and scale innovations. But the question remains for further debate: **Which activities should be standardized across the province, and which should be adapted to local areas?** We suggest this is a key topic for further stakeholder discussion in Ontario.

Sharing accountability across organizations and providers.

Several of the recommendations made throughout this roadmap draw heavily on the notion of improving, and in many cases instituting new accountability measures. These accountability measures and structures represent a key mechanism that aims to contribute to minimizing unwarranted variation and discrepancies in the quality of care between providers and regions. Presently, there are gaps regarding the accountability of primary care providers and specialists outside of hospitals in part due to limited means of measuring patient outcomes and patient experience across the continuum of care. For example, **what meaningful strategies are currently in place to hold physicians accountable for the quality of care** they provide? Hospital admitting privileges apply for those working in hospital care, but what about primary care? These challenges, and those related to promoting shared accountability between organizations warrant further stakeholder dialogue and debate.

Getting data to those who need it.

The availability of real-time, locally-relevant health care performance data will become increasingly important in the coming years. As data about patient experience, patient-reported outcomes, clinical and diagnostic information, regional variations, and broader system metrics are generated and stored in larger quantities, their potential for informing

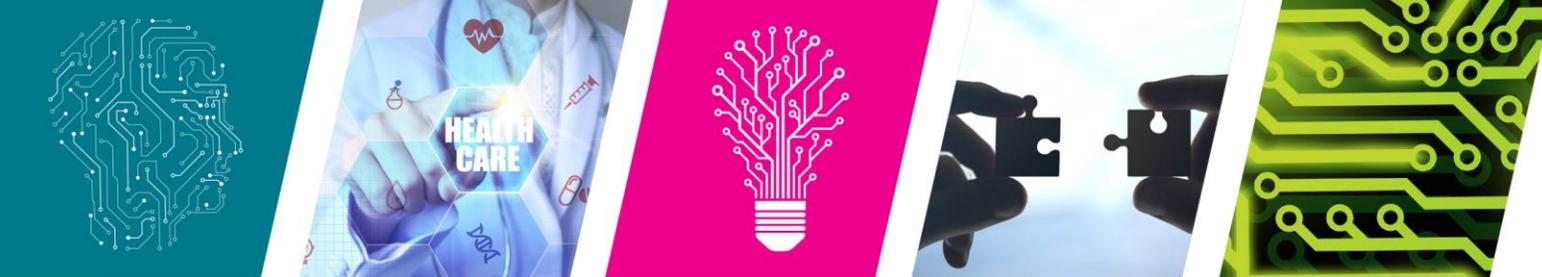


meaningful quality improvement also grows. There is a clear opportunity to better coordinate the existing data storage and analysis resources in Ontario to ensure this data can be analyzed and applied to practical efforts to improve local care. Doing so will rely on harnessing the expertise of the growing field of data science, but will also depend on a commitment to getting the data infrastructure right. **How will data be made available to health care providers and organizational leaders hoping to inform improvement efforts in their local areas?** This is also a topic that requires further discussion and the creative application of a range of expertise that already exists within Ontario's health system.

Health human resources and labour force planning.

The symposium highlighted the challenges of sustaining a strong workforce in the health system. This challenge is especially visible in the home health care sector, where staff turnover is remarkably high – as one symposium participant reported, as high as 30% in some regions of Ontario. This is especially the case for groups such as personal support workers (PSWs), who often work in contract-based arrangements with unpredictable working conditions (patients' homes). **How can staff be retained, and encouraged to develop a sense of ownership and pride in their work, particularly in home and community care?**

Another example from the home health care sector provides a possible answer. Nursing wages in the home health care sector are substantially lower than their counterparts in acute care hospitals. Promoting more equity in wages across sectors would promote the vision of home care as an important and desirable place to work. **What are strategies to promote wage equity across sectors?** A starting point for this line of work might be the recent publication of a report on labour reforms in Ontario, which included publicly funded

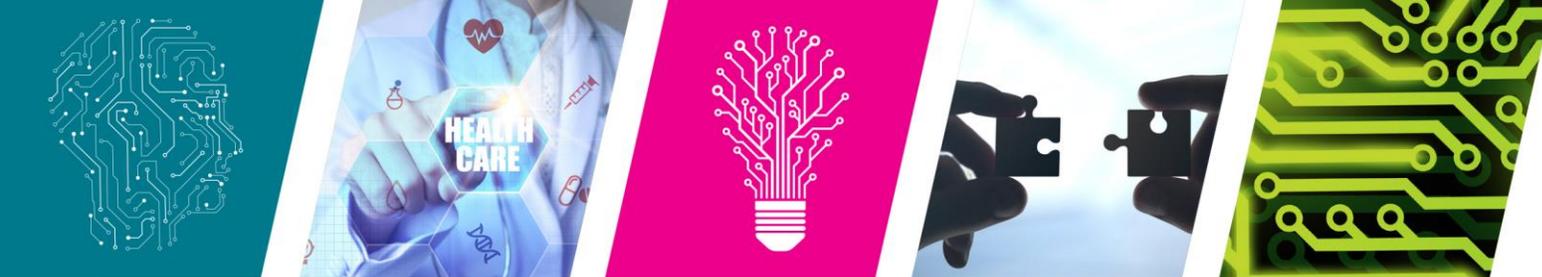


home care.⁶ Addressing this question, and the broader question of promoting pride in home care work, is central to the continued development of a strong home health care sector.

CONCLUSION

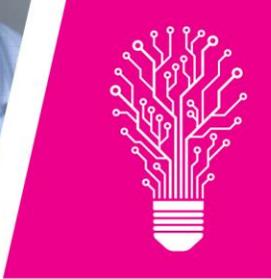
The topics and recommendations discussed in this paper represent action items that can be put into place as the Patients First policy is being implemented in the coming years. These represent the views of a wide range of stakeholders who provided input during the stakeholder dialogue symposium, and will encourage the development of more integrated care at the local level. Building on the innovative potential of care providers, guided by patient and family engagement, these strategies promote the development of new innovations at the sub-region level and their spread across the province – helping to fulfill the vision of Patients First as a platform for innovation in Ontario’s health system.

⁶Ontario Ministry of Labour, C. Michael Mitchell, and John C. Murray, *The Changing Workplaces Review: An Agenda For Workplace Rights*, 2017, 978-1-4868-0094-0, Ontario: Ontario Ministry of Labour, 2017.



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APPENDIX A – SYMPOSIUM AGENDA

Location: Women's College Hospital Conference Centre (the Pink Cube)

Date: Thursday, March 23rd, 2017

Time: 8:00am-3:30pm

Lunch provided

Agenda

8:00am-8:30: Registration and coffee

8:30-9:30: Introduction and overview

- Introductions and general description of the day
- Brief remarks from invited guests
- Overview of Bill 41 and the Patients First policy initiative (MOHLTC representative)

9:30-10:00: Patient and caregiver perspective on care coordination

- A patient and caregiver share their experiences and provide suggestions and thoughts

10:00-10:45: International lessons learned

- A panel describing the clinical, implementation, and policy level lessons learned from international experience

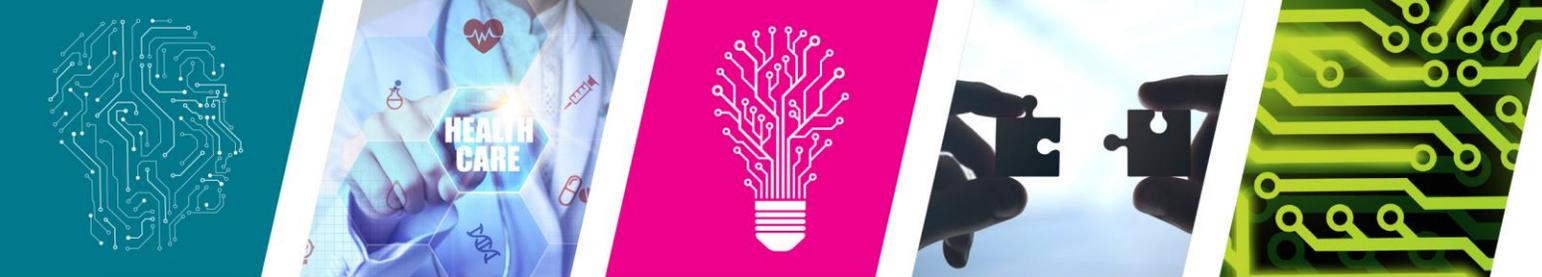
10:45-11:00: Break

11:00-11:30am: Primary care clinician panel

- Primary care engagement panel on physicians perspectives regarding local integration with services, including home and community care
 - Group discussion

11:30-12:15: Health care organizational leader panel

- Organizational leaders discuss promises and challenges of sub-LHIN regions, including perspectives from (a) a home care agency, (b) a LHIN, and (c) primary care
 - Group discussion



12:15-1:00pm: Lunch

1:00pm-2:00pm: Breakout sessions

- Topics:
 - Clinical: how do we engage clinicians?
 - Governance and accountability
 - Mechanisms for success (IMIT, finance and incentives, patient voice, etc.)
- The purpose of breakout sessions will be to address the overarching topics outlined above, and other issues that have already arisen during symposium discussion. Breakout groups will be asked to produce lists of issues that are remaining to be addressed.

2:00-2:15pm: Break

2:15-3:15: Group Discussion

3:15-3:30pm: Closing Remarks