



Ontario College of Family Physicians

Education | Leadership | Research | Advocacy

A Chapter of the College of Family Physicians of Canada

Advancing the Pillars of the Patient's Medical Home in Ontario's Evolving Health System

Patient's Medical Home Symposium Proceedings

August 10, 2016

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1. Introduction

On May 27th, 2016, members of the Ontario College of Family Physicians (OCFP) and invited guests held a symposium at St. Paul's Anglican Church Conference Centre in Toronto to develop directions to advance the pillars of the Patient's Medical Home (PMH) in Ontario's evolving health system. The OCFP sponsored the symposium with support from The College of Family Physicians of Canada (CFPC).

The OCFP launched a three-part policy initiative about the PMH in Ontario that started with a Citizen's Panel and then a Stakeholder Dialogue, followed by the PMH symposium attended by family physicians.

The following is a brief overview of the three phases of the PMH Initiative:

1. The Citizen Panel was hosted by McMaster Health Forum in partnership with the OCFP on February 6, 2016. The purpose of the discussion was to obtain feedback from the public/patients on the PMH pillars and how to build a primary care 'home' for every Ontarian, and to identify barriers and opportunities to advancement.
2. The Stakeholder Dialogue also hosted by McMaster Health Forum in partnership with the OCFP was held on March 11, 2016 with family physician leaders, representatives from the Ministry of Health and Long-Term Care and Local Health Integration Networks, researchers and leaders from other primary care associations. Also focused on how to build a primary care 'home' for every Ontarian, the purpose of the discussion was to confirm the value of the framework, to deliberate issues and identify potential opportunities from primary care stakeholders who operate at a provincial health-system level on how to advance the PMH in Ontario.
3. The PMH Symposium was hosted by the OCFP in partnership with the CFPC on May 27, 2016 with family physician members from Ontario and across Canada working in various practice models, and included members of the CFPC's Patient's Medical Home Steering Committee. Michael Rowland, President of Change Focus, acted as the facilitator for the PMH Symposium. This report details the event and the findings.

2. PMH Member Symposium

OBJECTIVES

The day-long PMH symposium was grounded in four objectives, which were informed by the McMaster Health Forum Citizen Panel and Stakeholder Dialogue:

1. Understand the key challenges and opportunities for family medicine and family physicians in Ontario's evolving health care system;
2. Seek input on directions that will advance the pillars of the PMH;
3. Discuss strategies to develop and support family physician leadership to advance the pillars of the PMH at the practice and community levels;

4. Identify priority policy and advocacy directions for the College to support members and bring the family physician voice to ongoing policy and planning tables.

The day was structured so that attendees were able to reflect on the PMH concept, discuss and debate how to advance the pillars in light of ongoing primary care transformation and identify barriers and, most importantly opportunities. The event was divided into three main components:

- An overview of the PMH vision and an assessment of how well the pillars are currently being implemented in Ontario, as well as the levers needed for change;
- A presentation from the Southcentral Foundation on the Nuka System of Care that reflects the concept of the PMH and provides concepts for what can be achieved; and,
- Small working group discussions with family physicians designed to generate dialogue, debate and discussion on the greatest challenges and opportunities to advancing the pillars in Ontario.

The PMH Symposium agenda can be found in Appendix B. The following section details what was presented at the PMH Symposium.

PARTICIPANTS

Over 60 members and guests from across Ontario and other provinces and territories attended the session, along with staff from the CFPC and the OCFP. A list of participants is provided in Appendix A.

The symposium was planned by the PMH Advisory Committee of the OCFP Board of Directors and was organized by OCFP staff (see Figure 1 below).

Figure 1 - Symposium Organizing Team

Physician Advisory Committee	OCFP Staff Support
<ul style="list-style-type: none"> • Dr. Glenn Brown, Kingston • Dr. Cathy Faulds, London • Dr. Sarah-Lynn Newbery, Marathon • Dr. Jennifer Young, Collingwood 	<ul style="list-style-type: none"> • Jessica Hill • Leanne Clarke • Andrea Doxey • Rachel Roke

ACCREDITATION

The symposium was accredited by The College of Family Physicians of Canada and the Ontario Chapter for up to 6.25 Mainpro-M1 credits. Faculty/presenters included Dr. Sarah-Lynn Newbery, Dr. Jennifer Young, Dr. Glenn Brown, and Dr. Cathy Faulds, all board directors for the OCFP. They were disclosed as having no relationships with commercial interest.

OPENING REMARKS

Dr. Newbery outlined the concept of the Patient's Medical Home and its centrality to the vision of the OCFP which is that every Ontarian receive high-quality, coordinated, comprehensive and continuing care from a primary health care team led by family physicians and supported by an integrated and sustainable

health-care system. She encouraged participants to contribute their ideas on the key questions being posed through the symposium.

The President of The College of Family Physicians of Canada, Dr. Jennifer Hall, outlined the history and continued relevance of the Patient's Medical Home vision and principles. Dr. Hall encouraged participants to share their views on what is needed, what works and what does not work, and to be realistic about tailoring the model within the unique Ontario context.

Dr. Hall highlighted the new Patient's Medical Home website, patientsmedicalhome.ca, which provides new tools and approaches including a self-assessment tool that members can use to assess their practice relative to the principles and features of the PMH model.

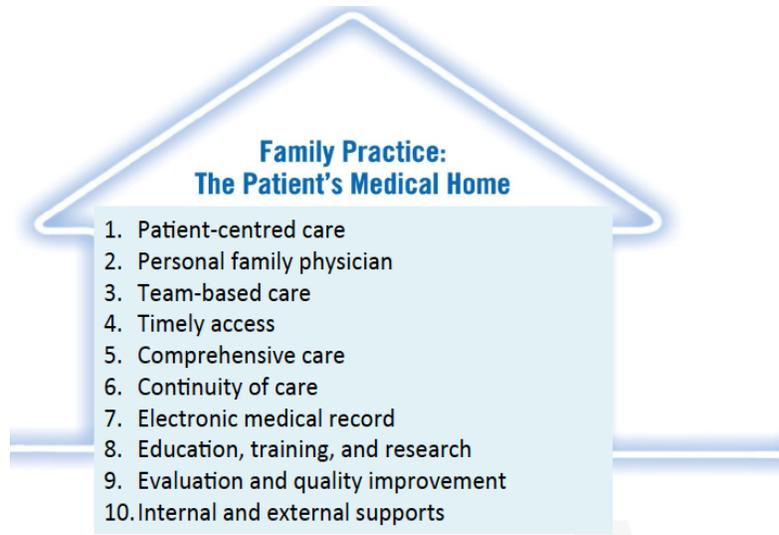
3. Key Challenges and Opportunities

Before engaging the participants in small group discussions, two plenary presentations outlined some of the overall challenges and opportunities related to moving the pillars of the PMH forward.

PMH IMPLEMENTATION ASSESSMENT

Dr. Newbery provided a 'diagnostic' on how we are doing implementing the PMH in Ontario. Dr. Newbery outlined the ten pillars of the PMH and noted that the model shares similarities with the Starfield model of comprehensive primary care.

Figure 2 - Ten Pillars of the Patient's Medical Home



Participants were encouraged to think about the PMH in the following ways:

- A tool to measure all current family medicine practices
- A vision to which every family practice across Canada can aspire

- A frame of reference for patients, physicians, other team members
- A framework for quality improvement initiatives
- A foundation for education and research

The PMH vision was launched five years ago by CFPC. The OCFP has been collaborating with other organizations to advance the vision. This has included the Ontario Medical Association, the members of the Ontario Primary Care Council and the Local Health Integration Networks..

In October 2015, the OCFP released an evidence brief on *Preparing for a Devolved, Population-Based Approach to Primary Care*.^{*} The research in the evidence brief stresses the importance of physician engagement in order to advance system wide changes in primary care such as the adoption of the PMH in Ontario. Two other important factors in the advancement of the PMH framework are the need for accessible data to inform quality improvement efforts and the skills and capacity to use the data in a meaningful way. To help address this issue, in May 2015, the OCFP developed a report in partnership with Health Quality Ontario on *Advancing Practice Improvement in Primary Care*.^{*}

Dr. Newbery highlighted the evolution of primary care models in Ontario and the growing emphasis on interdisciplinary teams and increased attachment through rosters. Primary care transformation is being driven by Canadian values of access and equity and is characterized by risk-adjusted population-based planning and delivery. She then provided her observations on progress in Ontario relative to key pillars of the Patient's Medical Home drawing on various sources including findings from the McMaster Health Forum Stakeholder Dialogue and Citizens Panel.

^{*}Source: OCFP Evidence Brief, *Preparing for a Devolved, Population-Based Approach to Primary Care*, 2015

^{*}Source: OCFP/Health Quality Ontario Report, *Advancing Practice Improvement in Primary Care*, 2015

Figure 3 - Observations on PMH Implementation Progress in Ontario*

The following chart details a high-level assessment offered to the group by Dr. Newbery on how well six key pillars from the PMH are being implemented in Ontario and strategies for advancement. Although all ten pillars are critical to a holistic PMH-style practice, the following six pillars were selected by the OCFP for review as they were seen as the most central to promoting the PMH vision.

Pillar	Assessment	Strategies for Advancement
Patient-centred Care	<ul style="list-style-type: none"> - Continues to be the cornerstone of family practice through the relationship between the physician and patient - Ongoing shifts are required to have a the patient as full partner in their care - The McMaster Citizen Panel confirmed patients value the relationship with their family physician, however better communication is needed between primary care and other levels of care in the system so that the PMH is the centre of their care ‘hub’ 	<ul style="list-style-type: none"> - Services delivered through a population-based approach is recommended i.e. ‘Patient Medical Neighbourhood’ - Improve communication between physician’s office and patient and between primary, hospital and home and community care. - PMH needs to continue to be the centre of the patient care hub
Team-based Care	<ul style="list-style-type: none"> - Only 25% of family physicians practice in models with funded Interprofessional Health Providers - Currently a mal-distribution of HP resources across Ontario - Not all providers on teams are working at full scope - There is a role for “focussed practice” physicians in the “network” or “neighbourhood” 	<ul style="list-style-type: none"> - Develop equitable distribution of clinical resources across Ontario to support family physicians practicing outside of team-based environments - Integrate all providers on the team and support them to work to full scope to deliver efficient care
Timely Access	<ul style="list-style-type: none"> - Clarification for family physicians around access and accountability metrics are needed 	<ul style="list-style-type: none"> - Develop clear and meaningful metrics around access that are informed by family physicians - Alignment of incentives and disincentives across practice models is required to better support appropriate and equitable access

Pillar	Assessment	Strategies for Advancement
Comprehensive Care	<ul style="list-style-type: none"> - Comprehensive care that is coordinated between providers is strongly desired - Greater emphasis on health equity is required - An increasing number of family physicians are working in focused practices and lack strong connections to comprehensive primary care 	<ul style="list-style-type: none"> - Resources need to be planned based on community and population need to increase access and equity - Need to more effectively incorporate focused and comprehensive practices
Education, Training and Research	<ul style="list-style-type: none"> - Improvements have been made in increasing the recruitment and retention rates of family medicine residents over the past 10 years - Residents are being trained in team-based models, but there are a lack of jobs available in those models 	<ul style="list-style-type: none"> - Need broader access to team based models for newly graduated residents - Need training and skills development in order to optimize the effectiveness of formal and informal teams
Evaluation and Quality Improvement	<ul style="list-style-type: none"> - Approximately 1000/13,000 family doctors have requested a Primary Care Practice Report from Health Quality Ontario - Currently, only Family Health Teams, Community Health Centres and Aboriginal Health Access Centres are submitting Quality Improvement Plans - Quality improvement tools exist but are not widely accessed nor accessible 	<ul style="list-style-type: none"> - Develop easier access to Health Quality Ontario reports and support for use of timely data for practice improvement - Enhance Electronic Medical Record integration and data availability - Develop metrics/measurement by engaging with family physicians - Utilize the CFPC PMH Self-Assessment Questionnaire - Develop Quality Improvement strategies that are supportive and provide more resources.

*Source: Dr. Sarah-Lynn Newbery presentation, PMH Symposium, May 27th, 2016

Dr. Newbery recognized some of the key challenges in trying to move the PMH pillars forward in Ontario. These include:

- The lack of a Physician Services Agreement
- A pause on implementation of team-based models
- Issues with Electronic Medical Records (EMR) related to standardization, interoperability and their ability to generate meaningful data

- Lack of digital health integration across practice settings
- More integration responsibilities are shifting to the LHINs yet plans are unknown and physician engagement is inconsistent
- * There are many payment models in primary care but none is perfect

Dr. Newbery ended her remarks by encouraging members to "own the profession" and define the best way to move forward drawing on local knowledge and the experiences of other jurisdictions.

LESSONS FROM THE NUKA SYSTEM OF CARE

To help demonstrate the opportunities and outcomes associated with implementing a PMH-style model, the OCFP invited Dr. Verlyn Corbett and Melissa Merrick from the Southcentral Foundation in Anchorage, Alaska to present their change management experience through the development and implementation of the Nuka System of Care. The OCFP believes it is important to learn from other jurisdictions that have implemented the PMH vision to build on existing best practices and to stimulate ideas of how they could be adapted to the Ontario context.

Overview

The Southcentral Foundation (SCF) is part of the Alaska Native Health System and provides primary care services in Anchorage, the Matanuska-Susitna Valley and the Anchorage Service unit. Incorporated in 1982, it serves 65,000 customer-owners spread across 591,000 square miles of territory and encompassing Anchorage, the Valley and about 55 villages. SCF is a result of a customer driven overhaul of what was previously a bureaucratic system centrally controlled by the Indian Health Service. Alaska Native people are in control as the "customer-owners" of this health care system. The vision and mission focus on physical, mental, emotional, and spiritual wellness and working together as a Native Community. Coupled with operational principles based on relationships, core concepts and key points, this framework has fostered an environment for creativity, innovation and continuous quality improvement. Alaska Native people have received national and international recognition for their work and have set high standards for performance excellence, community engagement, and overall impact on population health.

Transition Strategy

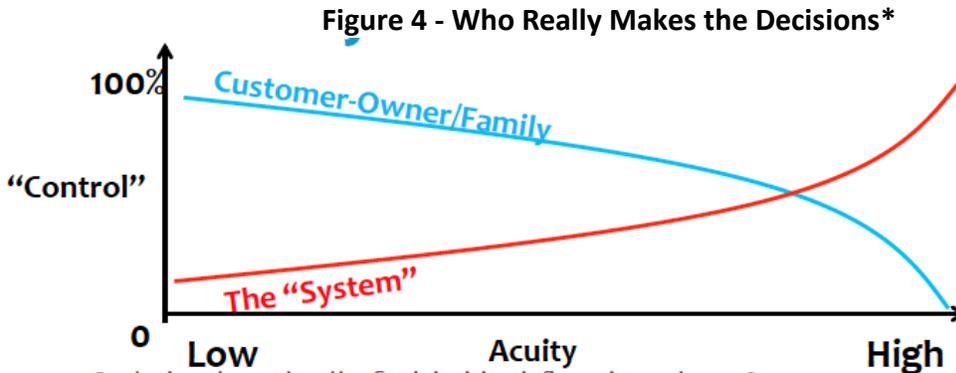
Dr. Verlyn Corbett and Mellissa Merrick described the dramatic, intentional transition that the SCF undertook as an organization. Historically, people seen by the SCF said that staff were unfriendly, there were long waits for service, there was no customer input and that patients received inconsistent treatment. Staff and management of the SCF were frustrated and wanted to improve customer service and the quality of their working lives and health of the organization.

The transition strategy was founded on some core principles that gave a philosophic focus to the organization. The focus was placed on:

- Patient outcome not provider income

- The person, not the disease
- Population health, not process
- Service, not practice

Intentional program design was used to ensure that programs supported each other and contributed to population health. Key to the model's underpinnings was the concept of giving over as much control as possible to 'customer-owner' in non-acute situations (see Figure 4 below).



*Source: Southcentral Foundation, Alaska. May 27th, 2016 Presentation to OCFP

A significant amount of customer input was sought before any changes were made. As well, there were many staff discussions and time spent with the Board and other organizations.

Improvements Made

The presenters outlined the various improvements that were put into place as part of the transition. These included:

- Customer-ownership was promoted so that people were active partners, took responsibility for their health, sought out information, asked questions and inquired about options
- Health care providers shifted from being the "hero", to being a partner
- Integrated care teams were established
- Providers were given a choice regarding their desired roles
- Staff were given lots of support through reasonable expectations, transparent communication, training to ensure successful relationships, letting them problem solve, providing tools and advisory support, ensuring leadership visibility, and having fun
- Same-day access to a primary care provider was provided
- Monitoring for culturally appropriate care was implemented
- Data infrastructure to support staff was implemented
- Performance data was un-blinded
- A cycle of performance improvement was implemented (PDSA)
- A new organization structure was put into place

- The building was re-designed to be more welcoming and open, including the elimination of Nurse Stations and all private offices

Integrated Care Team

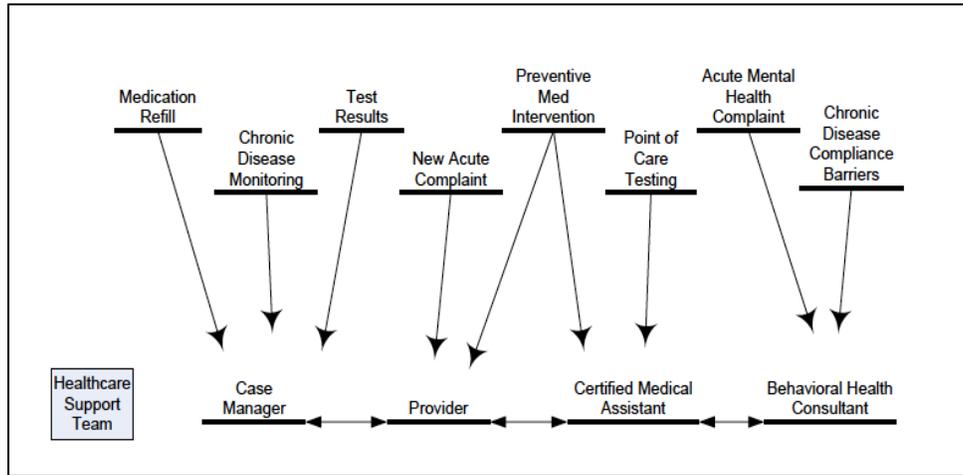
Work-flow analysis was done and found that the SCF received 3,500-4,000 physical visits per year per FTE. The process rate was severely limited by the reliance on physical visits and nearly 50% of encounters had some behavioural health component. They also found that only 30% of visits were new customers without a diagnosis or plan to date and where a physical visit added value.

To address these issues, the SCF:

- Created integrated care teams involving a Provider, a Manager/Supervisor, a Behavioural Health Consultant, a Certified Medical Assistant, Case Management Support, a RN Case Manager
- Empanelled customers-owners
- Gave customers-owners open access to the Integrated Care Team
- Provided direct access via email, phone, talking rooms

The new system of parallel work flow design shifted all work flows from going through the provider to largely only new acute complaints and some preventive medical interventions going through the provider (see Figure 5).

Figure 5 - Parallel Work Flow Redesign*



*Source: Southcentral Foundation, Alaska. May 27th, 2016 Presentation to OCFP

Results Achieved

With these changes the SCF has achieved incredible results, recognized by their receipt of the Malcolm Baldrige National Quality Award. Results include:

- Evidenced-based generational change reducing family violence
- 50% drop in ER visits, Hospital Days, and visit to Specialists
- 75-90% percentile on most HEDIS outcomes and quality
- Benchmarked data nationally and internationally showing top in class performance in utilization, quality, satisfaction
- Employee turnover rate less than 12% annualized
- Sustained customer and staff satisfaction over 90%

3. Advancing the Pillars of the PMH in Ontario

Following the keynote presentation, the symposium agenda turned to how to advance the pillars of the PMH in Ontario.

PMH VISION AND CHANGE STRATEGIES

Dr. Sarah-Lynn Newbery positioned the discussion as focusing on what members can do in their practice role and in their role as clinical leaders with their peers in the community. The discussion also involved what the College can do in terms of advocacy, thought leadership and harnessing evidence.

OCFP's evidence brief, *Preparing for a Devolved, Population-Based Approach to Primary Care, October 2015*, identified five key levers for system change:

1. **Change in culture and a culture of change:** Owning the change will be key for family medicine and family physicians. A culture shift is needed. To develop a culture change, frontline involvement in design and delivery of the PMH will be required.
2. **Transformational leadership:** It will be important to nurture and support clinician leaders and role models who can bring to bear the attributes of transformational leadership.
3. **Physician engagement:** Physician engagement will be key. The factors that facilitate physician engagement were highlighted.
4. **A foundation for integrated decision-making and collaboration:** Primary, community, acute, mental health, public health and social care providers must all work together with a sense of urgency, a willingness to innovate, a mandate to solve problems, aligned incentives, support from central authorities, and positive working relationships.
5. **Measurement:** Data and measurement are critical to primary care reform and must include targets, comparison, audit and peer review with the needed supporting infrastructure and functionality.

GROUP DISCUSSION RESULTS

Participants were divided into small discussion groups for three rounds of discussions focused on the following three themes:

- Equitable and timely access to comprehensive and continuous, person centred care
- Interdisciplinary, team-based care and education, training and skills
- Family physician leadership at the practice and community levels

Volunteer facilitators led the discussions with support from staff recorders from the OCFP and CFPC.

Figure 6 - Discussion Group Facilitators and Recorders

Small Group Discussion Facilitators	Recorders (College Staff)
Dr. John Brewer	Shirley Connor
Dr. Amy Catania	Farwah Gheewala
Dr. Cathy Faulds	Sarah Hicks
Dr. Michael Green	Arlen Keen
Dr. Dee Mangin	Susan Rock
Dr. Jennifer Young	Artem Safarov

THEME A. Equitable and timely access to comprehensive and continuous, person-centred care

Participants were asked to discuss three questions related to advancing PMH pillars and principles of equitable and timely access to comprehensive and continuous, person-centered care.

The detailed results from the six table discussions of these questions are presented in Appendix C. The summary themes from these results are shown below. Comments from across the six discussion tables were grouped under common themes and ranked by frequency in order to identify the common themes.

1. I am best able to provide equitable and timely access to comprehensive and continuous, person-centred care when...(keys to success)

The common themes in response to this question were:

- Have effective linkages with external networks
- There is support for patients to facilitate access and navigate the system
- Appropriate funding is provided
- Patient population and community are understood
- Accessible hours are offered

- There are clear and common expectations
- Patients are partners and have shared accountability
- There is access to effective technology
- There is ongoing monitoring and evaluation
- There is flexibility
- Roster sizes are manageable
- People are working to their full scope

2. What actions should be pursued to strengthen equitable, timely access to comprehensive, continuous person-centered care in your community?

The common themes in response to this question were:

- Improve system access and interconnectivity of EMRs
- Promote patient education, engagement and accountability
- Promote and support team-based care
- Increase access to care
- Re-allocate resources/change funding models
- Promote collaboration and coordination
- Promote performance measurement and quality improvement
- Revise physician education and training
- Introduce new models of care

3. Of all of the actions proposed by your table discussion group, which would have the greatest impact and could be implemented within the next three years?

Specific actions under the following themes were given the highest priority by the table groups (see Appendix C for specific actions):

- Improve access to and promote use of EMRs
- Promote patient education, engagement, and accountability
- Promote and support team-based care
- Increase access to care
- Re-allocate resources/change funding models
- Promote collaboration and coordination
- Revise physician education and training
- Introduce new models of care
- Address physician accountability and compensation

THEME B. Interdisciplinary, team-based care and education, training and skills

Participants were asked to discuss four questions related to interdisciplinary, team-based care and education, training and skills.

The detailed results from the six table discussions of these questions are presented in Appendix C. The summary themes from these results are shown below.

1. What kind of primary care team is needed to deliver interdisciplinary, team-based care?

The table groups were given pre-printed cards with potential primary care team roles on them. As well, each group was given blank cards on which they could write additional roles. The groups were asked to sort the cards/roles into the following four categories - must have, should have, could have, and not needed. The care team could be under one roof, a virtual team or connected through relationships established with others in close-by facilities.

The process assumed that the patient was at the centre as a partner in care. Linkages to specialists are critical and are assumed as part of the discussion.

The following conclusions can be drawn from the results:

- There is great interest and perceived value in having an inter-disciplinary care team with a wide range of capabilities to meet community needs wherever possible
- In addition to the family physician, the most common roles for the core (must have) care team included a social worker, EMR/data/IT support, a case manager/care coordinator, and either a registered nurse or nurse practitioner.
- The most commonly mentioned roles at the next highest level of need tended to be a pharmacist, a dietician, and several roles able to provide counselling and mental health support.
- Nurse educator roles are of interest to many to help deal with chronic disease management.

In the course of the discussion, participants pointed out that:

- The care team mix will depend on community needs
- The emphasis needs to be on roles, not titles
- Roles should be flexible
- Budget/funding restraints will dictate priorities
- The mix depends on how far the family physician wants to stray from his/her core practice
- It is important for all members of the care team to be working at full scope

2. For the PMH pillars to be successfully implemented in Ontario, training for family physicians must give more emphasis to...

Participants felt that for implementation of the PMH pillars to be successful, training for family physicians needs to give greater emphasis to several areas. The main categories are listed below. The detailed comments on needs within these categories are show in Appendix C.

- Management
- Leadership
- Informatics/EMR/IT
- Interdisciplinary care teams
- PMH principles/concept
- Clinical skills
- Healthcare systems

3. What actions should be pursued to strengthen interdisciplinary, team-based care and training for family physicians in order to implement the PMH pillars?

The common themes in response to this question were:

- Promote PMH type models of care
- Support PMH implementation through family physician education and training
- Re-allocate resources/change funding models
- Improve access to, integration and effectiveness of EMRs
- Promote patient and community education, engagement, and accountability
- Facilitate collaboration
- Advocate for policy change
- Address physician accountability

4. Of all of the actions proposed by your table discussion group, which would have the greatest impact and could be implemented within the next three years?

Specific actions under the following themes were given the highest priority by the table groups (see Appendix C for specific actions):

- Promote PMH type models of care
- Support PMH implementation through family physician education and training
- Re-allocate resources/change funding models
- Improve access to, integration and effectiveness of EMRs
- Promote patient and community education, engagement, and accountability
- Facilitate collaboration
- Advocate for policy change

THEME C. Family physician leadership at the practice and community levels

Finally, participants were asked to discuss three questions related to family physician leadership at the practice and community levels.

The detailed results from the six table discussions of these questions are presented in Appendix C. The summary themes from these results are shown below.

1. What do family physicians need in order to be effective leaders to advance the pillars of the PMH at the practice and community levels?

The common themes in response to this question were:

- Mentorship
- Outreach and communication
- Leadership development
- System and peer support
- Promotion and understanding of PMH
- Means of connecting with others
- Data
- Clear roles
- Stable funding and compensation
- Change management support

2. What actions should be pursued to develop and support family physician leadership at the practice and community levels?

The common themes in response to this question were:

- Invest in leadership development
- Promote understanding of PMH
- Encourage and support mentorship
- Provide outreach and communication

3. Of all the actions proposed by the table group, which would have the greatest impact and could be implemented in the next three years?

Specific actions under the following themes were given the highest priority by the table groups (see Appendix C for specific actions):

- Invest in leadership development
- Encourage system and peer support for leadership
- Promote understanding of PMH
- Encourage and support mentorship
- Help communities of practice to connect with each other

FACILITATOR PANEL REFLECTIONS

Following the small group discussions the facilitators were formed into a panel and asked to reflect on the following questions.

- What were your 'aha' moments from the discussion today?
- What are the one or two things that the College could do to support members and advance the pillars of the PMH?
- What should the College pay attention to as policy/advocacy and CPD priorities to support members?

The main points made by the panel members and other participants are shown in the table below, under themes developed after the session by the facilitator.

Theme	Facilitator Panel Comments
Be strategic	<ul style="list-style-type: none">• Form must follow function and function needs to be designed with a focus on the end goal

Theme	Facilitator Panel Comments
	<ul style="list-style-type: none"> • It is important to shape the system proactively, or it will be done to us, not by us
Need to work in partnership with others	<ul style="list-style-type: none"> • Need for a systems-based approach in order to cross beyond individual or specific groups' interests • Alliances have more impact than individuals or single groups • Primary and secondary care need to work together • Foundational issues such as incentives and compensation are critical to the success of advancing the PMH • The OMA is a key ally in this • Need to understand what others are doing and map our goals and proposals to theirs • The College can play a supportive role on PMH implementation regardless of what the MOHLTC or OMA do
Need to develop leadership at both practice and community levels	<ul style="list-style-type: none"> • There is a need for many levels and types of leadership contributions at the practice and community level • Need to integrate new family physicians (in first five years) into PMH thinking and development • Care integration within teams is really important - front desk/reception staff play a key role • A happy team makes a big difference to care • We need to celebrate our leadership more • Need to provide support at the local level • Leadership needs to be made 'cool' • PMH needs to be owned by family physicians • Need to recognize leadership strengths and accomplishments and build optimism around a new sense that we are getting there
Collaborative, comprehensive care is key	<ul style="list-style-type: none"> • Continuous, comprehensive care is what works and has impact • Need to focus on creating the patient's medical neighbourhood to connect the patient with community providers, not just health professionals immediately associated with the family physician • Practicing at the full scope of a professional discipline's practice is a key to success
Flexibility required	<ul style="list-style-type: none"> • Flexibility is important - a shared vision, set of values, and goals are more important than a common model • PMH is not a model or a structure - it is a vision for us to build relationships with our patients

4. Next Steps

The OCFP Board of Directors will review all it has learned from the PMH Symposium, the McMaster Health Forum's Citizen Panel and Stakeholder Dialogue, as well as from the OCFP's evidence brief, *Preparing for a Devolved, Population-Based Approach to Primary Care* in combination with the OCFP/Heath Quality Ontario report on, *Advancing Practice Improvement in Primary Care* as it considers strategies to advance the vision of Patient's Medical Home in Ontario. The OCFP is committed to working in partnership with other organizations and the LHINs to support our members in our shared commitment to excellence in primary care for patients in Ontario.

The College would like to thank the 67 PMH Symposium participants for attending and for engaging with each other on how we can continue to advance the vision for primary care in Ontario. Your commitment to working together and with the OCFP is appreciated. .

The OCFP would also like to thank the members of the Patient's Medical Home (PMH) Advisory Committee, College staff and colleagues from the CFPC for their financial support, input and direction on the PMH Symposium.

Appendix A.

List of Participants

Dr. John Brewer, Ottawa
Dr. Robert Algie, Fort Frances
Dr. Javed Alloo, Toronto
Dr. Sundeep Banwatt, Mississauga
Dr. Jonathan Bertram, Toronto
Dr. Marc Bilodeau, Ottawa
Ms. Lisa Bitonti-Bengert, Kitchener
Dr. Sean Blaine, Stratford
Dr. Gary Bloch, Toronto
Dr. Glenn Brown, Napanee
Dr. Amy Catania, Orangeville
Dr. Nelson Chan, London
Dr. Jane Charters, Oakville
Dr. Simone Dahrouge, Ottawa
Dr. Lee Donohue, Gloucester
Dr. Maxine Dumas Pilon, Montreal
Dr. Anne DuVall, Barrie
Dr. Mario Elia, London
Dr. Mark Essak, Coburg
Dr. Jennifer Everson, Ancaster
Dr. Cathy Faulds, London
Dr. Lisa Graves, Ancaster
Dr. Michael Green, Kingston
Dr. Dale Guenter, Hamilton
Dr. Jennifer Hall, Mississauga
Dr. Isabelle Hebert, Laval
Dr. Jon Hunter, Toronto
Dr. Peter Hutten-Czapski, Haileybury
Dr. Nadia Knarr, Belleville
Dr. Art Kushner, Etobicoke
Dr. Darren Larsen, Thornhill
Dr. Francine Lemire, Mississauga
Dr. Sabrina Lim Reinders, Kitchener
Dr. Cathy MacLean, St. John's
Dr. Shiraz Malik, London
Dr. Dee Mangin, Hamilton
Dr. Frank Martino, Brampton
Dr. Garey Mazowita, Vancouver
Mr. Terry McCarthy, Hamilton
Dr. Elizabeth Muggah, Ottawa
Dr. Suraiya Naidoo, Yellowknife
Dr. Sarah Newbery, Marathon
Dr. Christie Newton, Vancouver
Dr. Anjali Oberai, Wawa
Dr. Harry O'Halloran, Collingwood
Dr. Ademola Olufemi, Oakville
Dr. Maria Pelova, Yellowknife
Ms. Joanne Plaxton, Toronto
Dr. Val Rachlis, North York
Dr. Arun Radhakrishnan, Ottawa
Dr. Abhishek Raut, Toronto
Dr. Robert Reid, Mississauga
Dr. Mercedes Rodriguez Molares, Nobleton
Dr. Deanna Russell, Kingston
Dr. Paul Sawchuk, Winnipeg
Dr. Gordon Schacter, London
Dr. David Schieck, Elora
Dr. Karen Schultz, Kingston
Dr. Richard Seeley, Hamilton
Dr. Adam Steacie, Brockville
Dr. Rebecca Van Iersel, Orillia
Dr. Robert Webster, Belleville
Dr. Jennifer Young, Collingwood

Appendix B.

PMH Symposium Agenda

The PMH Symposium was a day-long event with three main components;

1. An overview of the PMH vision and which stimulated discussion of how well the pillars are currently being implemented in Ontario;
2. Exploring another jurisdiction by hearing how the Southcentral Foundation's Nuka System of Care was developed and implemented;
3. Through small working group discussions with family physicians responding to questions that were categorized into themes. The questions were posed to generate dialogue, debate and discussion on the greatest challenges and opportunities to advancing the pillars in Ontario. Summative feedback to the posed questions can be found in Appendix C.

Time	Item	Format
7:45 a.m.	Registration and breakfast available	
8:15 a.m.	1. Getting Started <ul style="list-style-type: none"> Welcome and opening remarks from OCFP/CFPC Presidents, Dr. Sarah-Lynn Newbery and Dr. Jennifer Hall (15 minutes) Symposium overview, Michael Rowland (10 minutes) 	Plenary format
8:40 a.m.	2. Key Challenges and Opportunities for Family Medicine and Family Physicians in Ontario <ul style="list-style-type: none"> <i>How are we doing implementing the PMH pillars? A 'diagnostic'</i>, Dr. Sarah Newbery (15 minutes) Keynote: <i>Enabling a culture shift – Lessons from the Nuka System of Care</i>, Dr. Verlyn Corbett and Ms. Melissa Merrick from Southcentral Foundation, Alaska (50-60 minutes presentation; 20 minutes Q&A) 	Plenary format
10:15 a.m.	Break	
10:30 a.m.	3. Advancing the pillars of the PMH in Ontario <ul style="list-style-type: none"> <i>PMH vision and change strategies</i>, Dr. Sarah Newbery (20 minutes) Overview of group discussion process, Michael Rowland (10 minutes) Round 1 – group discussions (60 minutes) 	Group discussions
12:00 p.m.	Lunch (45 mins)	
Time	Item	Format
12:45 p.m.	3. Advancing the pillars of the PMH in Ontario (cont'd) <ul style="list-style-type: none"> Round 2– group discussions (60 minutes) Round 3– group discussions (60 minutes) 	Group discussions
2:45 p.m.	Break	
3:00 p.m.	4. Summary and Assessment of Directions <ul style="list-style-type: none"> Reflections on group discussions, facilitators (30 minutes) <ul style="list-style-type: none"> Dr. John Brewer Dr. Amy Catania Dr. Cathy Faulds Dr. Michael Green Dr. Dee Mangin Dr. Jennifer Young Discussion among participants (15 minutes) 	Plenary format Moderated panel
3:45 p.m.	5. Next Steps <ul style="list-style-type: none"> <i>Next steps – what will the College (OCFP/CFPC) do with the results from today?</i> Dr. Glenn Brown, OCFP President-Elect (15 minutes) 	Plenary format
4:00 p.m.	End of Symposium	

Appendix C.

Themes and Comments from Small Group Discussions

Theme A: Equitable and Timely Access to Comprehensive and Continuous Person-Centred Care

1. I am best able to provide equitable and timely access to comprehensive and continuous, person-centred care when...(keys to success)

Themes & Comments

Theme 1: I am working in a team-based care model

- True team collaboration and communication
- Confidence in the circle of care
- Shared vision and goals
- Collegial environment in a community of practice
- Access to allied health professionals
- A network of physicians and team members regardless of payment model and physical space
- Right staff with right skills
- Clear team roles
- Patient understanding of and trust in how the team functions
- Education of the community that the team provides the care
- Optimizing staff in their roles
- Right space to support team-care
- Proper training for all team members
- Being part of a group for coverage
- Proper oversight and review of clerical staff
- Community and practice facilitators for family physician retention

Theme 2: Have effective linkages with external networks

- Good communication with Emergency Rooms
- Good communication with homecare services
- Good communication with secondary care providers, particularly after hours

Theme 3: There is patient support for access and navigation

- System navigation support for patients
- Patient care needs met by phone and in-person
- Commitment to managing access

Theme 4: Appropriate funding is provided

- Workable funding model to support access
- Transparency in resource allocation by the MOHLTC
- Population-based funding
- Funding aligned with patient-centred care

Theme 5: Patient population and community are understood

- Understanding of the community
- Knowing your patient population
- Understanding the patient experience
- Understanding barriers to equitable care faced by the population

Theme 6: Accessible hours are offered

- After hours coverage
- 8-8 schedule to meet patient needs
- Hours that fit local context and drivers of demand
- Providing coverage outside of traditional office hours

Theme 7: There is access to good, well-utilized information

- Data analytics at the point of care
- Receiving patient information prior to appointment from secondary care
- Capturing good detailed intelligence in triage to ensure that the patient sees the right person

Theme 8: There are clear and common expectations

- Less expectations to do everything (care, research, training, administration)
- Clear and consistent expectations among providers and patients
- Managing patient expectations

Theme 9: Patients are partners and have shared accountability

- Patient accountability
- Shared responsibility

Theme 10: There is access to effective technology

- Addressing privacy requirements in order to enhance access through technology
- Functioning, inter-operative EMR

Theme 11: There is ongoing monitoring and evaluation

- Benchmarks, performance data and monitoring at individual and community level
- Monitoring of supply and demand and flexibility to respond in the moment
- Process to discuss feedback on outcomes

Theme 12: There is flexibility

- Able to experiment, autonomy, flexibility
- Provide alternative methods of care delivery
- Allocating your resources with flexibility

Theme 13: Roster sizes are manageable

- Appropriate sized roster

Theme 14: People are working to their full scope

- Less non-medical administration
- Everyone working to their full scope of practice

Other

- Provider wellness

2. What actions should be pursued to strengthen equitable, timely access to comprehensive, continuous person-centered care in your community?

Themes and Comments

Theme 1: Improve access to and use of EMRs

- Integrate health care information in EMR across vertical and horizontal planes
- Mandate one EMR across Ontario (Canada)
- Implement a web-based EMR portal that allows patient provider communication and shares system information
- Provide EMR connectivity between afterhours care and primary care

Theme 2: Promote patient education, engagement and accountability

- Increase patient responsibility and knowledge about appropriate access to services
- Understand why patients use walk-in clinics
- Understand what hinders unattached patients
- Engage patients to determine expectations and educate them about options
- Promote more patient accountability
- Engage patients in co-design of access

Theme 3: Promote and support team-based care

- Improve and expand mechanisms to assist in shared care (e.g. e-consult)
- Build relationships with physicians and health care colleagues so that patients get correct care
- Ensure teams include the right roles
- Empower full scope of practice within teams
- Know your specialist network and resources
- Co-locate/virtually network all primary care services with CCACs and mental health
- Agree on a basket of services
- Ensure the right people are in the right jobs to accomplish their tasks

Theme 4: Increase access to care

- Clearly define access
- Create a regional referral service for specialists
- Advocate for non-face-to-face care
- Provide for 7 days a week and after hours care
- Develop call groups for afterhours care
- Foster physician commitment and engagement to enhancing access to primary care
- Ensure that timely access and comprehensive, continuing care is the responsibility of all health professionals

Theme 5: Re-allocate resources/change funding models

- Provide funding for team-based care for all
- Align funding with PMH pillars
- Establish a more equitable distribution of resources to promote access
- Reallocate gains/savings in secondary care to primary care system
- Share resources to help patients who have more needs in the community

Theme 6: Promote collaboration and coordination

- Enhance collaboration within the system
- Coordinate community services and get rid of duplication
- Improve transparency and care coordination across the health care system (rules of engagement)

Theme 7: Promote performance measurement and quality improvement

- Develop better indicators to measure access
- Facilitate receptivity and uptake of provider data and encourage use for performance measurement
- Adopt a quality improvement mentality to drive process improvement

Theme 8: Revise physician education and training

- Provide inter-disciplinary education for team members to enable collaboration
- Train physicians to fulfill greater accountability on advancing access
- Re-shape the education system to support equitable, timely, person-centred care

Theme 9: Introduce new models of care

- Develop a model for patients who do not have a family physician
- Create models of care that are regionally based

Theme 10: Address physician accountability and compensation

- Put physicians on salary and clearly define their responsibilities
- Strengthen physician accountability

Other

- Educate and advocate for PMH model to physicians and patients
- Improve understanding of local population and context through data and link to human resource planning
- Adopt a more business-like approach regarding human resources and professional development
- Address the health human resource issues
- Understand and work to change physician expectations regarding work/life balance and income
- Create a customer/owner service orientation

3. Of all of the actions proposed by your table discussion group, which three would have the greatest impact and could be implemented within the next three years?

Themes and Comments

Theme 1: Improve access to and promote use of EMRs

- Providing EMR connectivity between after hours and primary care
- Promote inter-operability of EMRs including two-way communication among providers and patients
- Integrate health care information in EMR across vertical and horizontal planes

Theme 2: Promote patient education, engagement, and accountability

- Engage patients to determine expectations and establish a shared understanding
- Engage patients in the co-design of what access is
- Design mechanisms to increase patient knowledge and responsibility about shared care

Theme 3: Promote and support team-based care

- Provide universal access to mechanisms to support shared care
- Coordinate to ensure that the right person is working in the right job to achieve their tasks

Theme 4: Increase access to care

- Provide 7 day a week after hours care through a call group
- Foster physician commitment to providing accessible, continuous, comprehensive patient-centred care
- Ensure that timely access and comprehensive, continuing care is the responsibility of all health professionals

Theme 5: Re-allocate resources/change funding models

- Reallocate gains/savings in secondary care to primary care system

Theme 6: Promote collaboration and coordination

- Enhance collaboration by understanding how primary care resources work together and ensure that there are systems to connect them

Theme 7: Promote performance measurement and quality improvement

- (no actions selected as top three)

Theme 8: Revise physician education and training

- Train family physicians about what advance access is

Theme 9: Introduce new models of care

- Develop models to ensure that every patient has access to a family doctor

Theme 10: Address physician accountability and compensation

- Clearly define physician responsibilities, accountabilities and link to compensation (i.e. primary care providers on salary)

Other

- Improve understanding of the local context, population and human resource needs
- Adopt a customer service orientation within your practice

Theme B: Inter-disciplinary, Team-Based Care and Education, Training and Skills

1. What kind of primary care team is needed to deliver interdisciplinary, team-based care?

Themes and Comments		
Need Level	Role	Frequency of Mention Among Six Groups
Must have	Family physician	6
	Social worker	5
	EMR/data support/IT	5
	Case manager/care coordinator	5
	RN/NP	4
	Mental health worker/psychotherapist	3
	Supportive/behavioural counselling	2
	Quality improvement coach/support	2
	Referral clerk	1
	Front-office clerk	1
	Office manager	1
	RPN	1
	Medical Office Assistant	1
Should have	Pharmacist	5
	Dietician	4
	Physiotherapist/occupational therapist	3
	Physician assistant	2
	Nurse practitioner	2

	Psychotherapist/clinical psychologist	2
	Diabetes nurse educator	2
	Asthma/COPD nurse educator	2
	Focused practice family physician	2
	EMR/data support	2
	Mental health/social worker	1
	Gerontologist	1
	Kinesiologist	1
	Family physician (enhanced skills)	1
Could have	Physician assistant	3
	Focused practice family physician	3
	Asthma/COPD educator	3
	Quality improvement support	1
	Diabetes nurse educator	2
	Pharmacist	2
	Psychotherapy	1
	Nurse practitioner	1
	RN	1
	Social worker	1
	Office manager	1
	Other specialists	1
	Dietician	1
Not needed	Physician Assistant	1
	Asthma/COPD educator	1
	Diabetes nurse educator	1

2. For the PMH pillars to be successfully implemented in Ontario, training for family physicians must give more emphasis to....

Themes	Frequency of Mention Among Six Table Groups
Management	
Quality improvement	5
Change management	4
General operational management/practice management	2
Communication skills	2
Governance	2
Mentorship (through and in)	1
Decision-making	1
What matters to patients	1
How to manage patient care out of office (social media, emails etc.)	1
Exposure to different environments (quality committees, clinic meetings)	1
Self-assessment	1
Boundary setting (interpersonal)	1
Meeting needs of the community (population health/community health)	1
Leadership	4
Informatics/EMR/IT	3
Inter-disciplinary care teams	
Working with inter-professional teams in team-based care	2
Working at full scope of family physician and other team members' practices	2
Enacting inter-professional team role as teachers	1
Interdisciplinary training	1

PMH principles/concept	2
Clinical	
Complex chronic disease management	2
End of life care (palliative)	2
Mental health (including pediatric)	1
Chronic pain management	1
How to engage patients as partners	1
Response training	1
Complex patient care	1
Patient safety	1
Clinical courage	1
Health Care Systems	
Access	1
Advocacy for system change	1
Systems education	1

3. What actions should be pursued to strengthen interdisciplinary, team-based care and training for family physicians in order to implement the PMH pillars?

Themes and Comments

Theme 1: Promote PMH type models of care

- Resume expansion of team-based care
- Ensure equitable access to these models
- Strengthen inter-disciplinary, team-based care
- Encourage flexibility in tasks by role

Theme 2: Support PMH implementation through family physician education and training

- Promote training on inter-disciplinary care teams
- Identify a group of mentors experienced with the PMH model who can coach others
- Model PMH in medical school and residency
- Delay focused-practice training in favour of extended generalist training
- Mandate competencies in geriatric and palliative care

Theme 3: Re-allocate resources/change funding models

- Flexible funding models to meet community needs and encourage team-based care
- Advocate for funding reform
- Create pay-for performance incentives for PMH adoption
- Advocate for gain sharing - investing costs saved in hospitals into primary care
- Align services and funding around patients and their needs, not programs and systems

Theme 4: Improve access to, integration and effectiveness of EMRs

- Advocate for EMRs that meet doctors' needs
- Facilitate EMR integration with primary care and hospitals
- Facilitate electronic support and communication systems

Theme 5: Promote patient and community education, engagement, and accountability

- Activate and educate the community in move towards PMH
- Empower patients to be partners

Theme 6: Facilitate collaboration

- Provide a systematic process to identify available community resources that is current and searchable
- Improve collaboration processes with other specialists to support transitions of care
- Create communities of practice
- Facilitate systems of communication horizontally and vertically

Theme 7: Advocate for policy change

- Advocate for increased access to counselling
- Create a PMH policy that we can advocate for
- Force policy clarity on the role of Family Health Teams and team-based care
- Advocate for supports for family physicians involved in administration

Theme 8: Address physician accountability

- Define full scope of practice
- Ensure that education is a core function of being an family physician

Other

- Promote a culture of equity
- Re-examine annual physicians survey in the context of PMH
- Focus on shifting to a culture of service
- Develop more specific practice management tools and supports
- Be responsive to community needs
- Identify population needs and send them to multiple levels

3. Of all of the actions proposed by your table discussion group, which three would have the greatest impact and could be implemented within the next three years?

Themes and Comments

Theme 1: Promote PMH type models of care

- Resume expansion of team-based care
- Ensure equitable access to these models

Theme 2: Support PMH implementation through family physician education and training

- Model PMH in medical school and residency
- Provide training in how to use practice data

Theme 3: Re-allocate resources/change funding models

- Align services and funding around patients and their needs, not programs and systems
- Flexible funding models to meet community needs
- Advocate for gain sharing - investing costs saved in hospitals into primary care

Theme 4 Improve access to, integration and effectiveness of EMRs

- Facilitate EMR integration and systems of communication within and across primary care and hospitals

- Facilitate electronic support systems and communication

Theme 5: Promote patient and community education, engagement, and accountability

- Involve patients as partners in planning and execution of reforms
- Educate and activate patients on PMH

Theme 6: Facilitate collaboration

- Provide regular forums for mentoring, educating, coaching and sharing successful models of teams
- Provide a systematic process to identify available community resources that is current and searchable

Theme 7: Advocate for policy change

- Create a specific policy that we, as a profession, can advocate for
- Advocate for increased access to counselling

Theme 8: Address physician accountability

- (no actions selected as top three)

Other

- Identify population needs and send them to multiple levels
- Focus on shifting to a culture of service
- Develop more specific practice management tools and supports

Theme C: Family Physician Leadership at the Practice and Community Levels

1. What do family physicians need in order to be effective leaders to advance the pillars of the PMH at the practice and community levels?

Themes and Comments

Theme 1: Mentorship

- Face-to-face mentorship (locally)

- Peer mentorship
- Coaching new leaders
- Work with identified champions
- Leading by example

Theme 2: Outreach and communication

- Find a way to understand and represent the silent majority
- Effective communication structure, strategies and processes
- Focus on the positives in PMH adoption
- Groups that have political mandate and voice below the College
- Voice/seats at the table
- Common language regarding corporate/administrative roles and structures
- Define leadership

Theme 3: Leadership development

- Leadership skills customized to primary care
- A way to identify family physicians locally who are leaders
- Leadership training to build confidence
- Exposure during medical school and residency

Theme 4: Supports for leadership

- Support resources (in-kind, financial, practice support)
- Practice support
- Administrative support
- Supportive governance

Theme 5: System and peer support

- Peer support for the PMH goals
- Shared system support for defined PMH goals
- Feedback from team and patients
- Effective relationships with key stakeholders
- Receptive audience at the physician and Ministry levels

Theme 6: Promotion and understanding of PMH

- Increased profile of PMH at the LHIN level
- Tools to use in promoting PMH to peers
- Education and support on the practicalities of PMH

- Understand and raise awareness of PMH

Theme 7: Means of connecting with others

- Knowing who the leaders are
- Knowing other health care providers in the region
- The means to connect with others with similar interests
- On-line communities of practice

Theme 8: Data

- Information on population health needs
- Quality data and interpretation of data

Theme 9: Clear roles

- Strong role definition/clarity on role
- Empower physicians to understand their role in change

Theme 10: Stable funding and compensation

- Physician Services Agreement
- Predictable funding

Theme 11: Change management

- Change management/culture skills change and education

Other

- Understanding barriers to leadership
- Leadership valued in promotion
- Value and respect for who we are
- Phased-in approach to leadership
- Pathways to success
- Change in our culture that makes accreditation positive

3. What actions should be pursued to develop and support family physician leadership at the practice and community levels?

Themes and Comments

Theme 1: Invest in leadership development

- Improve or develop leadership training
- Promote and nurture transparency and accountability in leadership
- Develop skills to delegate leadership to others
- Encourage participation by mandating community involvement
- Create expectation that leadership development is part of training
- Ask the College to create a program supporting leadership development, like section of researchers
- Use residency funding to support P63 education on leadership
- Conduct a needs assessment
- LHIN integration of Rotman leadership
- Collaborate with hospitals on PMI/team courses
- Ask people to get involved
- Provide face-to-face education opportunities for rural and remote family physicians

Theme 2: Encourage system and peer support for leadership

- Promote community leadership collaboration
- Encourage a culture of collegial support for leadership
- Recognize and celebrate leadership
- Identify pathways to celebrate successful leadership
- Illustrate positive outcomes of leadership
- Educate hospitals that primary care is part of their core business
- Recognize leadership time as valuable
- Advocate for leadership to be a regular part of paid time
- Make the family physician the architect of other health care professionals' involvement
- Define a culture change to make accreditation a positive experience

Theme 3: Promote understanding of PMH

- Recognize practices that meet PMH goals
- Create tools to talk with peers and LHINS about PMH
- Increase the profile of PMH at the LHIN level
- Develop a PMH checklist
- Establish a consensus among Canadian doctors on support for PMH

- Define a practical future state and ensure that the PMH pillars are reflected in it

Theme 4: Encourage and support mentorship

- Identify champions
- Existing leaders should seek out and identify future leaders for sustainability
- Create leadership development materials and mentoring programs
- Create a mechanism to identify mentors
- Ask the College to create a leadership mentoring network (like MMAP)

Theme 5: Provide outreach and communication

- Hold stakeholders forums
- Establish a clear patient role/voice as co-leaders in system design
- Actively share success stories

Theme 6: Fund leadership development and activity

- Create funding streams to support family physician leadership development
- Re-invest gains from secondary care savings into primary care leadership development

Theme 7: Provide supports for leadership

- Create a safe space for newer practitioners to get timely support
- Hold regular team meetings to create a shared, positive culture

Theme 8: Help communities of practice to connect with each other

- Create links/platforms for communities of practice to connect people with common interests
- Establish a formal point person at the sub-LHI level to facilitate creation of communities of practice

Other

- Widespread strike until there is an agreement
- Support residents and family physicians on research projects
- Define what care needs to be provided between patient and family physician and then think about what kind a of care is needed
- Establish an integrated EMR to facilitate continuity of care
- Ensure information flows from all parts of the system back to the family physician

3. Of all of the actions proposed by your table discussion group, which three would have the greatest impact and could be implemented within the next three years?

Themes and Comments

Theme 1: Invest in leadership development

- Promote and nurture transparency and accountability in leadership
- Ask the College to create a program supporting leadership development, like section of researchers
- Re-develop/expand a primary care specific leadership development program
- Require all family physicians to contribute a leadership role and provide recognition of this

Theme 2: Encourage system and peer support for leadership

- Identify pathways to celebrate successful leadership
- Define a culture change to make accreditation a positive experience
- Make the family physician the architect of other health care professionals' involvement

Theme 3: Promote understanding of PMH

- Increase the profile of the PMH model at the LHIN level
- Define a practical future state and ensure that the PMH pillars are reflected in it

Theme 4: Encourage and support mentorship

- Identify champions
- Create leadership development materials and mentoring programs
- Ask the College to create a leadership mentoring network (like MMAP)
- Formalize a leadership mentoring process

Theme 6: Fund leadership development and activity

- Fund and nurture leadership
- Create funding streams to support family physician leadership development
- Re-invest gains from secondary care savings into primary care leadership development

Theme 8: Help communities of practice to connect with each other

- Establish a formal point person at the sub-LHI level to facilitate creation of communities of practice
- Create and support peer-to-peers communities of practice to share knowledge and experience

Other

- Define what care needs to be provided between patient and family physician and then think about what kind a of care is needed