SPOR PIHCI Network Programmatic Grants - Priorities

Alberta

1. Reaching Vulnerable Populations
    - Identifying individuals who are not attached to a primary care team but would like to be
    - Communities experiencing barriers to receiving primary health care
    - Exploring preventive and therapeutic interventions targeted at high use and high needs patients of all ages that are effective and efficient

2. Models of Care Emphasizing Health and Social Needs Prevention in Primary Care and evaluating primary care-centred systemic innovation
    - Integrated system re-design to support and promote community based patient care, and methods that promote self-management
    - Intersectoral and integrated care pathways and communication protocols for disease prevention and management in community-based primary health care settings
    - Intersectoral collaboration leading to health solutions
    - Appropriate specialist referral and integrated communication and transition back to primary care
    - Evaluation of integrated funding models

3. Data Sharing and Liberation
    - Utilizing health and social data that inform and evaluate primary health care-centred innovative health and social system redesign
    - Improving the process of how best to share, integrate, link and use primary care data
    - Innovative methods to analyze primary care and social determinants of health data
    - Evaluating the utility of mechanisms that allow patients to access their own medical data

British Columbia

1. Optimizing community primary health care service delivery, including:
    - Assessing the relative effectiveness of community primary health care service governance options (e.g. government/health authorities, non-profit societies, Divisions of Family Practice)
    - Assessing the relative effectiveness of integrated primary health care delivery models and service organization (e.g. traditional family practice, community health centers, models of in- home care for chronic disease; comprehensive team-based and collaborative care models, etc.)
    - Assessing the relative effectiveness of funding mechanisms, in both urban and rural settings (e.g. cost and outcome comparisons for fee-for service, capitation, blended funding, etc.; lowering system level per capita costs, etc.)
    - Determining how to best optimize service integration and coordination across community primary health care services, with special attention to children, adults and elderly with complex /chronic health needs (e.g. community models of care for frail seniors and children with complex care requirements)
    - Determining how to best utilize multidisciplinary teams (e.g. provider roles and responsibilities and competency requirements; use of lay providers, traditional healers, and paraprofessionals in management of chronic disease)
    - Determining how to best increase access and strengthen the interface/improve transitions between primary

and specialist care and treatment with special attention to non-urban/rural geographical areas (e.g. strategies to improve access to medical and surgical specialty consultation and treatment)

- Determining how to improve transitions from hospital and facilities to community based primary health care and community supports, including utilization of appropriate care pathways, with special attention to non-urban/rural geographical areas (e.g. models to support hospital transition' medication reconciliation with transfers to home and community)

2. Improving patient experience and cultural appropriateness across the primary health care system (e.g. culturally appropriate interventions for prevention or management of chronic disease; use of multi-cultural health workers; cultural competency training)
3. Developing an adequate primary care workforce, including determining future demand for a range of providers and optimal roles and scope, and supporting optimal provider experience (e.g. specialized nursing practices in chronic care management; pharmacist interventions in chronic disease; improving chronic disease care and outcomes with nurse practitioners)
4. Enhancing optimal access, utilization and continuity of patient information, both across providers within the primary health care system and with other levels of care across the health system

Manitoba

1. Redesign of community care to support continuity of care and reduced health system utilization
   - Models of care that support meeting patient needs in community settings such as primary care, home care and public health instead of in acute care settings such as the Emergency Department and hospitals
   - Enhancing outcomes for people using multiple services i.e. safe transitions or hand-offs between health and social sectors or enhancing continuity from pediatric to adult care
   - Identify options for a continuum of successful housing support for socially complex individuals or those who are frequent users of the healthcare system including social supports, home care and personal care homes
   - Self-management can support people to stay healthy and reduce demand on health care system. What are future opportunities to enhance and better align self-management within community care settings?
2. Optimal Health System design to support fiscal and clinical efficiencies
   - How have other jurisdictions organized health systems to support improved health outcomes, individual experience of care, reduced per capita costs and reduced inequities? This could include financing, centralized or decentralized models, health workforce, health information, medical products, technology, leadership and governance components.
   - These systems should ensure that the needs of populations such as First Nations, seniors, infants and children, new Canadians and individuals living in rural and remote communities are addressed.
3. Mental Health and Addictions services to support improved outcomes
   - Redesign of mental health and addictions services to support access and coordination with consideration of continuum from health promotion, management, treatment and acute care services
4. Performance management and economic evaluation to measure efficiency and effectiveness
   - Explore funding mechanisms and payment systems that support fiscal and clinical efficiencies and lead to improved health outcomes and reduced inequities
   - Enhancing the focus on outcome-based measurement to track and report on success, impact of initiatives and value for money
   - How do other jurisdictions develop, implement and evaluate cost benefit and return on investment

analysis to support identification of cost effective programs to inform decision makers?

New Brunswick

1. Primary Health Care (PHC) Models
    - Improve access to PHC providers and decrease inappropriate utilization of emergency departments and walk-in clinics– same day/next day appts, after hour arrangements, Family Medicine New Brunswick
    - Improve access and provision of team-based care
    - Leverage existing assets to improve care coordination and outcomes for those living with complex needs
    - Explore specific needs of vulnerable populations to ensure existing and new models of care are relevant to the care needs of specific populations
    - Improve mental health integration into PHC
    - Work on upstream policy levers that can be used to better address tobacco utilization and obesity (with an initial focus on youth)
2. Transitions of Care and Inter-sectoral Communication
    - Pediatric and adult care
    - Outpatient and inpatient
    - Emergency department, tertiary care and primary care
    - Primary care and home care
3. System Gaps and Pressures
    - Access to primary care providers
    - Addictions and Mental Health
    - Equitable distribution of programs to support patients/families with chronic illness and multi-morbidity
    - Appropriate care for older adults (aging population, increasing demands for long-term care, increasing prevalence dementia, many patients as “Alternate Level of Care” ALC occupying hospital beds)

Newfoundland and Labrador

1. Primary Healthcare Models in Context
    - Best models to curb high health system utilization/costs where appropriate
    - Best models for rural/urban/inner city/disadvantaged populations
2. Transitions of Care and Inter-sectoral Communication
    - Pediatric and adult care
    - Outpatient and inpatient
    - Emergency department, tertiary care and primary care
    - Primary care and home care
3. System Gaps

- High provider turnover
- Mental healthcare across the lifespan (youth and adult)
- Electronic enhancements to care (eHealth, TeleHealth)
- Primary prevention of chronic disease
- Availability of chronic care
- Appropriate care for older adults

Northwest Territories

1. Improving chronic disease prevention

2. Innovation in Indigenous relevant models of care and health systems stewardship

3. Integration of care and models services in remote and rural regions & Indigenous context (priority topics - mental health, emergency measures, traditional knowledge/medicines, food security, building design)

4. Electronic Medical Records and primary and integrated care reform and case definition standards to facilitate health analytics and client centred quality care

5. Integration of care with non-health sectors and departments, i.e. Early childhood education, justice, housing

6. Measuring health systems performance

7. Stable workforce, capacity in rural and remote regions

Nova Scotia

1. Integrating health promotion and addressing the social determinants of health in care delivery: preventing future complex needs. For example:
    - Determining the best composition for collaborative care teams to integrate health promotion and the social determinants of health
    - Creation of supportive environments to promote health and healthy living
        - Mental health and addictions
        - Healthy start for children and families
        - Early childhood interventions
        - Active living

2. Using innovative tools and strategies to aid in the identification and categorization of patients with complex needs and to understand the needs of those patients. For example:
    - Giving patients with complex needs a voice – what do they believe their needs are?
    - Identifying sub-populations with common needs
    - Screening targeted populations, such as:

    - Frail populations (i.e. Frailty Portal and other frailty screening)
    - People with multiple chronic conditions (especially confluence of mental + physical health issues)
    - High system users
- Using tools such as:
    - Decision aids
    - Administrative health databases
    - Electronic medical records

3. Redesigning service delivery to meet the needs of complex patients. For example:
    - Optimizing community primary healthcare and integrated care to better meet the needs of complex patients
    - Improvements in, and more use of, community focused care for seniors and patients with chronic conditions
        - Continuing care
        - Dementia strategy
        - Polypharmacy
        - Integrated Palliative Care
    - Optimizing collaborative primary and integrated care to maximize efficiency and cost-effectiveness
        - Identification of what models of care work best for complex needs patients
            - Group medical visits
            - Collaborative care team mix
    - The expanded development and use of innovation technologies and strategies
    - Best practices to support the management and coordination of care of those with chronic disease through a central location
    - Patient self-care: Identification and application of successful self-management interventions/strategies

4. Strategies to enable the primary health care workforce to meet the needs of complex patients and future demands for a range of services. For example:
    - Enhancing provider skills and competency to meet complex needs
    - Promotion of leadership, competence, productivity and collaboration
    - Attention to cultural appropriateness and person-focused care
    - Creating interdisciplinary teams

Ontario

1. Community and self-management resources to support people with complex needs and their caregivers, to improve quality of care in the community and delay or avoid institutional care;

2. Cross-sector resources to help support the smooth transition of youths to adulthood in the primary, community and social care system; and,

3. Innovations that connect primary health care to community supports and/or social services that address upstream social determinants of health such as housing, food, income and education.

eHealth innovations identified as a cross-cutting theme with considerable potential for impact on each of the three priority areas. Solutions meeting the needs of people with complex health should be particularly inclusive to those with mental health problems and illnesses, developmental delays and cognitive or neurological impairments.

Prince Edward Island

1. To develop and evaluate e-health solutions with collaborative care models for patients with complex needs – especially strategies for self-management, establishing adherence and compliance, and improving system efficacy.

2. To evaluate the effectiveness of programs and systems of healthcare delivery within PEI on patient health, economic impact, and appropriateness of service

3. To develop and evaluate upstream prevention strategies for early intervention for children to promote optimal health over the lifespan

4. To assess and develop innovative service delivery models for frequent users of health care services, multi-morbidity, pre-frail and frail populations

5. Examine health and social needs of vulnerable populations and evaluate the effectiveness of program and policy interventions (e.g. low income, low education, Aboriginal)

Quebec

1. Enhancing patient, provider, and decision-maker communication and information-sharing over the entire care trajectory and between different sectors and levels of care

2. Valuing an active role by patients and their care-givers in maintaining and managing their health and in partnering with the healthcare team (e.g. for older patients and those with mental health problems)

3. Improving accessibility, coordination and care integration in view of enhanced clinical care trajectories for persons with complex care needs

4. Enhancing the ability of primary health care services to respond to needs of vulnerable youth, including preventive services and upstream public health services

Saskatchewan

Over the next year, the focus will be on the development of PHC Networks that provide service integration and coordination across community-based services, as well as implementation of high quality transitions that help patients move seamlessly from acute to community-based care and vise-a-versa (likely pilots of both). We suggest that our priorities as identified in 2015 are still valid - e.g. #2 speaks to strengthening community based care to reduce demand on the health care system – this directly aligns with current work around building an “accountable care system’ that includes accountable community-based care, accountable acute care that are bridged by high quality transitions. We also would consider adding some priorities that are more specific around integration of care, models of delivery (i.e. composition/governance of PHC Networks), and transition (i.e.

improve transitions from hospital and facilities to community based PHC/community supports; how to strengthen transitions between primary and specialist care and treatment). It could also be timely to look at collaborative care and integrated funding models that would support this.

PICHI Network – Innovation Priorities

1. Innovations that integrate primary-care based multi-disciplinary teams, community resources and patients and caregivers that allow patients to live in their communities avoid institutional care. Focus on older individuals with multi-morbidity and their care givers.

2. Innovations that integrate cross-sector resources and primary care to help support the smooth transition of children/youth with complex needs to the “adult” primary, community and social care system. Focus on individuals with complex health problems, including mental health issues, developmental delays or congenital/ acquired neurological or cognitive impairment.

3. Innovations that connect primary health care to community supports that focus on upstream social determinants including housing, food, income and income support. Focus on “hot spot” populations that are high users of health care and social services with mental health and addictions issues who face income, food and housing insecurity.

4. Innovations in virtual care including telehealth, e-health and virtual visits designed to improve integration of primary and community-based care. Focus on populations that face barriers in access to integrated due to geography or social circumstance.