BRIEFING REPORT:

HEALTH SYSTEM IMPROVEMENT

ROUNDTABLE

Shared learning on leading quality in primary healthcare in Alberta and Nova Scotia

June 4, 2019

Canadian Foundation for Healthcare Improvement
Fondation canadienne pour l'amélioration des services de santé

nova scotia health authority

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OVERVIEW

Building on its pan-Canadian work to support primary healthcare (PHC) transformation, the Canadian Foundation for Healthcare Improvement (CFHI) and the Nova Scotia Health Authority (NSHA) Primary Health Care PHC team co-hosted a roundtable on June 4, 2019 in Halifax, Nova Scotia (NS). The roundtable aimed to facilitate an exchange of learnings from work being led by both the Health Quality Council of Alberta (HQCA) and the NSHA related to:

i. Designing PHC quality and system performance frameworks,

ii. Monitoring and reporting on PHC system performance, and

iii. Using data for practice-level quality improvement (QI) in PHC.

PARTICIPANTS

More than 50 health system policy and decision-makers, physicians, providers, researchers and patient advisors from across Nova Scotia, Alberta, Newfoundland and Quebec as well as representatives from select pan-Canadian organizations, including CFHI and the Canadian Institute for Health Information (CIHI) participated. The full participant list is in Appendix 1.

OBJECTIVES

- **To share themes from pan-Canadian dialogues regarding opportunities and challenges associated with PHC transformation**, including data infrastructure and the optimized use of electronic medical records (EMRs) and other data for quality improvement (QI).
- **To describe and discuss the process by which HQCA developed and designed its PHC QI framework, including practice-level QI and overarching system performance monitoring plan** including selection of indicators, data sources used, the difference it is making on system planning, provider engagement and performance, and how patient experience and outcomes is reported to PHC practices and the public.
- **To provide an overview of NSHA's vision for PHC and highlight progress toward the development of a framework to guide the quality and system performance of the PHC system in Nova Scotia.**
- **To discuss how pan-Canadian organizations like CFHI and CIHI can support provinces' and territories' PHC transformation efforts**, including facilitating additional cross-jurisdictional exchange opportunities and supporting the development of comparable EMR data, tools and resources.

SETTING THE STAGE

Maria Judd, VP Programs, CFHI opened the discussion using the analogy of the square, the tower and the well. The tower can represent hierarchical authority of governments and system leaders. The square represents the social and networked nature of healthcare where providers and patients live, work and play. And the well is a place of gathering where system leaders, providers, patients and citizens can gather to exchange and better understand one another and work towards common priorities of improved care, outcomes, value for money and provider satisfaction. All perspectives and voices are necessary to inform thoughtful dialogue and participants felt that on this day we were all in the well together.

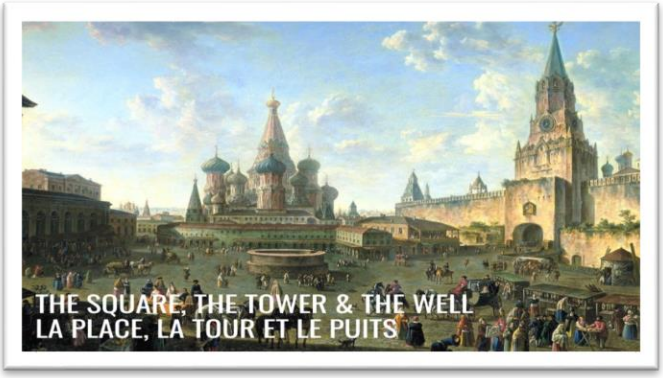


Figure 1: *Inspired by Niall Ferguson's book "The Square and the Tower: Networks and Power, from the Freemasons to Facebook." Photo of painting of Red Square from Wikimedia Commons (public domain)*

ACTIONABLE NEXT STEPS

Three breakout sessions were designed to allow a deeper focused discussion of core issues relating to PHC quality and system performance. Each breakout group identified top actionable next steps for:

- **NOW** (those steps that could be actioned / put in place immediately);
- **NEXT** (those steps that could be done in the next eight to -12 months); and
- **FUTURE** (those that require further discussion and pre-work to accomplish a longer term goal / objective in the next 12-18 months or beyond).

The following is a summary of the discussion questions posed, and the actionable next steps that were discussed.

QUALITY & SYSTEM PERFORMANCE: FRAMEWORKS THAT WORK

Discussion Questions:

What does a quality improvement framework mean to you? How will it help to improve the PHC system, including service delivery, health outcomes and sustainability? What would it look like?

- PHC staff, providers and patients from various settings can see their roles and work reflected in the framework.
- Start from foundation and commitment to quality, and draw upon the existing literature and foundational model and framework on quality, safety and development of a learning culture.
- Select a core set (no more than 25) of high-value comparable quality/performance indicators that include patient-reported measures selected based feasibility (i.e. availability of appropriate data sources), credibility, comparability, understandable to a range of audiences, and importance (identified as a priority indicator of system performance)
- Success is improved patient outcomes and reduced variation in care.
- Have an operational implementation plan, which includes clear direction on what should be tracked, yet still allow and enable teams the freedom to innovate and improve.
- Other considerations: QI capacity development needs to include spread/scale of 'what works', different versions and communication methods (e.g. one pagers) according to stakeholder and public needs. This should reflect the use of culturally appropriate language, leveraging the provincial safety incident management system (SIMS) to audit framework implementation, alignment with provincial/corporate frameworks and plans.

NOW

- Develop a core set of measures that everyone agrees to (e.g. key performance indicators).
- Identify the major stakeholder groups and define their role and mandate.
- Develop a clear framework visual (1 page) and work to brand and create clear messaging to ensure staff and teams feel ownership over this work. They need to understand the framework/approach/plan and see themselves in it - so a very intentional approach needs to be taken.

NEXT

- Engage key stakeholders in the development of a comprehensive framework to guide PHC quality and system performance with a focus on cultivating a learning system based on a foundation robust improvement science processes. This term can be used too casually and needs to be defined as a critical element that needs to be resourced.

FUTURE

- Track data over time on key performance indicators from a variety of data sources. When possible, it is ideal for data sources to be linkable (ex., HCN). It takes about four years to demonstrate performance and understand the progress towards fully realizing the health home model, including collaborative family practice teams.
- Having a trusted and objective source of truth that holds the data and is a sense-maker to support this work.
- There is a balance to be found between what is done provincially and what is local. Spread and scale needs to be intentional and so there needs to be a balance between what we are all committed to (such as improve in a particular chronic disease, screening measure, immunization, etc.) and what local improvement looks like.

PHC LEADERSHIP ENGAGEMENT FOR QUALITY

Discussion Questions:

Thinking about yourself, the team you work in, or the team you support (in the current reality), how would physicians know if they are 'performing' better, worse or the same as the average? Would they have evidence or data to support that assessment?

- One effective strategy to engage physicians in quality is to draw on data. Some believe it would be helpful to have a better understanding of where their own performance ranks in comparison to best practice.
- In the current reality, there is a lack of confidence in the validity of the data and existing reports lack context.
- Need to focus on building relationships BEFORE you access the data, and work together to design reports that are meaningful, accurate and helpful to inform future practice.
- Encourage work with system partners, including professional colleges.
- Make sure there is something in it for both all parties and not an audit tool.
- Develop a value statement for the work and enhanced team engagement.

Assuming access to comparative data would be helpful, what data sources should we make use of? Who would physicians trust to analyze their data and report back on their performance?

- EMR, laboratory, pharmacy and billing data.
- Need to consider appropriate dissemination strategies and how to get the data out of the EMR in a way that is most useful.
- Work to be done to access patient data[1] which is stored within EMR systems, that are owned and managed by physicians and/or teams, in order to be able to use this as a viable data source to monitor system performance. This will require relationship development and agreements in place to govern data access and use.
- All other disciplines report to health authority systems.
- QI can be a disincentive as fee for services physicians lose income to do this work – need to think about creating a system of incentives and consult with physicians to determine what holds value.

NOW

- Leverage existing relationships and work with early adopters. Work with clinicians and teams who want to do something with the data now, and are willing to accept developmental data sources.
- Learn from and leverage Newfoundland, which is using the same EMR as one of the two new ones that NS is using, e.g. How to extract data and cross-link to other data sets – can feed this back to NS in terms of what the EMR can tell them.

NEXT

- Start promoting primary healthcare reporting as a service NS has to offer to healthcare providers. Provide examples of what can be done with the data and how the data will be useful to them (e.g. efficiencies).
- Incentivize the use of data for improvement, and data quality and consistency. Dispel myths such as the data will be used to punish providers for variations in quality/outcomes.
- Provide support and resources to healthcare providers to do QI (e.g. Newfoundland is working on a physician-oriented curriculum for data-informed QI in PHC).
- Morph Dalhousie's family medicine residency research projects into QI projects, which are thought to be much more practical and useful when they begin their practice.

FUTURE

Success would mean:

- Patients understand how the PHC system is performing - enhanced accountability.
- Change the narrative by providing people with data.
- Framing the question before you go with the data.
- Data provides a better understanding to community stakeholders about how hospitals and physicians are doing.
- Ask the public what it is they need to know. Have discussions regarding how public do you want to make your data and how do you educate and manage expectations around what the data tells us?

[1] https://www.cfpc.ca/position-statement-supporting-access-data-electronic-medical-records-quality-improvement-research/

GETTING TECHNICAL: MEASURING PRIMARY HEALTH CARE SYSTEM PERFORMANCE

Discussion Questions:

How can data play a key role in informing PHC performance and improvement at the local / team level (micro), zone (meso) and PHC system / provincial (macro) levels? // What is your experience in balancing the amount of reporting to focus on quality vs quantity? // What are the most reliable sources of data for PHC in your province? What Information / data sources could add value for primary health and how can we move towards access to such information within the next five years? What needs to be done within the PHC system to get these? Health / Performance Analytics?

- NSHA currently has over 800 clinical applications that house data used across the system from PHC team sites to hospitals, much of it in primary healthcare, yet little ability for provincial-level comparison.
- There are challenges in infrastructure and access to primary health care data; it is not in one place and is also not in NSHA's custodianship; the environment to build that functionality is needed.
- Start somewhere, get good at that, and begin layering on new sets of information (e.g. begin with patients' desired experiences first to define priority datasets and cascade from there).
- Look at what other provinces and jurisdictions have done and learn what worked and didn't.
- On privacy issues: our job is to get to "yes" (e.g. how can we make this happen and manage and mitigate privacy risks).
- Key "*consideration is the role of public sector (e.g. government and health authorities) in health data identification, collection, analysis and feedback versus the private sector (e.g. vendors). Is it something the public system takes on or it is something that the private sector is encouraged to do? Or is it a collaborative effort?*" – Dr. Rod Elford

NOW

- Assemble the right people to prioritize which datasets to focus on first, second, etc.
- Use of existing billing data may be a good place to start, then next focus on EMR, lab and pharmacy data.

NEXT

- Clarify and strengthen governance of PHC performance information at NHSA Department of Health and Wellness (DHW), and Izaak Walton Killam (IWK) Health Centre (e.g. leveraging the existing DHW IM/IT PHC task group, existing agreements with the collaborative family practice teams).
- Ensure there is a plan for structured, standardized and consistent EMR data to allow the identification of differences in care, and provide useful information to patients and citizens (e.g. My Health). Use three key areas of continuity, access and comprehensiveness as a starting point.

FUTURE

- Complete governance work (e.g. set roles and governance committee membership and establish data sharing agreements).
- Implement the plan for structured EMR data across practices; established benchmarks to facilitate comparison of data over time in order to inform system improvement.
- Make data available to physicians/providers and the public in useful formats (e.g. patient-, clinic-, and system-level data).

PAN-CANADIAN HEALTH ORGANIZATIONS' ROLES

Representatives from the CFHI and CIHI discussed pan-Canadian activities and opportunities for improving PHC. A sample of each organization's involvements in PHC improvement is summarized in Appendix 2. Several roles were identified for helping to move forward primary healthcare transformation efforts:

- **Convene cross-jurisdictional exchanges** to connect improvement leaders in order to learn from best evidence and the policy and practice efforts of others
- **Help to spread and scale quality improvements** by leading partnerships, developing tools, and building leaders' QI capacities
- **System performance monitoring and reporting and data linkage** to help better understand improvement efforts in primary healthcare and how they impact other parts of the health system such as acute care hospitalizations and ED visit data.
- **Support primary care EMR data standardization efforts** to help improve usability and quality of EMR data in Canada

KEY DISCUSSION THEMES

PRIMARY HEALTH CARE IS THE BEDROCK OF A STRONG HEALTHCARE SYSTEM

It is widely accepted that robust primary healthcare is the foundation of a high performing healthcare system and leads to better health outcomes and lower overall healthcare costs. Expert presenters emphasized that a strong primary healthcare system is what will help sustain publicly funded healthcare.

CFHI commissioned the review *Policy Innovations in Primary Care Across Canada*[2] which helps identify jurisdictions that have progressed primary care most innovatively through the last decade (Figure 2). Six criteria are identified as necessary components for more effective and efficient primary care systems:

- Development of new models of primary care facilitating access **to interprofessional teams**
- Introduction of **tight patient rostering** to contain costs, and improve accountability and continuity of care
- Requirement that primary care practices provide patients with **a comprehensive range of after-hour (24/7) primary care services**
- Effective **investment in, and use of, information communications technology** accessible to both patients and providers
- **Changes in primary care physician remuneration** to encourage greater continuity and quality of care
- **Health system organization changes** producing health system alignment for greater physician accountability to patients and health systems

Figure 2: *Cover from Policy Innovations in Primary Care across Canada*

Figure 3 illustrates Alberta Health Services' vision of enhanced care in the community which aims to shift services out of hospitals and into community settings when it's safe to do so, and support people in their residences or in their community so they can enjoy the highest quality of life possible.

Figure 3: *Alberta Health Services vision for enhanced care in the community.*

[2] Peckham A, Ho J, Marchildon GP. (2018). *Policy innovations in primary care across Canada*. Toronto: North American Observatory on Health Systems and Policies. Rapid Review (No. 1). Available at https://ihpme.utoronto.ca/research/research-centres-initiatives/nao/rapid-reviews/rapid-review-1/

GET SERIOUS ABOUT PATIENT & CITIZEN PARTNERSHIP

Critical to NSHA's success is their work with Patient Family Advisors (PFA), which are part of all of NSHA's PHC quality and safety councils/teams. Currently there are more than 30 PFAs who work within the PHC system as members of the quality councils as well as those involved on an initiative or project basis based on particular areas of expertise and experience. In early 2019, the PHC team was awarded an NSHA silver quality award for their work with PFAs across the province!

Two of PHC's most experienced PFAs attended the roundtable and shared reflections throughout the day to help ensure a focus on the patient experience and outcomes. They offered insight and suggestions for effectively and meaningfully engaging patients in this work, and they emphasized the importance of communicating the work, up and down the system, to partners, patients and the public. When it comes to quality and system performance data, PFAs and participants agreed that it must speak to the patient experience and outcomes.

> *"You could think of the work… as teams walking around the base of Citadel Hill. Covering the foundation before the climb. But why climb anyway? Does change really need to happen? And will change make any difference? I suggest there is a definite need for change that involves patient experience and expertise.*
>
> *~Carole McDougall (Patient, Family Advisor)*

NSHA also knows the value of engaging citizens. Between February and November 2018, NSHA hosted 25 community conversations[3] about collaborative family practice teams. These conversations were held in each county across the province. More than 600 Nova Scotians attended. The purpose of the community conversations was to hear from Nova Scotians about collaborative family practice teams. We also wanted to find out what we need to know about communities to help support teams to be successful.

NSHA has laid out their vision for a culture and system of patient engagement in the *NSHA Patient Safety and Quality Culture Strategy Framework*[4], while the *NHSA Quality Improvement, Safety, and Performance Framework*[5] demonstrates NSHA's commitment to improving patients' experience of care and engagement in health service decision-making. Structurally, the NSHA's *Functions and Enablers for the Nova Scotia Primary Health Care System*[6] puts the health home at the center of the collaborative family practice's care delivery. The primary healthcare plan for collaborative family practice teams is population-based, envisioning that teams work together to provide integrated program and service delivery at the community cluster and community health network level.

TRANSFORMATION REQUIRES GREAT LEADERSHIP *AND* FOLLOWERSHIP

A key sentiment through the day was the many of the transformative ideas are already out there – we should not struggle in isolation but look to the experience of others and adapt to adjust and suit the local context. Jim Easton, Chief Executive, Care UK, talked about the difference between the private sector which is always trying to protect ideas whilst in healthcare we need to be in the business of trying to give secrets away!

> *"We didn't invent any of this. Not one thing. We evaluated a series of ideas and technologies from others and assembled them and optimized them through redesign to meet our needs.*
>
> *~Jim Easton (Chief Executive, Care UK)*

[3] https://www.engage4health.ca/cfpt-community-conversations
[4] https://www.cdha.nshealth.ca/system/files/sites/documents/nsha-patient-safety-quality-culture-framework.pdf
[5] https://www.cdha.nshealth.ca/system/files/sites/documents/nsha-qi-safety-performance-framework.pdf
[6] http://www.nshealth.ca/sites/nshealth.ca/files/phc_evidence_synthesis_april_2017_final_updated.pdf

Lynn Edwards, Senior Director of Primary Health Care and Chronic Disease Management noted that in "Nova Scotia, we are not starting from scratch - we are building upon a solid foundation of local expertise while consulting with those with experience such as the HQCA and others, as well as reviewing the evidence base to inform the development of a framework to guide NSHA's PHC quality and system performance work."

NSHA has two frameworks that underpin the work in PHC which include: NSHA's "Quality Improvement, Safety and Performance Framework" (2017)[7] as well as the "Patient Safety and Quality Culture Strategy Framework" (2018). These frameworks work in tandem and acknowledge the importance of safety as a drive of quality and aim to build a common provincial understanding of the NSHA approach to quality. In addition, the Nova Scotia DHW "Quality Framework for a High Performing Health and Wellness System in Nova Scotia" (2013) serves as a guide for the work happening across the health and wellness system, with a focus on ten dimensions of quality which are intended to improve the health and wellness journey for all Nova Scotians.

The NSHA PHC team is focusing on how to apply the organizational frameworks within the unique primary and community-based care context, including identifying key performance indicators and gathering input from stakeholders, in part through the June 4 roundtable.

> "Great leaders learn to R&D effectively.
> No, not Research & Develop. Rip-off & Duplicate!"
>
> *~unknown, shared by Carole McDougall, NSHA Patient Family Advisor*

The discussion focused on the fact that across provinces, we are working on many of the same things, so how can we learn from other jurisdictions and replicate what we know works. For example, NSHA could take up the model and architecture behind Alberta's *Primary Healthcare Panel Reports*[8] that support QI and patient panel management, and *FOCUS on Primary Healthcare*[9] reporting about things like patients' completion of screening tests and consistent use of the same family medicine practice. Indeed, HQCA generously offered their support to do just that.

There was also a focus on the characteristics of transformational leadership, and followership (Figure 4).

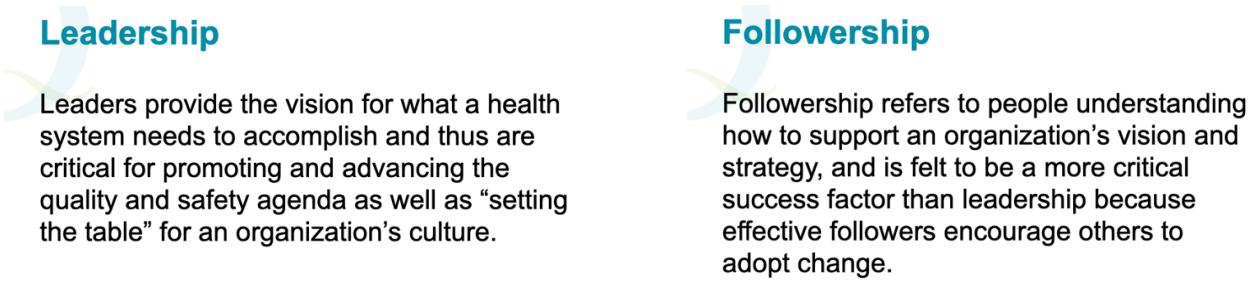


Figure 4: *Characteristics of transformational leadership and followership, slide from Andrew Neuner (CEO, HQCA)*

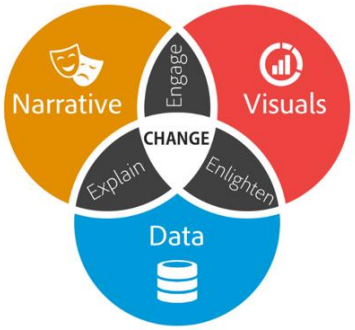
Presenters posed a set of questions for leaders and followers at all levels:

- Are you out there championing patient and family engagement?
- Do you have an ability to manage changes that feels huge on the ground? Are you the calming effect?
- Are you the trusted person that can help manage and jump between organizational priorities?
- Do you 'walk the halls' and know what people are talking about and their preferences?

[7] https://www.cdha.nshealth.ca/system/files/sites/documents/nsha-qi-safety-performance-framework.pdf
[8] https://www.hqca.ca/health-care-provider-resources/panel-reports
[9] https://focus.hqca.ca/primaryhealthcare/

DATA IS NECESSARY BUT NOT SUFFICIENT

For data to effect change in primary healthcare, it has to matter to clinicians and their work. Combining quality data from a variety of sources with narrative and visuals to engage, explain, and enlighten the audience can more effective in eliciting change (Figure 5). Participants agreed that competing data sources need to be eliminated, and standardized measures are critical for change to happen because without them we cannot appreciate and reduce variation in care and outcomes.



The Institute for Healthcare Improvement President Emeritus and Senior Fellow Don Berwick, emphasizes that the next era in healthcare[10] will have to reduce excessive measurement and increase transparency of what is measured. Participants agreed that what we measure needs to be determined by the outcomes we want to achieve.

> "If you can't measure it, you can't improve it."
>
> *~Peter Drucker*

Figure 5: *Data tells a story, slide from Andrew Neuner (CEO, HQCA)*

CHECK YOUR ASSUMPTIONS

We often have or make assumptions that help us be more efficient, productive, and decisive. Participants were reminded that in order to achieve the system improvements we want to see, we need to take stock of (and bust!) some common healthcare myths.

The public assumes that…

- We have actually designed the healthcare system to have the patient at the centre.
- The system is actually designed based on what people need.
- What we have that's called a primary healthcare system is actually functioning as a system.
- Having X in our community, whether X is a hospital, clinic, or family physician's office, means we actually have what we need in our community.

Patients assume that we …

- Actually share information that we gather about them.
- Actually know how well they are doing.
- Are actively trying to improve what we are doing.

We (providers and system leaders) assume that …

- We need permission to actually start doing something different.
- We cannot act without having certain things in place.
- We cannot do anything at all unless we are ready to do everything, or have the entire framework, or do it everywhere.
- Progress will be linear, logical and planned, it will follow a process which makes sense. This is not how complex adaptive systems like healthcare work!

Expert presenters and participants emphasized that since change is happening already, we don't have to start the transformation - we just have to shape it. Andrew Neuner, CEO HQCA, recommended the provincial PHC team 'think big' and be brave, focus on strengthening the foundation for transformative improvement, organize for the results they want to achieve, and be careful not to over-consult and under-deliver.

> "In healthcare everyone has two jobs: to do your work and to improve it."
>
> *~Paul Batalden*

[10] http://www.ihi.org/resources/Pages/Publications/Era-Three-for-Medicine-Health-Care.aspx

APPENDIX 1

PARTICIPANT LIST

- **Maria Alexiadis** | Head, Department of Family Practice, Central Zone, NSHA
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- **Denise MacDonald-Billard** | Project Executive, Department of Health and Wellness, NSHA
- **Gail Blackmore** | Senior Director, Quality and Improvement, Safety and Patient Relations, NSHA
- **Anne Breski** | Health Services Lead, PHC, Eastern Zone, NSHA
- **Mary Byrnes** | Manager, PHC Information, CIHI
- **Bill Callery** | Senior Improvement Lead, CFHI
- **Cameron Campbell** | Director, PHC, Government of Newfoundland and Labrador
- **Cassie Chisholm** | Manager, PHC, Government of Newfoundland and Labrador
- **Erin Christian** | Implementation Director, PHC, NSHA
- **Carl Drouin** | Scientific Coordinator, Information Management, National Institute of Excellence in Health and Social Services (INESSS), Québec
- **Jim Easton** | Chief Executive Officer, Health Care, Care UK
- **Lynn Edwards** | Senior Director, PHC, Family Practice and Chronic Disease Management, NSHA
- **Rod Elford** | Medical Director, HQCA
- **David Gass** | Interim Department Head, NSHA
- **Rick Gibson** | Senior Medical Director, PHC and Department of Family Practice, NSHA
- **Matthew Grandy** | Family Physician, NSHA
- **Matt Holland** | Manager, Planning and Development, Legal Services, NSHA
- **Cora-Lee Joudrey** | Health Services Lead, PHC, NSHA
- **Maria Judd** | Vice-President, Programs, CFHI
- **Tanya Khan** | Analytics Lead, CIHI
- **Graeme Kohler** | Director, PHC and Family Practice, Central Zone, NSHA
- **Markus Lahtinen** | Director, Health System Analytics, HQCA
- **Erin Leith** | Manager, Planning and Development, PHC, NSHA
- **Bill Lowe** | Head, Department of Family Practice, Northern Zone, NSHA
- **Amanda MacDonald** | Network Lead Central Zone / Family Physician, NSHA
- **Madonna MacDonald** | Vice-President, Health Services, NSHA
- **Jamey Martel** | IM/IT Director, Clinical Applications, NSHA
- **Bethany McCormick** | Senior Director, Planning, Performance and Accountability, NSHA
- **Beth McDougall** | Epidemiologist, PhD Student, NSHA
- **Carole McDougall** | Patient Advisor, Communications Consultant, Community Volunteer (Nova Scotia)
- **Elizabeth Michael** | Operations Consultant, PHC, NSHA
- **Mary-Jo Monk** | Senior Policy Analyst, PHC, Department of Health and Wellness, NSHA
- **Melanie Mooney** | Health Service Manager, PHC, NSHA
- **Matt Murphy** | Director, Performance, Analytics and Accountability, NSHA
- **Andrew Nemirovski** | Senior Director, IM/IT and CIO, NSHA
- **Andrew Neuner** | Chief Executive Officer, HQCA
- **Jackie Onions** | Manager, PHC and Community Applications, IM/IT, NSHA
- **Judy Porter** | Patient and Family Advisor (Nova Scotia)
- **Shannon Ryan Carson** | Director, PHC and Chronic Disease and Wellness, NSHA
- **Tara Sampalli** | Director, Research & Innovation, PHC, NSHA
- **Susan Savage** | Health Services Manager, PHC, NSHA
- **Aaron Smith** | Program Director, Medical Teaching Unit, NSHA
- **Colin Stevenson** | Quality System Performance and Transformation, NSHA
- **Deirdre Taylor** | Senior Communications Advisor, PHC, NSHA
- **Crystal Todd** | Head, Department of Family Practice, Western Zone, NSHA
- **Christine Tompkins** | Project Lead, NSHA
- **Barbara Wasilewski** | Executive Director, PHC, Manitoba Health
- **Jo-Anne Wentzell** | Director, PHC and Chronic Disease Management, Western Zone, NSHA
- **Laura Wentzell** | Health Services Manager, PHC, NSHA

APPENDIX 2

PAN-CANADIAN HEALTH ORGANIZATIONS' INVOLVEMENTS IN PHC IMPROVEMENT

Representatives from CFHI and CIHI discussed pan-Canadian activities and opportunities for improving PHC. Several roles were identified for helping to move forward primary healthcare transformation efforts, listed in the main report.

Organization	Canadian Foundation for Healthcare Improvement (CFHI)	Canadian Institute for Health Information (CIHI)
Roles in PHC	Lead partnerships to spread and scale proven innovations that deliver better care closer to home and community Connect leaders across health systems to share, learn and improve together (e.g. by sharing policy insights, levers for change)	Foster partnerships and innovation to produce comparable EMR data that demonstrate the value of EMR data linked to CIHI data assets Evolve supports, including pan-Canadian PHC EMR content standard and PHC indicators, to advance comparable EMR data and its use.
Recent Activity	Hosted the 2018 Pan-Canadian Primary Care Roundtable *Sharing What Works to Accelerate Primary Care Improvement* focused on exploring efforts to improve primary care across provinces and territories, and sharing learnings from those jurisdictions that have made more progress across six key areas. Key Themes: › Primary healthcare measurement (e.g. performance/ outcomes, patient-reported measures) › Electronic technologies (e.g. EMR, comparability, remote consult) › Financial reforms to support comprehensive care (e.g. interprofessional, integrated care) › Interprofessional care capacity (e.g. workforce readiness, scopes of practice) › Accountability mechanisms (e.g. physician-government relations, patient/family co-design) › Cross-sectoral integration (e.g. social determinants, Indigenous healthcare) More details available at https://www.cfhi-fcass.ca/WhatWeDo/health-system-transformation/primary-care-reform-and-integration	Hosted the 2018 Pan-Canadian Primary Care Forum *Forging the path: towards a shared standard for EMR* with the goal to understand how to better standardize primary care EMR data to support clinical care needs and health system use, and lay the foundation for the way forward. Key Themes: › There is agreement on the need for a national approach to standardize EMR diagnosis and treatment data across Canada in a clinician-friendly manner. › A forward-looking, outcomes orientation is needed to generate comparable EMR data that is fit for purpose. › Value proposition scenarios will help to promote the benefits of comparable data. › The experiences of clinicians with data collection and use should be considered when designing a solution. › It is necessary to address EMR data and information governance issues, such as defining data flows and resolving data privacy and security concerns. › Canadian public-sector stakeholders face primary care EMR data access issues. A collective strategy is needed to discuss these considerations with EMR vendors in a way that is mutually beneficial. › Both EMR data standards and artificial intelligence (AI) approaches could be used to produce a comparable minimum EMR data set for health system use. › Canada should build on lessons from the journey of the United Kingdom's National Health Service (NHS) Digital to standardize EMR data, such as building on policy drivers and taking a phased implementation approach. More details are available at https://www.cihi.ca/en/primary-health-care

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