eHealth
CENTRE OF EXCELLENCE

Primary Care Network

Enablers at the Local Level

2024

www.ehealthce.ca

A Message from Dr. Mohamed Alarakhia

Family Physician
Chief Executive Officer, eHealth Centre of Excellence

The creation and advancement of Ontario Health Teams (OHTs) has provided a new way of organizing and integrating local care delivery and has supported building a more connected healthcare system. Primary care has been engaged in many OHTs; however, there is now an opportunity to continue to build partnerships and connections between OHTs and family physicians, nurse practitioners, and other primary care clinicians in their regions.

"Your Health: A Plan for Connected and Convenient Care" proposed the idea that every OHT will include primary care clinicians organized in a Primary Care Network (PCN) to be part of decision-making and to improve access to care for patients. An engaged and supported primary care sector is foundational to successfully improving care and is recognized as an evidence-based best practice globally, to advance population health through integrated and equitable approaches to care. Ontario Health continues to align elements of the health system and has identified PCNs as an OHT Acceleration Priority.

The eHealth Centre of Excellence currently supports primary care and OHTs by delivering quality digital health solutions from the provincial and local OHT levels to support improved experience and efficiencies. In addition to this offering, we can also support your OHT through Integrated Care Manager facilitation services, which can assist you with the development and implementation of your PCNs, helping your OHT meet the requirements of your assessment submission and network launch. We received an overwhelmingly positive response from all partners when we produced the Digital Supports for OHTs document a few years ago and therefore are following up with a specific document focused on enablers for PCNs.

Our team offers professional advisory capacity, facilitation, project management, change management, knowledge translation and evaluation, and IT support, in addition to recommendations on which digital tools will advance clinical models and successful compliance with PCN guidance from OH and the Ministry of Health. We are happy to continue the dialogue on how we can provide professional support and coaching to enable expedited success with your PCN development. We look forward to hearing from you!

Meet the eHealth Centre of Excellence team!

The team at the **eHealth Centre of Excellence** encompasses a broad range of experts from a variety of disciplines – including **Change Management**, **Practice Facilitation**, **Program Management**, **Knowledge Translation & Evaluation**, **Integrated Care**, **Privacy and Cybersecurity**, as well as a team of **Clinical Advisors**, and more – all working together to support and advocate for primary care. It is our mission to be a trusted digital health partner and we have the experience and expertise needed to support Ontario Health Teams (OHTs) with Primary Care Network (PCN) maturity.

A bit more about who we are:

Change Management Specialists, Practice Facilitators, and Program Managers: We have experience working with clinicians, healthcare organizations and agencies across Canada to employ meaningful and sustainable strategies to ensure that project or program deliverables are met.

Quality Improvement and Evaluation Experts: We have a team dedicated to evaluating evidence and monitoring quality improvement efforts to ensure that digital health technologies are enabling best practices and ultimately improving care delivery and patient outcomes.

Integrated Care Managers: This team possesses a strong understanding of the digital health gaps and the funding opportunities available; they also help to identify and adopt the solutions that best support integrated care pathways.

Cybersecurity and Privacy Advisors: Our team has a deep knowledge of cybersecurity and privacy and can equip PCNs with the skills needed to keep their patient information and other sensitive data safe and secure, as well as support with privacy assessments and other requirements.

That's not all we do... LEARN MORE

We have supported 11,000 primary care clinicians from across Ontario!

Our Support

We support the creation and development of PCNs within OHTs by providing expertise in facilitation and coaching teams through many Operational and Continuous Improvement strategies, demonstrating improved access to care and value for money.

RECOMMENDED VISION and OBJECTIVES for PCNs from the Ministry

**Primary Care Networks in Ontario Health Teams: Guidance Document, January 2024

VISION:

PCNs will connect, integrate, and support primary care providers within OHTs to improve the delivery and coordination of care for patients.

OBJECTIVES:

PCNs have two core objectives...

1. To organize the local primary care sector in OHT planning and provide a voice in OHT decision-making.
2. To serve as a vehicle to support OHTs in the implementation of local and provincial priorities.

Initial Clinical Priorities and Guiding Principles supporting the PCN recommended Vision and Objectives

**Primary Care Networks in Ontario Health Teams: Guidance Document, January 2024

INITIAL CLINICAL PRIORITIES:

CORE SET OF URGENT CLINICAL PRIORITIES:

- Improve access and attachment to comprehensive primary care, with a focus on equity-deserving populations (e.g. Indigenous, Black, Francophone, etc.)
- Implement integrated chronic disease prevention and management strategies, with a focus on equity-deserving populations, as above.
- Implement additional local priorities as defined by the OHT and PCN.

GUIDING PRINCIPLES:

- Joining a PCN is voluntary, but strongly encouraged. Participation should be driven by a strong value proposition and be built on local relationships to implement a quintuple aim approach that will improve patient care, primary care provider experiences, and enable system transformation.
- PCNs will build and enable the clinical leadership with the capacity to deliver on its core functions. PCNs should work to ensure that clinical leadership represents primary care providers broadly, but at a minimum includes family physicians and nurse practitioners.
- PCNs will adopt a health equity lens including in its clinical priorities, with a focus on the needs of equity-deserving populations including First Nations, Inuit, Metis and urban Indigenous, Francophone, Black and other racialized communities, 2SLGBTQIA+, and other underserved and underrepresented communities in alignment with Ontario Health's Equity, Inclusion, Diversity and Anti-Racism Framework and the Patient, Family
- As the OHT matures, its PCN will be critical to supporting the local primary care sector, including through connecting primary care providers to information and clinical tools that are useful and supportive to a primary care provider in the network.
- PCNs will work within OHT collaborative governance structures to ensure a strong primary care clinical voice and perspective is a critical part of local OHT decision making.
- Over time, every OHT across the province will be required to have a PCN that organizes family physicians, nurse practitioners and other primary care providers to the common vision, objectives and functions outlined in this document.

The next few pages will explore how our team can support primary care and OHTs with the five functions identified in the PCN guidance document.

Overarching

Foundational PCN Documents

Examples: ToR, Governance Structure, Project Charters

We can assist OHT working groups and committees in their development of Terms of Reference, Governance Structures, Project Charters, and other foundational documents.

Collaborating with patients, families, caregivers and the community

Example: PFACC, Community Advisors, Surveys, Interviews

We have experience supporting OHTs with the creation and/or expansion of patient, family, and caregiver councils (PFACCs), ensuring appropriate recruitment and that PFACC members can provide feedback on key initiatives. Our organization has experience creating surveys, performing key informant interviews, and leading community engagement, and has knowledge of best practices in the PFACC space.

Operational staff

Example: Non-clinical roles (Project Management and Implementation Lead, Change Management support, Knowledge Translation & Evaluation)

We have been flexible to support OHTs in non-clinical roles to support overall OHT development. Some roles include but are not limited to: Project Managers, Digital Health Leads, Change Management and Practice Facilitation, etc. Our change management approach incorporates change management, co-design and practice facilitation.

Function 1: Connects Primary Care within the OHT

Membership Recruitment and Tracking

Example: Client Resource Management at the local level, data analysis

Our organization has over a decade of experience managing and using "customer relationship management" to support clinician recruitment and engagement in a manner that meets clinician needs.

Communications

Example: Email and social media campaigns, satisfaction surveys

We have implemented communications campaigns to get in touch with primary care clinicians through a variety of platforms. Our team has also been involved in the development of communications plans for a number of OHT-specific initiatives. We work closely with primary care and have a strong understanding of the messages that land with them.

Function 2: Primary Care Voice in OHT Decision-Making

Clinical Leadership Selection

Note that Clinical Leadership refers to the application of relevant frontline clinical expertise and experience, that can only be provided by primary care clinicians to inform planning, decision-making processes and operations.

Our team has crafted clinical lead job postings and has inquired about what other OHTs are doing in terms of selecting leads to ensure a consistent and equitable approach. Over the past ten years, we have planned for, recruited, and operationalized a clinician advisory group that informs the development of many initiatives.

Voice

We can draft work plans for committees in alignment with OHT Strategic Plans and act as a liaison within different committees and working groups to ensure the primary care perspective is incorporated. We also make sure the primary care voice is present in any change-related initiative in the OHT. Our advocacy has led to the establishment of two provincial programs that are supporting primary care needs by improving connections within the broader healthcare system.

Function 3: Supports primary care members to advance OHT clinical change management and population health management approaches that relate to primary care

Data and Population Health Management

Examples from OHTs: OHT Dashboard, Environmental Scan, DSA work, IDS, SHIIP

For years, our organization has built insights and actions to provide more proactive care from primary care data, and we have supported OHTs to extract and analyze data from dashboards to support population health management. We work to support the development of evidence-based case studies and have conducted evaluations for government and health agencies.

Access and Attachment to Comprehensive Primary Care, with a Focus on Equity-deserving Populations (e.g., Indigenous, Black, Francophone, etc.)

Examples from OHTs: Referral, Social Determinants of Health

We support OHTs to improve care access by providing change management and project management in ways that support primary care with practice efficiencies (i.e., our team supports the adoption of eReferral and other digital health assets). Our eCE Automates division has been developing and deploying customizable robotic process automation "bots" to help clinicians quickly and efficiently identify patients for care interventions, segmenting their roster into priority groups based on postal code and other social determinants of health. An example of one of these bots is included in the Appendix.

Integrated Chronic Disease Prevention and Management, with a Focus on Equity-deserving Populations (e.g., Indigenous, Black, Francophone, etc.)

Example: Clinical Decision Support in EMR tools

We can support OHTs with improving chronic disease management for special populations and patients by implementing EMR optimization and evidence-based digital tools. The eHealth Centre of Excellence has partnered with industry leaders to develop and deploy tools to support more effective Chronic Disease Management (e.g., hypertension management); we have also created automated solutions to support equitable patient outreach (see example in the appendix).

Local Primary Care Priorities

Example: Ophthalmology and DI pathways for eReferral, Online Appointment Booking, automation to support efficient workflows, change management and practice facilitation support with incorporating the priorities into day-to-day work

Acting as a digital health partner with experience in over 30 Ontario Health Teams has enabled our team to build awareness as to how to best realize local priorities. We work closely with OHTs to identify potential local clinical priorities and are very knowledgeable about the available suite of digital tools to support ongoing success. Our approach incorporates change management, co-design and practice facilitation which can be leveraged by primary care to achieve their priorities.

Our organization has developed and collaborated with partners to create and support the implementation of effective digital solutions and we are committed to working with clinicians to co-design solutions that meet their specific needs.

Function 4: Facilitates access to clinical and digital supports and improvement for Primary Care

Digital Health Enablers

Example: EMR Knowledge, OHT eServices Dashboard, Digital Asset Inventory, Vendor Comparison

Our organization has many years of experience managing and using "customer relationship management" systems and we have experience completing vendor evaluations, as well as supporting primary care in navigating platform options - including functionalities and alignment with their EMR, workflow, etc. We have also acquired knowledge of the various EMRs used by primary care and supported integration initiatives that enable more efficient and connected care delivery; for instance, we have used bot technology to support the transfer and visualization of data between different clinical information systems.

Clinical Supports

Note that collaborating with partners within and outside of the OHT will likely be required. Consider: human resources such as nurse navigators, chronic disease nurses, Prevention Specialists, Quality Improvement Decision Support Specialists, etc. and programs such as SCOPE, Best Care, Online Appointment Booking, etc.

Examples: Environmental Scans, Readiness/Needs assessments

Our team has demonstrated experience coordinating easy access to clinician supports (such as digital health supports), overseeing quality improvement, and evaluating impact and ongoing needs to inform new support requirements to implement integrated clinical pathways. Our certified practice facilitators can support clinicians with their priority improvements.

Our team is here to help your PCN achieve its goals!

Scan the QR code to fill out an **Expression of Interest form**, and someone from our team will be in touch. Our contact details are also included below.

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info@ehealthce.ca

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235 The Boardwalk, Suite 301
Kitchener, Ontario

Website :
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THANK YOU!

Appendix

MEET POPPY:

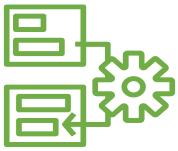
Poppy is a **population health management bot** that identifies patients overdue for cancer screening (colorectal, cervical, breast), stratifies identified patients into priority groups and automatically initiates patient follow-up actions such as the completion of FIT requisitions and direct patient communication through existing secure messaging channels.

HOW POPPY WORKS:

Poppy utilizes advanced algorithms to help a primary care clinician to pull a list of patients due for their cancer screening(s) and stratifies patients into higher-precedence categories by a priority neighbourhood

One of the patients identified is Patient A, who is 52, and lives in a high-priority neighbourhood – although her mammogram is up to date, her cervical and colon cancer screenings are overdue

Poppy stratifies Patient A into higher-precedence category due to her residency in a priority neighbourhood



Poppy sends a secure message to Patient A to schedule a PAP smear using an online appointment booking link and in addition, a FIT requisition is automatically completed and sent to the lab

Patient A books a PAP smear appointment online, appreciating the flexibility of choosing a time that fits into her schedule; she is also able to request a female provider as that is her preference if her family physician is not available

This process reduces administrative burden by automating patient communication where possible (e.g., secure messaging, referrals, ordering tests, etc.)

Patient A's pap smear is conducted by a female clinician and a discussion about the FIT kit takes place

The clinic contacts Patient A to discuss the results of the screenings

Interested in learning more about how Poppy could support your team?

Click here to start the conversation!

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eCE Automates

eCE Automates is a division of the eHealth Centre of Excellence.