Synthesis of Potential High Impact Actions for Ontario That Were Identified at September 21 and 25 , 2019 Sessions

Impact Idea	What does it mean?	How Does That Create A Better Provider Experience?
Integrate EMRs	Either single or intra-operable EMR / EHR systems that can both push and pull required information	Enhances quality of care provided and practice efficiency by promoting easier and better communication. Enables quality improvement.
Recognize and Support Primary Continuity (the core team) (formerly Accountable Relationships)	Promote the patient/ caregiver – provider relationship	The longitudinal relationship a family doctor / nurse practitioner has with his / her patient and their family / caregivers is the core 'team'. This relationship has to be recognized and supported in any health care transformation.
Build the Extended Team	Identify and support the extended team that wraps around the patient and his/ her family / caregivers. Provide the supports the team needs to be high-performing.	Consistent with the Patient Medical Home where there is an identifiable team that works with the core team (where core team = family doctor / nurse practitioner and his / her patient and their family / caregivers). This extended team, which can include health and social services, has the supports it needs to be responsive, and maximally productive. Consistent with SDoH (social determinates of health). Promotes timely patient access to range of services where all members of the team are working to their defined scope / expectation and have the resources they need (including mentoring, team development) to deliver the best quality care.
No patient or practice left behind	Easier and equitable access to team-based resources that support the importance of continuity of care.	All providers, regardless of practice model, geography, etc. have access to team-based resources (health and social services) which promotes wider range of patient care delivery options and allows everyone to work to their ideal scope. Addresses the inequity that currently exists where over 75% of family practices, and the

		patients they serve, do not have access to team-based care.
Alternative Consultation	Enable alternative digital consultation modalities to be available to all providers. This includes (virtual care (including telephone, email, text, videoconference) as well as e-consult, e-referral.	Greater care delivery options available which can free up time for providers while still maximizing patient access and convenience
Access to Mental Health and Addictions Supports	Provide mental health and addictions supports in the community	This is one of the most challenging problems at present for front line providers in Ontario.
Encourage Innovation	Provide seed money for local innovations and initiatives	Innovation needs to be supported and encouraged if you want providers to engage in health system transformation. You have to 'walk the talk'
Practice Facilitation and Change Management	Provide funding support for change management and QI participation. This includes funding for coaching / mentoring.	Provide dedicated resources to enable peer -to -peer coaching and uptake by providers. A QI-enabled, evidence-driven health care system, in turn, enables best practices.
Clinical Leadership	Provide funding and other support for clinical leadership	If primary care is to drive Ontario's health care transformation, need dedicated support, akin to protected time in academic settings, that enables clinical leaders to engage with other stakeholders, their peers, etc. Can't be expected to continue to engage in health system change off the side of one's desk.
Navigate and Coordinate	Promote patient navigator role that can enable easier patient / caregiver access to resources including those that go beyond health care resources. This could include linking home care coordination to primary care.	Another pain point in daily provision of care at present. Dedicated patient navigators will be critical in current OHT concept.

Shared Risk/Shared Reward	Promote gain sharing across primary care, home care and emergency.	The current focus in Ontario is keeping people out of emergency departments. Promoting gain sharing across those sectors incentivizes them to work toward this objective together while mitigating current potential risk i.e., they are potentially penalized for not meeting system expectations. Gain sharing might also enable shifting of funds to those sectors (primary care, home care) that are doing the heavy lifting keeping people out of hospital.
Patients as Partners	Empower patients to take greater control / ownership of their health. This could include: province-wide patient portal; community – based education and development that foster patient self-care or health literacy; greater support for social determinants of health needs; funding for current services that are non-funded or extremely limited (eg., physiotherapy); and even feedback loops to patients that can track and support patient progress.	Supports the patient/caregiver-provider partnership. Not everything rests on the provider's shoulders and patients and caregivers have the tools they need to maximize self-care capability.
Streamline and Reduce Admin	Reduce bureaucracy and administrative burden. Examples include one single diagnostic services requisition form (as opposed to each hospital having their own form); eliminating restricted access to outpatient clinics and services currently faced by non-PEM family doctors.	Streamlines office practices, and ensures equitable access to needed resources regardless of practice model, geography, etc.
Value of Time	Enable personal productivity. Examples include speed reading, touch typing courses.	Promotes personal productivity which frees up time.
Organize Primary Care	Promote greater access to the FHO model.	The current OHT concept is predicated on the team-based model of care. New grads are trained in this model so restricting their access to it is antithetical to

		government ambitions. Ideally moving everyone to team-based care will provide the supportive environment Ontario needs to enable the OHT concept to flourish and take hold.
Building connections to address the social determinants of health and incorporation of Social Prescribing	Recognition that many factors that influence an individual's health and wellbeing are factors outside of access to healthcare services	By creating and strengthening the connections to the factors and resources that impact an individuals' health and wellbeing, promotes a wholistic provision of care while also focusing primary care's time to be spent on addressing the health care needs