

Getting Past Yes—to Go!

The Change Foundation's report from the 2009 *Meeting of the Minds*
First things first: fostering accountable, connected, quality primary care

 **Meeting**
of the Minds



THE CHANGE FOUNDATION

HEALTH CARE DESERVES
OUR FINEST THOUGHT

About The Change Foundation

The Change Foundation is an independent health policy think tank that generates research, analysis and informed discussion on health system integration and quality improvement in home and community care in Ontario. Located in Toronto, The Change Foundation is governed by a 12–member board of directors, led by President and CEO Cathy Fooks and supported by a small professional staff. Established in 1996 through an endowment by the Ontario Hospital Association, The Change Foundation is an independent charitable foundation with a mandate to promote, support and improve health and the delivery of health care in Ontario.

About the *Meeting of the Minds*

The *Meeting of the Minds* is The Change Foundation’s exclusive invitational exchange for senior health leaders in Ontario, delivering on our commitment to drive informed discussion about key and emerging policy issues. It is a forum for substantive, frank debate about issues that need illumination and action, and is informed by the knowledge and experience in the room as well as the insights and analysis of respected speakers drawn from across the country and world.

The Change Foundation dedicated its first *Meeting of the Minds (Lessons & Confessions from the Regionalized Health-Care Front: Where can they lead Ontario?)* in May 2008 to examining the lessons learned from more than a decade of regionalized health-care across the country—lessons that could be instructive for Ontario during the early days of devolved decision-making under the Local Health Integration Networks. Those who led—and lived through—health-care regionalization (including CEOs of Regional Health Authorities and hospitals, former deputy ministers of health, royal commissioners, and key authorities on health-care regionalization) assessed what went right and wrong and deliberated with Ontario leaders about what might improve the prospects for success as the province’s health integration agenda evolves. The isolation of primary care from the rest of the system was raised repeatedly as a barrier to creating an integrated health-care system.

Like last year, this year’s *Meeting of the Minds* featured an opening night debate—this year’s probed whether primary care should come under the authority of the Local Health Integration Networks (LHINs)—and Charter House rules again applied. We introduced a new feature this year: the use of instantaneous computerized keypad voting to allow participants to “take the temperature” of the room on a number of important questions, both before and after key presentations, and to gain insight into areas of commonality and divergence. The results of some of those voting exercises are woven throughout this report.

About this report

This report summarizes selected highlights from the 2009 *Meeting of the Minds, First Things First: Fostering Accountable, Connected, Quality Primary Health Care*, held in Toronto June 16–17, 2009. It also tracks some of the developments in primary care in Ontario since then and outlines options for change to improve the quality and accountability of primary care, to better connect it to the rest of the system, and to align it more closely to system goals.

Acknowledgements

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VOICES OVER THE YEARS

Consistent Calls For Primary Care Reform

PROVIDER ATTITUDES AND BELIEFS, lack of government support, lack of enabling legislation, lack of capital and start-up funding especially for consumer-sponsored programs, and cost constraints associated with an ailing economy – all of these have contributed to the lack of growth of comprehensive community based programs in Canada.

–Hastings and Vayda, 1986

THE SOLO DOCTOR who embodies every process needed to ensure highest-quality health care is now nearly a myth. All physicians depend on systems, from the local ones in their private offices to the gargantuan ones of national health care.

–Don Berwick, 1989

THE HSRC BELIEVES that an effective primary health care system does not exist in Ontario today. Although there are many dedicated primary care providers who serve the population, health care is fragmented, unstructured, and not part of an integrated and coordinated health care system. Serious access problems exist in a number of areas in the province, especially in rural and remote areas. Much of the activity to date aimed at improving the health system has related to hospital services. Attention is badly needed to improve primary care now.

–Health Services Restructuring Commission, 1999

THE PRIMARY CARE SECTOR is structured like a 19th century cottage industry rather than a 21st century service industry, consisting as it does largely of individual physician practices which are not clustered together, making 7/24 service impossible. The first and essential step in organizational change must be primary care reform. This has been recognized by the Sinclair Commission in Ontario, the Clair Commission in Quebec and the Fyke Commission in Saskatchewan. It is why the federal government agreed to contribute \$800 million to primary care reform following the F/P/T agreement on September 2000.

–Standing Senate Committee on Social Affairs, Science and Technology, 2001

SASKATCHEWAN HAS SKILLED AND CARING PROFESSIONALS who can provide good quality care in communities large and small. But these skills are not employed as effectively as they could be. Physicians, in today's model, are isolated from the rest of the health system. Working in independent practice, and paid a fee for each service, doctors cannot easily share work with nurses, nutritionists, mental health counsellors or other professionals.

–Saskatchewan Commission on Medicare, 2001

EVERY REPORT REVIEWED IDENTIFIED the need to restructure the way we deliver primary care. Without reforming primary care, we cannot do much about other important parts of the system.

–Fooks and Lewis, 2002

PRIMARY HEALTH CARE IS about fundamental change across the entire health care system. It is about transforming the way the health care system works today – taking away the almost overwhelming focus on hospitals and medical treatments, breaking down the barriers that too frequently exist between health care providers, and putting the focus on consistent efforts to prevent illness and injury, and improve health. In fact, no other initiative holds as much potential for improving health and sustaining our health care system.

–*Roy Romanow, 2002*

DESPITE THE BROAD CONSENSUS on the importance of primary care reform in theory, achieving such reform is proving difficult in practice. In Canada, all provinces and territories have been designing and implementing reforms in primary care. Their approaches to program design, implementation and pace differ, but nowhere is the process proving to be speedy.

–*Ruth Wilson et al, 2004*

IN SHORT, the implementation of primary care reforms must be the central issue to be solved in Canadian health care in this decade. New models or new studies are not the solution, nor will rehashing old debates solve the problem: what is needed to meet the challenge is a lot of energy devoted to issues of implementation.

–*Michael Decter, 2004*

THE CURRENT POLITICAL DEBATE with respect to medicare is focused on wait times and sustainability. Unfortunately, neither of these two issues has a clear direct connection to primary care renewal, which places future ongoing investment in primary care at risk.

–*Alan Katz, 2008*

UNLESS MEASURES ARE TAKEN to rebalance the system in favour of primary care and to align secondary and tertiary care in support of primary care, the performance of the Canadian health care system could even fall behind the US system in future international comparisons.

–*Paul Lamarche, 2008*

PRIMARY CARE REFORM (and Family Health Teams in particular) hold a lot of potential to help LHINS achieve the goals of better health care and a better health system. Many physicians and other health professionals want to practice within a model of health care similar to family health teams.

–*Meeting of the Minds participant, 2008*

PRIMARY CARE PHYSICIANS are a huge issue, because they tend to be the most isolated in the system, particularly if they are not involved in hospital work, which in the most populated parts of our country, they're not. They often experience the interface with many parts of the system as an added burden versus something that should enable them to do a better job. To me, the first job of any health region should be to bring its primary care physicians into a more integrated role in the region, recognizing that they are a critical part of a high-quality health care system.

–*Penny Ballem, Former Deputy Minister of Health for BC and Clinical Professor of Medicine at UBC, 2009*

1. INTRODUCTION

Why this topic, and why now?

At The Change Foundation's second annual *Meeting of the Minds, First Things First: Fostering Accountable, Connected, Quality Primary Care (June 2009)*, we tackled a tough topic: how to make primary care more integrated with other parts of the system, better aligned with system goals, and more accountable for improving patient outcomes and experiences?

We chose the topic for several reasons: first, at the inaugural *Meeting of the Minds (Lessons & Confessions from the Regionalized Health-care Front: Where can they lead Ontario? May 2008)*, primary care reform was identified as foundational to improving health care, whether delivered within a regional health system structure or not. Second, despite an avalanche of evidence and general consensus that primary care reform is key to a more efficient, effective health system and central to better patient outcomes and experiences, it hasn't made it on to the public policy agenda as a priority, let alone been implemented in any meaningful way. As former health-care commissioner Kenneth Fyke put it so baldly—and boldly—during our lead-off debate in 2008:

“Leaving medical services isolated from regionalization was a mistake from the start. Some speciality services have seen improvements, but many have not. Primary Health is not included despite being key to chronic disease, the biggest illness issue facing Canada. Professionals are under utilized, and frustrated. Clients are harmed by errors and poorly served by the disarray in Primary Health. We should be ashamed at the lack of progress in making this a priority.”

The lack of lasting linkages between primary care and the rest of the system is a barrier to creating an integrated health system and better experiences for patients in Ontario—the purview of The Change Foundation. Our *Meeting of the Minds* was meant to nudge primary care reform back on the public policy agenda and to get people thinking about how to advance it within their own spheres of influence and beyond. While there were some differences during the *Meeting of the Minds* about the best route to drive changes to primary care, there was no disagreement that this should be job one—hence the title of this report: *Getting past yes—to go!*

The Change Foundation framed the issues for the day in a background paper (available at www.changefoundation.ca/reports.html) which highlighted Barbara Starfield's assertion that the achievement of an effective, efficient and high-performing health system is inextricably tied to how well a health system organizes, funds, incents and rewards its primary care sector.

The *Meeting of the Minds* opened again with an evening debate (and lots of discussion afterwards) between emergency physician and broadcaster Brian Goldman and

Champlain Local Health Integration Network (LHIN) CEO Robert Cushman about the relative merits of giving the LHINs authority over primary care. The next day featured presentations about how jurisdictions inside and outside Canada have brought primary care into the fold to good effect and generated much discussion about how to get some traction for change in Ontario.

Efforts to alter primary care in Ontario have waxed and waned over the years; beyond establishing family health teams, it is not currently a top priority. The focus instead is on shortening wait times (surgical, diagnostic and emergency department stays), reducing the incidence of patients receiving care in inappropriate settings (so-called alternate-level-of-care patients) and addressing institutional budget shortfalls—all issues whose long-term solutions could be found in a primary care sector that was better integrated with the rest of the health-care system.

Since our meeting in June, more research has been published confirming the value of primary care (*Increasing Value for Money in the Canadian Healthcare System: New Findings on the Contribution of Primary Care Services*, Marcus J. Hollander, et al Healthcare Quarterly, 2009) and describing Canada's continued poor performance in it (*A Survey of Primary Care Physicians in 11 Countries, 2009: Perspectives on Care, Costs, and Experiences*, The Commonwealth Fund). The Health Council of Canada also underscored chronic problems with primary care in an evidence and issue brief it produced with a stakeholder engagement designed and conducted by the McMaster Health Forum. At the same time, the province's constrained financial flexibility makes the need to fix the problems with

primary care even more pressing—not only to improve patient experiences and outcomes, but also to eke out efficiencies.

To continue the conversations begun during the 2009 *Meeting of the Minds*, The Change Foundation is canvassing the LHINs to identify their level of involvement with the primary care sector and present ideas for how to build on promising interactions. We anticipate—and encourage—more discussion about how to create a more accountable and connected primary care system for patients and communities as the province enters the pre-election period and looks ahead to another round of bargaining with the Ontario Medical Association (OMA). Where will primary care reform be amid the crowd of competing issues? Can we expect calls for, and commitments to, a high performing primary care sector directly linked to, and supported by, other levels of care with explicit accountabilities for improved patient outcomes? Can we get past yes—to go? We hope so.

2. Going over the groundwork: It's all been said (but not done)

As the quotations that open this report indicate, there has been no real disagreement over the years among health-care authorities on the definition, desirability and details of robust primary care. As Change Foundation CEO Cathy Fooks said as she opened the June 17th session, every major provincial report, royal commission, Senate Committee, and First Ministers' health agreement in the past two decades has been of one mind on the following:

There is no disagreement over the foundational positioning of primary care within a continuum of care—or the need to change how it is organized, funded and rewarded to tap its potential.

Whether from the Ontario Health Services Restructuring Commission, the Romanow Commission, the First Ministers' Agreement on Health-Care Renewal, or other seminal documents, the conclusions were the same: the key to efficient, timely, quality care is primary care reform. And yet, changes to primary care have been incremental across the jurisdictions.

There is no disagreement over the key attributes of a high-performing primary care sector: comprehensiveness of services with a focus on health promotion and illness prevention; 24/7 access, including access to telephone advice; interprofessional teams of providers; group practices; voluntary enrolment of patients; information management systems to support information flow and clinical decision-making.

There is no disagreement over the role of primary care in achieving health, service, and system goals simultaneously.

Effective primary care is essential to a high performing health system; Barbara Starfield's work over the years generated evidence that countries with a strong primary care system have healthier populations. And countries with weaker primary care systems have significantly higher health-care costs. Well-integrated primary care models can achieve distinct health, service and system goals simultaneously.

Health goals would include:

- A focus on health promotion and illness prevention
- Effective chronic disease management
- Holistic treatment and cure

Service goals would include:

- Evidence-based quality outcomes
- Timeliness/access
- Comprehensiveness of service
- Excellent communication with patients and providers

System goals would include:

- Coordinated care
- Ease of patient navigation
- Inter-professional collaboration
- Enhanced patient safety
- Optimal scope of practice

3. Primary care policy in Ontario: What has been done?

a) Brief overview of policy development

Fooks outlined four waves of foci in primary care service provision in Ontario since the introduction of Medicare in the province in the early 1970s and characterized them as funding models for service provision.

1. First, a focus on physicians, and moving them into a publicly funded system in the 1970s.
2. Second, trying to include other professionals, such as nurse practitioners, and other models such as community health centres in the 1980s.
3. Third, promoting multidisciplinary/inter-professional care and introducing family health teams during the 2000s.
4. Fourth, creating incentives to use this delivery system to improve chronic disease management, which is occurring now.

None of these reforms changed the basic positioning of primary care as a stand-alone sector, not particularly connected to other parts of the delivery continuum.

b) Where are we in Ontario today?

In a word: behind.

Canada and Ontario are slower than other jurisdictions to meet the challenges of access, timeliness and comprehensiveness. Despite government investment and plenty of evidence supporting the benefits of a well-organized primary care system, Canada is behind other countries with similar resources—particularly in access to after-hours care, wait times, chronic disease management, quality improvement foci and electronic health records. (Schoen 2006, 2007; Starfield 2005, 2008a) Canada's primary care sector has been characterized by fragmentation, inefficient use of providers and resources, lack of health promotion, poor information sharing and misaligned incentives. (Deber 2006)

Ontario has a variety of primary care models and the current focus is on family health teams (FHT), nurse practitioner-led clinics, and to a lesser extent, community health centres. The province created the Quality Improvement and Innovation Partnership (QIIP) project in 2007 to help family health teams and Community Health Centres improve the quality of primary care through networks, resource sharing and learning collaboratives.

Contractual accountabilities and reporting requirements vary within these models as does the existence of community board oversight. Funding, and to some extent non-clinical primary care policy, is negotiated between the provincial government and the Ontario Medical Association; other groups are not at the table or able to influence the outcome. LHINs do not have formal funding or planning authority for primary care, yet they need the sector to be aligned to stated health priorities to achieve demonstrated outcomes and have used a variety of approaches to bring people to the table. For example, the Erie St. Clair LHIN set up a primary care task group and the Toronto Central LHIN is developing a primary care advisory group. Other LHINs have identified primary care as a priority in their most recent Integrated Health Services Plans.

4. The sticking point: How to attach primary care to the rest of the health-care system?

a) Debating the merits of giving LHINs authority over primary care

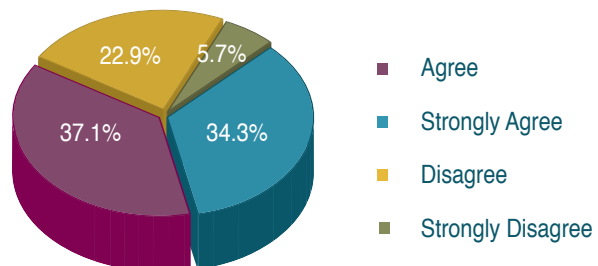
One of the possibilities explored during the opening night *Meeting of the Minds* debate was to give the planning bodies responsible for integrating health services—the LHINs—the authority to direct or incent primary care, to support health service and system goals. The question under debate—Be it resolved that Local Health Integration Networks be given authority over primary care—was argued in the affirmative by Champlain LHIN CEO Dr. Robert Cushman and in the negative by Dr. Brian Goldman, emergency physician and award-winning broadcaster and host of CBC Radio's *White Coat, Black Art*.

Taking the pulse: Keypad Voting Results

At various points during the *Meeting of the Minds*, participants had the opportunity to voice their views via keypad voting. Prior to the debate, 71.4% of respondents said they agreed or strongly agreed with placing primary care under the authority of Local Health Integration Networks.

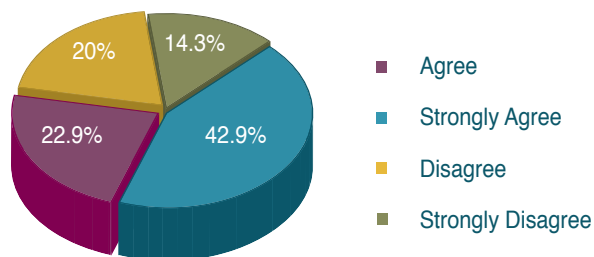
Before the Debate

Be It Resolved That: Primary care be under the authority of the LHINs



And whether or not LHINs were given authority to fund primary care providers, there was support for giving the LHINs the authority to drive primary care reform.

The LHINs have to be given the responsibility and the full authority to drive primary care reform if it is going to succeed



Both debaters agreed on the primacy of primary care, but diverged on whether a shift in its structure and authority would improve delivery, maximize resources, and tailor appropriate regional solutions and approaches to health.

“Ontario is too big. . . We all know the problems of primary care but they won’t be solved in downtown Toronto. . . . That’s why the LHINs are so important. You can’t introduce major change with a command-and-control structure in a place as big as this. In the Ottawa area, two communities touch on one another—one extremely rich, one extremely poor. Hence the need for local adaptations, for variation, for community responsiveness and engagement.”

—Robert Cushman

“We have to decide where family medicine is going before we decide who’s in charge. It’s easy to say we want a Prius rather than a school bus. But we need to know where we’re going before we decide what we’re going in and who’s driving the bus. . . .”

—Brian Goldman

On the affirmative: put the LHINs in charge

Successful integration of primary care into the broader health continuum requires approaches that are flexible and responsive to unique regional needs and situations. Any attempt to impose change on the primary care sector from a central authority will fail.

LHINs are best positioned to tailor appropriate local primary care improvements, as their situation provides them with an understanding of the subtleties of community variations that require distinct approaches. Ontario’s geography and demography pose significant challenges to any “centralized command and control” approach to primary care.

The diversity within one LHIN alone creates formidable challenges—attempting to apply solutions across an entire province would be completely unworkable. LHINs clearly offer the best potential solution for improving and integrating primary care.

On the negative: leave it to practitioners to organize

Ontario’s size and the diversity of its communities create significant challenges for improving and integrating primary care. These challenges, combined with the independence of most primary care physicians, are the precise reasons that placing primary care under LHINs’ authority is doomed to fail.

Family physicians and general practitioners are fiercely independent and “bred and trained to submit to no one but themselves.” Intervention must occur much earlier in the process to change such attitudes. Changing the system to encourage teamwork requires recruiting those who are good at working in teams.

“Before we decide who is in charge of primary care, let’s figure out what we mean by it and what society wants from it. . . . Other jurisdictions that are further along integrating health care have learned that trying to compel change doesn’t work.”

Any plan to place primary care under a broader authority—whether it be a central or regional health authority—is “a recipe for non-compliance, aggression, and game playing; doing so will only provoke resistance from organized medicine.”

Both debaters agreed that the central bargaining process contributes to some of the problems in the province’s primary care sector. Cushman said changing the authority to centrally negotiate for primary care physicians in province-wide agreements would facilitate primary care sector engagement by fostering local solutions to local problems.

Goldman said replacing central bargaining politics with LHIN authority is unlikely to help the current situation and would only serve to make it more chaotic and confusing. He noted that physicians do not currently have representation on most LHINs. Without physician buy-in, any attempt to reorganize primary care will fail, he said.

“Regional health authorities are organized along geopolitical boundaries, which makes sense because that’s where people live. They encompass public health, community care, mental health, et cetera, and are engaged with primary health providers. The LHIN is not a natural geopolitical unit, which is the way in which people’s health naturally occurs.”

—From the Floor

“[The LHINs] don’t need more accountability or authority; we need to look at the health of the population. The role of the LHIN is to serve as the catalyst of change, not to do the changes.”

—From the Floor

From the Floor

Questions, challenges and comments from participants sparked even more lively exchanges on the challenges, desired direction, and possible pitfalls of attempts to reorient primary care in Ontario. Many saw a potential role for the LHINs to play, but most were cautious about what that role should be, how much authority should be vested in particular agencies or organizations, and whether change was possible without revamping other critical elements in the system, such as the central fee bargaining process. Strong views were expressed:

“Where the authority should rest is a secondary question. The primary goal of the health system is to improve the health of the population—the issue of structure is secondary. . . . We need to totally reframe the conversation so it’s not about how to create authorities and divide up the pot. . . . Health happens in a community. LHIN is provider-centric. The real question is how we set up a real community that can engage consumers and providers at the same time.”

“Power tends to follow the money. A real solution requires finding a way to take the primary-care funding envelope out of the hands of the OMA, and giving financial authority to the LHINs. Having a bifurcated leadership with political leadership from the OMA and other authority in the LHINs is a recipe for conflict.”

Participants also stressed the importance of interdisciplinary approaches and locally tailored solutions to community-based priorities. “Primary care encompasses more disciplines than physicians. The authority should lie with those people within the LHIN.”

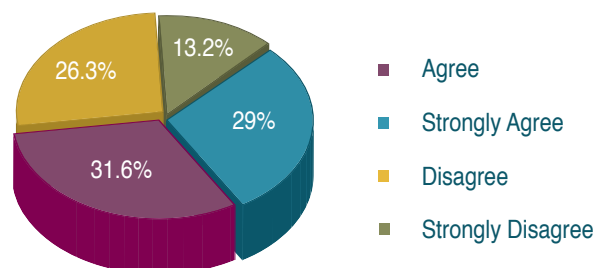
Some saw the LHIN as the logical level at which to organize primary care. Others, however, identified a need to craft change strategies that meshed with more organic structures, which would mesh better with their communities.

“We need integration at a local level with acute care and with public health care—intersectional integration. At a provincial level, we need strong legislation and regulation. On a national level, there’s a strong federal role to be played on the determinants of health. But the local level is the place with the most potential for integration on a voluntary basis. . . . Bottom-up change is where it needs to happen.”

—From the Floor

After the Debate

Be It Resolved That: Primary care be under the authority of the LHINs



Following the debate, keypad voting indicated that audience opinion had shifted somewhat: 61% of respondents agreed or strongly agreed that primary care should fall under the authority of LHINs, down from 71.4% prior to the debate. A significant number of respondents—23.33%—said their opinion had changed as a result of the debate.

It appears that the audience didn't descend into despair after the evening's debate and discussion: 54% of respondents said they were more optimistic about the prospects for significant primary care reform at the conclusion of the evening.

From the Floor

“Just because we don't have a funding agreement doesn't mean something doesn't fall under the purview of the LHINs. We're at a stage now where we're mature enough to reach out and develop relationships with physicians. . . . Chronic disease management is a priority for the Ministry and almost every LHIN. We need to see groups connecting, listening, learning, and engaging.”

—From the Floor

“We're sitting here with the structures of the LHINs and a bunch of family health teams. How do we challenge the government to take these structures and leverage them into meaningful change?”

“We have made a great deal of progress in Ontario around quality improvement. That work tends to be focused on technical aspects of care and processes of care. . . . I want to caution that there's a whole other element out there that's important—the art and humanity that's involved in the provision of care. It marries the art and science of what we do in primary care and underscores the importance of supporting the whole package.”

“One simple and likely inexpensive way of improving primary care is to build in the processes and measures for ongoing performance assessment and measurement. If you set a goal, identify the changes in practice that will help achieve it—set the targets, measure it. Then make sure it gets reported back to the practitioner so they can see how they're doing compared to others and the target.”

5. Efforts underway elsewhere to integrate primary care

a) England

The NHS plan was a 10-year plan. Improvements in primary care integration have taken place with a continuous direction, despite changes of government, changes in policy. Many experiments and approaches were unsuccessful along the way, but a clear momentum has allowed people to experiment, learn, and improve the system.

—Tony Woolgar

England is often looked to as an example of a jurisdiction that is attempting to integrate its primary care model, currently known as Primary Care Trusts (PCT)—with other service providers funded through a regional authority.

Tony Woolgar, former National Health Service (NHS) executive and LHIN CEO, highlighted the key elements and strengths of England's NHS primary care model. Among them:

- Purchaser-provider split with separate roles for commissioning or purchasing and providing services
- Purchase of services based on competition and choice—money follows the patient
- Model provides a vehicle for health system integration and transformation at the local level
- Rigorous policing of performance against targets
- Focus on health and wellness and incentives for health status improvement in local populations
- GP Fund-holding put GPs in the driving seat
- One NHS and a single-payer system

Primary care trusts are local health agencies established by the NHS to commission health services for primary, some secondary and community care. Each establishes their own budgets and priorities, based on the directions established by the Strategic Health Authorities. Local solutions need not all fit the same mould; primary care trusts can adapt the models that best serve their populations, while trying to attain overall goals.

Woolgar said that unlike Ontario, rewards and incentives are provided for meeting or exceeding benchmarks. While national reporting of performance against fiscal, quality and access standards occurs, local accountability is provided through primary care trusts and clinical auditing and benchmarking encourage transparency and openness. The model includes consistent, clear public reporting and a true commitment to population health improvement. In addition, the NHS provides service frameworks with national standards for both acute and primary care, which are lacking in Ontario.

Woolgar said PCTs have been catalysts for change because money shifted to primary care physicians, providing them with an incentive to keep patients out of hospitals whenever possible and move them out of hospital as soon as possible. The key principle, said Woolgar, is primary care physicians as decision makers about primary and community care and as gatekeepers to the secondary care system.

Woolgar acknowledged that hard evidence on truly integrated health care in the NHS is lacking, primarily owing to the continued separation between the provision of health and social care, and noted that the optimum size for a primary care trust is a matter of debate, although recent experience suggests that a population of one million may be ideal. The model also continues to focus excessively on meeting national targets rather than local priorities. Further, despite sustained investment in e-health, the technology is not yet fully deployed, said Woolgar. When in place, the technology could make a difference as long as professionals buy in and use it. Sustained investment in eHealth and clinical information systems remains essential.

Woolgar said Ontario has much to learn from NHS England, chiefly the need to commit to change and act on it.

“Change cannot stop at the top. There’s no point in policy without reform, investment without results, or change without development. . . . “Be bold and be prepared to get it wrong. You can have different models—family health teams, health networks—try them, learn by your mistakes, then change it based on evaluation.” Tony Woolgar

b) Lessons from an NHS England Primary Care Trust (PCT)

Commissioning services involves more than purchasing services from providers and putting service agreements in place. It also requires identifying the health needs of the population, developing service review mechanisms to consider the effectiveness, health benefits, and outcomes of services, and working with potential providers to develop appropriate and accessible services to meet these needs.”

—David Knowles

David Knowles, Vice Chair of the Kingston-upon-Thames NHS Primary Care Trust and senior associate of The King’s Fund, was asked to reflect on his experience with PCTs thus far. Knowles made six central points about PCTs and effective integrated primary care:

- It is essential that the trusts are commissioners and contractors of services, but they should not manage them. Commissioning services involves more than purchasing services from providers and putting service agreements in place. It also requires identifying the health needs of the population, developing service review mechanisms to consider the effectiveness, health benefits, and outcomes of services, and working with potential providers to develop appropriate and accessible services to meet these needs. In Kingston-upon-Thames, contracts with primary care providers are treated in much the same way as those with any other service provider, and primary care providers are similarly held to account.
- It is critical to ensure that every person has a general physician and that GPs are held to account for money allocated to them. They are rewarded by the PCT for meeting or exceeding benchmarks and sometimes disciplined for failing to do so.
- Engagement, cooperation and collaboration are key activities for trusts. Trusts are assessed annually; they are evaluated by their service to their communities and their success in engaging its members and practitioners, and they are held accountable for their performance.

- Service integration is dependent on organizational integration, so what is emerging instead is the centrality of commissioning for integrated care. Joint commissioning with local authorities for both health and social services is emerging, which can help achieve broader population health goals and accelerate meaningful integrated care.
- Flexibility is important, necessitating a range of commissioning models from which to choose.
- Effective integrated primary care requires a clear regulatory framework as an essential prerequisite.

“The issue is not about authority. It is simply what should or could be the relationship of the LHIN to the existing providers of primary care in Ontario and how the LHINs should develop this in the interest of their communities.”

—From the Floor

“In the UK, physicians have created an organization that reviews referrals and have reduced referrals to hospitals by 24%. . . . If they see a problem, they refer it back to the physician and ask if they want to rethink the referral.”

—From the Floor

c) Australia’s General Practice Divisions

Dr. Jacques Lemelin, Chair of Family Medicine, University of Ottawa, outlined Australia’s organizational model for primary care called divisions of family practice. They were introduced to address problems familiar to Ontario—a fragmented primary care system, lack of infrastructure, difficult access to the full range of health practitioners, absence of coordination of on-going care in the community, lack of physician engagement and no primary-care voice in health policy.

Created and funded by the federal government, they are regional networks with an established infrastructure consisting of physicians and other health-care providers providing a primary care communication vehicle with governments and local health authorities and an interaction channel for the family practice sector. They are semi-autonomous not-for-profit corporations.

Lemelin said after some initial resistance over changes in funding, 80% of primary care physicians are now enrolled in divisions, whose roles include:

- Engaging primary care physicians
- Providing primary care input into local health services initiatives
- Improving health outcomes
- Enabling greater integration of health services
- Developing more accessible services in communities
- Facilitating continuous quality assurance of primary care services

The key to this approach’s success is its usefulness to primary care physicians and other providers, resulting in considerable professional buy-in. It is not a question of authority but a matter of utility, he said.

d) What Can We Learn From Canadian Approaches?

British Columbia

“The new model has some significant strengths and advantages. Divisions can counterbalance the acute care system and their grassroots approach has encouraged buy-in and anticipation, with room for local solutions.”

—Dr. Garey Mazowita

Dr. Garey Mazowita, Chair of Family and Community Medicine, Providence Health Care, Vancouver, reported on changes to the delivery of primary care in British Columbia and opportunities for innovation and creativity in a culture where family physicians were traditionally characterized by their independence, given the predominant “business model” of practice, and family doctors felt increasingly isolated and marginalized.

British Columbia is the first province to implement Divisions of family practice, in which groups of family physicians work together to address gaps in care and to support family practice. The divisions are designed to meet the Institute for Healthcare Improvement’s Triple Aim framework: improve the health of the population; enhance the patient experience of care, including quality, access, and

reliability; and reduce or control the per capita cost of care.

The Divisions are being established to work in partnership with the Ministry of Health, the Health Authorities, and the GPSC (General Practice Services Committee). Mazowita said the emphasis is on shared care and collaboration in a respectful, mutual way, with a particular emphasis on the value to the system of generalist physicians. To support this voluntary initiative, significant changes have been made to remuneration and continuity, through new measures such as discharge planning fees and complex care fees.

The Divisions will have Society status, with elected Boards and geographically-based membership. An initial “Document of Intent” sets out mutual expectations and working relationships. Infrastructure dollars from the Ministry are available to support engagement and organization., said Mazowita.

Many of the Divisions’ stated goals align directly with those outlined in the province’s Primary Health Care Charter, including an emphasis on longitudinal, person-focused comprehensive care with outcomes that reflect continuity, comprehensiveness, coordination, and access. While the relationship between the family physician and the patient remains the cornerstone of primary care, these physicians and their patients will increasingly benefit from interdisciplinary resources defined and even deployed through Divisions.

The new model has significant strengths and advantages: Divisions can counterbalance the acute care system and their grassroots approach has encouraged buy-in and anticipation, with room for local solutions. Mazowita acknowledged the risk inherent in such a “transformative” undertaking, but suggested that failure cannot be an option. The Ministry’s commitment to “PDSA” cycles to learn about Divisions (as opposed to more discrete “pilot projects” with termination dates) should foster an evolutionary, organic and inclusive process. While the model appears to have early traction in small and medium population bases, it is unclear exactly how it will work or look in larger and more complex urban centres. While it is still too early to assess success, “the early returns are promising and family physician engagement has been significant.”

Quebec

“In Quebec, the law specifies that the purpose of establishing a local health and social services network is to foster a greater sense of responsibility among all the health and social service providers in the network to ensure that the people in the network’s territory have continuous access to a broad range of general, specialized, and super-specialized health services and social services.”

—Dr. Serge Dulude

Dr. Serge Dulude, director of planning and regionalization, *Federation des omnipraticiens du Québec* (FMOQ), presented an overview of the provisions introduced in the province in 2005 to integrate health and social services at the local level and improve primary care.

In Quebec, one-quarter of family physicians’ clinical activities take place in hospital emergency rooms, intensive care units, and palliative care. This compares to about one-tenth for GPs in the rest of Canada. If Quebec’s family practitioners are doing this work, they are not providing primary care, said Dulude.

The new integrated health and social service networks are coordinated through local authorities, *centres de santé et de services sociaux* (CSSS), which are responsible for defining clinical and organizational projects in each territory. The province has 18 regional health agencies and 95 CSSS. Dulude said the system is highly structured with tightly established performance targets, penalties, and rewards. During their first 15 years of practice, physicians are expected to dedicate 12 hours of their practice time per week to established priorities, which include emergency care, acute care, obstetrics, and treating vulnerable patients.

Both financial incentives and significant penalties are used to encourage family physicians to set up practice in under-served areas. Each year, the Ministry of Health establishes the number of new practices allowed in each region. If a practitioner chooses to open a practice in an area that is over-served, the Ministry imposes a 30% pay cut for administrative fees, and a ban on working in public institutions. Remuneration rates are significantly higher in

outlying regions—family physicians in Lac-Saint-Jean earn 40% more than those in Montreal—to create incentives for new billers to settle in these areas.

The creation of *guichets d'accès* (entry points) in each CSSS is another provincial innovation. This program refers vulnerable patients without family doctors to a GP, and family doctors who accept these patients receive financial incentives. The program has had a 40%–50% acceptance rate for these referred patients.

Quebec's approach is to use financial incentives to get resources where they are needed, using the CSSS structure to steer where the doctors go.

e) Who else has levers?

“A lot needs to be done in order to integrate primary health care with other parts of the system that are important for community health. Integration requires a policy framework, governance models, learning from other jurisdictions, and committed funding, and these are not within LHINs' current capacity.”

—Marie Fortier

Champlain LHIN Chair Marie Fortier, who has decades of health-care experience across jurisdictions, called the federal government's potential impact on primary care “limited” because of Canada's jurisdictional structure. She said while the federal Primary Health Care Transition Fund funded research and pilot projects aimed at improving primary care and assessing its impacts on overall health, the country is too diverse for that approach to work consistently and its impact in Ontario has been limited to pilot projects.

Meaningful change must be directed by the provinces, said Fortier. “The real architects of change will have to be provincial governments. Provinces have a number of levers at their disposal—more control over health legislation, the ability to fund publicly provided services, policy direction power. Effective policy must be driven by provincial governments.”

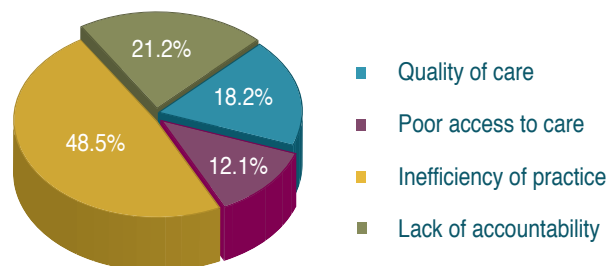
The establishment of LHINs in Ontario was a first step, she said, but their role in relation to primary care is unclear. LHINs are still in their infancy, and their effectiveness in engaging communities and providers to plan health-care services, including the integration of primary care into the overall model, has yet to be determined.

Fortier said organizations and players must now come together to develop ideas and models so that the integration of primary care is on the provincial government's agenda as part of its next mandate. “Right now there's no dialogue about it. Let's get realistic—we need time to figure it all out. It's a perfect time now to advance our thinking about it.”

6. Participants weigh in on primary care problems and priorities: keypad voting results

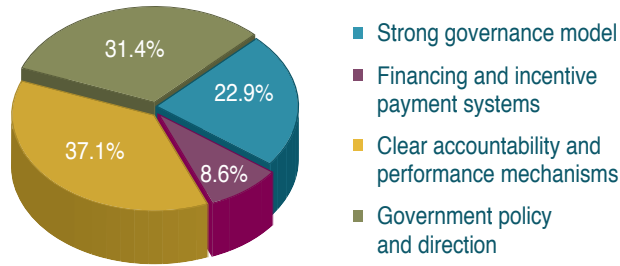
Participants were asked to advance their thinking through a series of key-pad voting exercises. First, they were asked what was the single biggest problem with primary care in Ontario. 48.5% said inefficiency of practice.

The single biggest problem with primary care in Ontario is:



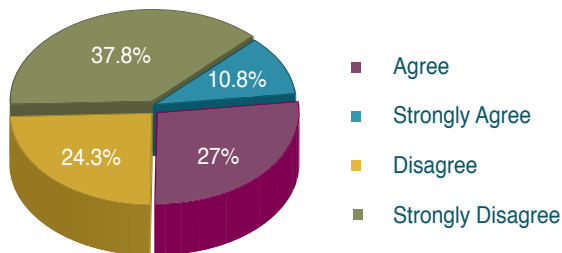
Then, they were asked what would be important to make progress: almost 70 per cent felt a focus on accountability and performance mechanisms and government direction were more important than another governance model.

Of the following, which is most important for Ontario to adopt in order to make progress on primary care reform?



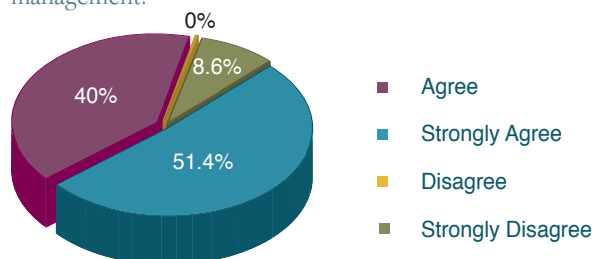
Participants were divided, however, as to whether goals and measurement with continued independence of physician practice was acceptable.

If primary care goals are clear and performance is measured and reported regularly, it's fine for doctors to practice as independently as they do now:



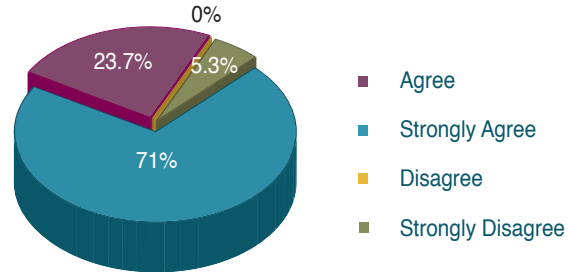
Participants were asked to consider roles for the LHINs beyond just funding of primary care providers. There was strong support for the LHINs having primary authority for chronic disease management.

LHINs should be given authority for chronic disease management:



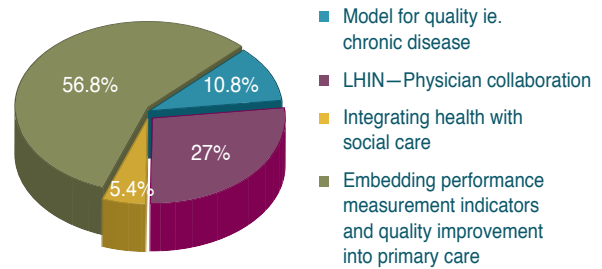
There was also strong support for LHINs developing a primary care policy and creating local fora for primary care discussions.

Each LHIN should have a primary care policy and a local forum for primary care voices:



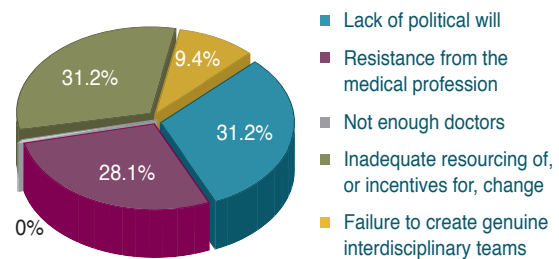
Participants were asked to provide advice to the Minister on where to start—what to act on first?

If you were Minister, what would you act on first?



And to speculate on where impediments to progress might be:

The biggest impediment to progress in primary care reform in Ontario has been:



Using these principles and further discussion at a follow-up breakfast discussion held at The Change Foundation, there are at least four potential options for supporting a strengthened primary care sector better integrated to the rest of the health-care delivery system.

7. Potential options to improve accountability in primary care in Ontario

- I. Status Quo with incentives
 - Use existing fee agreement and funding models to incent desired behaviour. Explore what sort of incentives would be possible under the current programs and contracts.
 - No need to change practice models
 - Does not require new agreements
- II. Further Develop and Support Family Health Teams
 - Focus on greater critical mass and use of non-physicians
 - Make chronic disease management more of an expected accountability
 - More funding for new teams
 - May require new agreements with existing teams
- III. Allow for formal relationship between LHINs and Group Practices (FHTs or otherwise)
 - Create new accountability to LHINs aligned with stated planning priorities
 - If using FHTs, essentially transfer the accountability from MOHLTC to LHIN
 - Would need a pilot
- IV. Create a Local Level Administrative Structure to Represent Geographically-Based Primary Care Practices
 - Contract for coverage and specific sets of services to be divided amongst practices
 - Could include working with Community Care Access Centres

Further to that last option, at the *Meeting of the Minds* Dr. Jacques Lemelin, Chair of Family Medicine at the University of Ottawa, proposed the establishment of a pilot for LHIN Primary Care Practice Networks in Ontario. The networks would be autonomous corporations with a base budget from the LHINs that might be augmented to implement specific initiatives. Their primary role would be to offer administrative support services to primary care practices,

and to provide primary care with a voice in health system decisions. “In Ontario, not only are primary care physicians not at the table, they’re not even on the radar.”

Lemelin, who also presented on Australia’s divisions of family practice model, said that many jurisdictions have identified the same integration and organizational issues as Ontario—fragmentation, lack of choice for primary care, and lack of infrastructure—and have been working on solutions for some time. While Ontario has various models of primary care, including Family Health Teams, Family Health Groups, and Family Health Networks, very little interaction and integration occurs among these groups and even less across the various models, he said.

Despite the fact that Ontarians are nearly six times more likely to access primary care than any other component of their local LHINs, said Lemelin, the administration of primary care receives no dedicated funding, while the LHINs receive significant administrative funding. “In a given year, 15% of patients will access LHINs; 85% will access primary care. Primary care gets zero dollars for administration. The Champlain LHIN gets \$1.4 million for administration. Primary care is the foundation. The foundation needs to be strong,” he said.

The Change Foundation is in discussions with the Ministry of Health to explore possibilities for supporting and studying this proposed pilot.

8. Concluding comments

As Dr. Michael Rachlis emphasized during the *Meeting of the Minds*, there is a need for engagement as a key facilitator for improving population health and primary care—engagement with doctors at all levels, especially around quality improvement initiatives; LHINs’ engagement of family physicians; engagement of public health; and engagement of communities through policy forums and policy-oriented learning.

That point was also underscored by Duncan Sinclair, former Queen’s University Dean of Medicine and chair of Ontario’s Health Services Restructuring Commission, who concluded the day with a clarion call for multi-pronged change to primary care in Ontario.

Previous analyses of primary-care reform efforts have provided sound advice and sensible warnings. In his 2008 paper, “A Long Time Coming: Primary Health Care Renewal in Canada” (Healthcare Papers, Vol 8, No. 3), Brian Hutchison makes the following points:

- policy legacies can limit the possibilities for change;
- there is no single “right” primary care model—pluralism is unavoidable and even desirable; funding and payment models are no panacea for the ills of primary care;
- and renewal requires major investment in infrastructure—tools to support quality improvement and coordination, information management systems, team staffing models, etc.

9. Continuing the conversation

The Change Foundation has continued the conversation begun at the 2009 *Meeting of the Minds*, working with others to identify and fortify the catalysts and levers for change, to align practice, process, and policy with system goals and outcomes for more integrated and effective health care and better health. As part of that process, we have canvassed the LHINs on their involvement with the primary care sector and are considering small and big ways to build on any promising models. The Change Foundation also co-sponsored a Policy Exchange on Primary Care with the US think tank, The Commonwealth Fund, in March 2010 and will be sharing the lessons and literature from that forum with Ontario’s health-care community. We will be looking at changes to legislation, funding, policy, regulation, negotiations, practice, culture, and political will, as part of our commitment to help move the need for primary care reform from agreement to action, from yes—to go.

10. Appendices

APPENDIX I. PROGRAM



First Things First: Fostering Accountable, Connected, Quality Primary Health Care

Invitational Dialogue • June 16 and 17 2009
Old Mill Inn and Spa • 21 Old Mill Road • Toronto, Ontario

PROGRAM

Tuesday June 16, 2009
The Humber Room

5:00 to 6:00 pm	NETWORKING RECEPTION	
6:00 to 7:00 pm	WELCOME & DINNER	Cathy Fooks, President & CEO The Change Foundation
	<i>The Great Debate</i>	
7:00 to 8:30 pm	Introductions, Debate Setup, Keypad Voting	Lillian Bayne, Facilitator Steven Lewis, Research Advisor
	“Be it resolved that primary health care be under the authority of the Local Health Integration Networks.”	Debaters: Robert Cushman, Champlain LHIN CEO (PRO) and Brian Goldman, Mount Sinai emergency physician & award-winning broadcaster (CON)
	Discussion and Keypad Voting	All Participants
8:30 to 9:00 pm	Closing remarks and tee-up for next day	Scott Dudgeon, Chair, The Change Foundation & Lillian Bayne

Guildhall A&B

<i>7:30 to 8:00 am</i>	BREAKFAST	
<i>8:00 to 8:30 am</i>	Welcome and Framing the Day's Discussions	Lillian Bayne & Cathy Fooks
<i>8:30 to 10:00 am</i>	International Panel: What Can We Learn from International Models? (UK & AU)	Tony Woolgar, former NHS Executive and LHIN CEO; Jacques Lemelin, Chair of Family Medicine, University of Ottawa; David Knowles, Sr. Associate, King's Fund, London UK; and Bruce Boissonnault, President & CEO, Niagara Health Quality Coalition (NY)
	Discussion	All participants
	Keypad Voting and Discussion	All participants
<i>10:00 to 10:15 am</i>	BREAK	
<i>10:15 to 11:30 am</i>	Canadian Panel: What Can We Learn from Canadian Approaches? (BC & QC)	Garey Mazowita, Chair, Family and Community Medicine, Providence Health Care, Vancouver; Serge Dulude, Directeur général adjoint, Directeur de la planification et de la régionalisation, Fédération des omnipraticiens du Québec (FMOQ); Marie Fortier, Chair, Champlain LHIN
	Keypad Voting & Discussion	All participants
<i>11:30 to 12:00 pm</i>	Building the Best: How to make primary care linkages in Ontario more likely and lasting	Michael Rachlis, Health Policy Consultant
	Discussion	All participants
<i>12:00 to 1:00 pm</i>	NETWORKING LUNCH Balmoral Room/Courtyard Patio	
<i>1:00 to 2:00 pm</i>	Building the Best: Your Message to the Minister Participants will be invited to join small groups to think through the key message and call to action they would bring to the Minister of Health on a pre-assigned topic. Groups will have 30 minutes to prepare their case: Why this action? What is the problem? What is the resolution?	All participants, working in small groups
<i>2:00 to 2:15 pm</i>	BREAK	
<i>2:15 to 3:15 pm</i>	Your Five Minutes with the Minister: Delivering the Message Minister responds Voting and discussion	Group spokespeople Minister Gladwell Hand (aka Steven Lewis) All participants
<i>3:15 to 3:30 pm</i>	Report out of results of voting over the course of the day/discussion	Lillian Bayne, Steven Lewis, all participants
<i>3:30 to 3:45 pm</i>	Take-aways from Today	Duncan Sinclair
<i>3:45 to 3:55 pm</i>	Closing Remarks	Cathy Fooks

APPENDIX II. PARTICIPANTS: 2009 MEETING OF THE MINDS

Speakers

Bruce Boissonnault, President and CEO, Niagara Health Quality Coalition, NY
 Robert Cushman, CEO, Champlain LHIN
 Scott Dudgeon, Chair, The Change Foundation
 Serge Dulude, Directeur Général Adjoint, Directeur de la Planification et Régionalisation Fédération des Omnipraticiens, Québec
 Cathy Fooks, President and CEO, The Change Foundation
 Marie Fortier, Chair, Champlain LHIN
 Brian Goldman, Emergency Physician, Mount Sinai Hospital, Toronto
 David Knowles, Senior Associate, King's Fund, London UK
 Jacques Lemelin, Chair, Dept. of Family Medicine, University of Ottawa
 Steven Lewis, Research Advisor, The Change Foundation
 Garey Mazowita, Chair, Family and Community Medicine, Providence Health Care, Vancouver
 Michael Rachlis, Health Policy Consultant
 Duncan Sinclair, Former Chair, Ontario Health Services Restructuring Commission
 Tony Woolgar, Former National Health Service Executive, England and former founding CEO, South West LHIN

Local Health Integration Networks

Kim Baker, Acting CEO, Central LHIN
 Remy Beaudoin, CEO, North East LHIN
 Bill Campbell, Director, Health System Development, Mississauga Halton LHIN
 Robert Cushman, CEO, Champlain LHIN
 Gwen DuBois-Wing, CEO, North West LHIN
 Deborah Hammons, CEO, Central East LHIN
 Mimi Lowi-Young, CEO, Central West LHIN
 Bill MacLeod, CEO, Mississauga Halton LHIN
 Pat Mandy, CEO, Hamilton Niagara Haldimand Brant LHIN

Stewart Sutley, Senior Director, Performance and Accountability Waterloo Wellington LHIN
 Ene Underwood, Strategy Lead, Toronto Central LHIN

Change Foundation Board

Larry Chambers, President and Chief Scientist, Élisabeth Bruyère Research Institute
 Gail Donner, past Chair, The Change Foundation, Dean Emeritus, Lawrence S. Bloomberg Faculty of Nursing, University of Toronto
 Scott Dudgeon, Chair, The Change Foundation, and CEO, Alzheimer Society of Canada
 Louise Lemieux-Charles, Professor and Chair, Dept. of Health Policy, Management and Evaluation, Faculty of Medicine, University of Toronto
 Neil Stuart, Health Policy Consultant

Health Care Executives and Practitioners

John Abbott, CEO, Health Council of Canada
 Ted Ball, Health Consultant, Quantum Transformation Technologies
 Debora Daigle, Manager of Social and Housing Services, City of Cornwall
 Anne DuVall, Chair, Association of Family Health Teams of Ontario
 Diane Gwartz, Primary Health Care Nurse Practitioner, Garden City Family Health Team, St. Catharine's and Practice Director, Nurse Practitioners' Association of Ontario
 Anton Hart, Publisher, Longwoods Publishing
 Ian Herrick, Dept. of Anaesthesia and Perioperative Medicine, University of Western Ontario
 William Hogg, Professor and Director of Research, Family Medicine, University of Ottawa

Brian Hutchison, Co-Chair, Quality Improvement Innovation Partnership
 Nick Kates, Co-Chair, Quality Improvement Innovation Partnership
 Jan Kasperski, CEO, Ontario College of Family Physicians
 Heather Manson, Senior Medical Advisor, Ontario Agency for Health Protection and Promotion
 Val Rachlis, Board Member, Association of Family Health Teams of Ontario
 Mark Rochon, CEO, Toronto Rehabilitation Institute
 Jane Sanders, Executive Director, Nurse Practitioners' Association of Ontario
 Donna Segal, Former Executive Director, Health Council of Canada and Founding CEO, Ontario Family Health Network
 Valerie Smith, Executive Director, Barrie and Community Family Health Team
 Ruth Wilson, Professor of Family Medicine, Queen's University and Former Chair, Ontario Family Health Network

Government

Vanessa Pearson, Regional Director, Strategic Policy and Inter-Governmental Affairs
 Health Canada, Ontario Region
 Vasanthi Srinivasan, Director, Health System Planning and Research Branch, MOHLTC
 Shaun Young, Senior Research Planning Advisor, Health System Planning and Research Branch, MOHLTC

APPENDIX III. FOR POWERPOINT PRESENTATIONS, GO TO
www.changefoundation.ca/presentations

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Mandate

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Mission

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To support outstanding research and policy analysis about health system integration.

To improve patient outcomes through innovative approaches to quality improvement and knowledge transfer.

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Innovation

We take innovative approaches in developing new ideas.

Collaboration

We work in partnership with others to achieve success.

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 **Meeting**
of the Minds



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