PRIMARY CARE BLUEPRINT FOR THE ALL NATIONS HEALTH PARTNER OHT

FINAL REPORT

March 2021

CORPUS SANCHEZ INTERNATIONAL

EXECUTIVE SUMMARY

The All Nations Health Partner OHT (ANHP-OHT) has been established to address the area's health care challenges, inequities and to ultimately meet the unique needs and goals of the ANHP defined geographic areas. These include improving health care services for everyone; being responsiveness to the needs of Indigenous communities; creating a seamless continuum of care across all healthcare providers; ensuring access to health services closer to home; delivering health outcomes that exceed Provincial standards; nurturing supportive environments for healthcare providers; and building an All Nations hospital and campus. To support these goals, advancing primary care was identified as a critical need.

To advance equitable access to primary care providers and services that are culturally appropriate for the residents of the All Nations Health Partner defined geographic area, the All Nations Health Partner OHT (ANHP-OHT) Primary Care Working Group (PCWG) identified the need for a Primary Care Service Delivery Blueprint to address health care gaps on and off reserve. The Blueprint serves as a guide and "sets the bar" for what primary care services will look like by establishing a single picture of primary care that everyone can work towards.

This Blueprint was informed by broad engagement that included over 185 stakeholders inclusive of the Primary Care Working Group, KCA WNHAC Elders & Youth, Seniors stakeholders, Shelter/Vulnerable stakeholders, Kenora Metis Council, Sioux Narrows & Nestor Falls stakeholders, Kenora Region stakeholders, Chiefs, Patient & Family stakeholders, Physicians, Nurse Practitioners, Home & Community, Interprofessional Stakeholders, Hospital, Long Term Care & Palliative Care, Home & Community Care, Public Health, and Indigenous Health Leads.

Key Learning: There is **clear consensus that a collective approach to Primary Care is required across the ANHP defined area.** This included:

- The need to support healthier communities, help people to live longer and ensure better quality of life;
- The need to "quilt" together models to create a region-specific primary care model focused on the continuity of care;
- The need for an equitable model for an on and off reserve primary care model where everyone gets the care and services they need; and
- The need to bring people together in a collaborative way to build trust and reduce territorialism.

This Blueprint provides a common starting point to guide future actions. Specifically, this includes:

- A collective vision for primary care grounded in the College of Family Physicians of Canada's Patient's Medical Home (PMH) Model. The vision respects the importance of traditional healing; focus on individuals and their family through every step of their life; and support the delivery of Quadruple Aim (e.g., improving health of the population, enhancing experience of care for individuals, reduce the per capita cost of health care, and attaining joy, pursuing equity, team well-being);
- 42 proposed priorities that identify the actions necessary to deliver on the ANHP Primary Care Vision; and
- A four-step Roadmap that identifies proposed next steps for the ANHP PCWG to consider as it plans to move forward.

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01 SETTING CONTEXT

The All Nations Health Partner OHT (ANHP-OHT) creates a partnership to jointly address the area's health care challenges, inequities and articulating the ultimate goal of building an All Nations health care system to meet the unique needs and goals of the region. These include improving health care services for everyone; being responsiveness to the needs of Indigenous communities; creating a seamless continuum of care across all healthcare providers; ensuring access to health services closer to home; delivering health outcomes that exceed Provincial standards; nurturing supportive environments for healthcare providers; and building an All Nations hospital and campus. To support these goals, advancing primary care was identified as a critical need.

To advance equitable access to primary care providers and services that is culturally appropriate for the residents of the All Nations Health Partner defined region, the All Nations Health Partner OHT (ANHP-OHT) Primary Care Working Group (PCWG) identified the need for a Primary Care Service Delivery Blueprint to address health care gaps on and off reserve. The Blueprint is intended to serve as a guide and "set the bar" for what primary care services will look like by establishing a single picture of primary care that everyone can work towards.

To build this Blueprint, a broad engagement plan was informed and guided by the Primary Care Working Group. Individual and group sessions were completed with the PCWG, followed by stakeholder interviews and focus groups, and co-design sessions with selected stakeholders from across the continuum of care. Over 185 stakeholders were engaged in interviews and focus groups; 25 system leaders and stakeholders participated in two design sessions and two validation sessions; and the Primary Care Working Group participated in numerous sessions to help build a Blueprint that would guide the work of the All Nations Health Partner OHT (see Appendix A: Engagement Overview).

Key Learning: There is **clear consensus that a collective approach to Primary Care is required across the ANHP defined area.** This included:

- The need to support healthier communities, help people to live longer and ensure better quality of life;
- The need to "quilt" together models to create a region-specific primary care model focused on the continuity of care;
- The need for an equitable model for an on and off reserve primary care model where everyone gets the care and services they need; and
- The need to bring people together in a collaborative way to build trust and reduce territorialism.

This Blueprint provides a common starting point to guide future actions. Specifically, this includes:

- *Launching the Change* by establishing a case for change that is endorsed by providers across the continuum and patients and families;
- *Designing an ANHP Vision for a Primary Care* that sets a clear and common goal, and identifies the themes and pillars to achieve the goal;
- *Building the Future Primary Care Service Model* identifies the priority actions necessary to achieve the identified pillars; and
- *A Roadmap* provides a plan to assist the ANHP PCWG move forward to improve primary care in the region.

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02 LAUNCHING THE CHANGE

Locally Inspired Change

The need to address a critical shortage of physicians was launched locally to understand and promote action

In the Spring of 2015, the critical shortage of physicians serving the Kenora area was addressed in a deputation to Kenora City Council entitled *Kenora Health Care – A Growing Industry Sector: The Importance of Physician Recruitment and Retention, Community Vision and Collaboration (A Physician Perspective).* The presentation focused on five key areas:

- The importance of physician recruitment and retention, and the need for a centralized physician recruitment process;
- The current state of health care in the Kenora area;
- An update on changes to health care affecting the Kenora area;
- A proposal for a community-based Health Care Commission; and
- The role of the City of Kenora in moving these issues forward.

In response, the City spearheaded the creation of the *Kenora Area Health Care Working Group* in September 2015. At that time, the group included representatives from the City of Kenora, Lake of the Woods Development Commission, Lake of the Woods District Hospital, Waasegiizhig Nanaandawe'iyewigamig, Kenora Chiefs' Advisory, Northwestern Health Unit, family physicians, and members of the community. The Working Group identified three key issues: (1) physician recruitment and retention; (2) cross border access to care between Ontario and Manitoba; and (3) the need for a long-term collective vision for health care in the Kenora area.

In less than a year, the working group completed a needs assessment, raised funds from committed stakeholders, and hired a healthcare professional recruiter. In less than two years, the working group made progress on the cross-border issue, identified the replacement of aging hospital infrastructure as an additional priority in support of both successful patient care and physician recruitment, and secured funding to begin a formal planning process.

Political leadership comprised of Grand Council Treaty#3 Ogichidaa, the Mayors of the City of Kenora and the Township of Sioux Narrows/Nestor Falls, Chief Lorraine Cobiness on behalf of the Kenora Area First Nation Chiefs, and the President of the Kenora Métis Council assembled in the roundhouse at Wauzhushk Onigum First Nation to sign a resolution. The resolution agreed to work together in partnership to develop an All Nations health care system, including construction of an All Nations hospital and campus, with the express purpose of improving health outcomes for all people of the region it serves through a healthcare service model built on a partnership between First Nations, Métis, and non-First Nations governments and providing an improved healthcare system that reflects the specific needs and costs of the North.

The signatories to this document wanted to grow and evolve the working group to create the *All Nations Health Partners*, a coalition of leaders in Indigenous and mainstream health services in the Kenora Region and of other stakeholders.

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Building on a System Recognition that Change is Required

There is clear support that change is necessary – from the system, from providers and from patients, families & community members

In the spirit of reconciliation, Indigenous and Municipal leaders then came together in 2016 to sign a formal resolution, through ceremony, agreeing to work in partnership jointly to address the area's health care challenges, inequities and articulating the ultimate goal of building an All Nations health care system and hospital to meet the unique needs of the region.

It has been recognized that there are many significant long-standing health issues in the region. The most pressing currently before the ANHP is the need to develop a robust primary care service – both on reserve and off reserve. There are health inequalities that COVID-19 shined a bright light on. This current situation has triggered the resolution from the Chiefs of nine Kenora-area First Nations with a call to action to "develop a new service delivery model for primary health care and health promotion that addresses the inequities in health care on reserve, ensuring on-reserve membership have access to primary health care and promotion". To do this, the current outdated models needed to be redesigned.

With the establishment of the All Nations Health Partners Ontario Health Team, the goal of establishing a fully integrated primary care system for both on and off reserve populations has become the priority. A first step has been initiated to ensure access to interim transitional funding through a pilot to expand the primary care model on reserve.

The *Expanding Primary Care for First Nations Communities in the Kenora Region* study (KCA 2019) confirmed an urgent need to address inequities in access to primary care. Seven broad inter-related areas of action were identified to close the gaps in primary care.

- Increase equitable access to primary care providers (e.g., timely access, successful recruitment, services closer to home);
- Increase equitable access to services (e.g., cancer screening, mental health, palliative, diabetes, rehab services, home care services);
- Increase cultural safety and decrease discrimination and racism (e.g., language barriers, limited access to traditional healing);
- Address indigenous determinants of health (e.g., education, housing, employment, food security, social supports);
- Improve infrastructure, technology and transportation (e.g., basic supplies, equipment, transportation, child care supports);
- Build relationships for an expanded primary care model (e.g., coordination between Indigenous and non-Indigenous providers); and
- Address the unique service and health needs of communities (e.g., road access, training in mercury poisoning, end of life care).

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Recent Progress Has Positioned ANHP for Success

Fortunately, there has been significant focus and progress to be ready for a change – the time has come to go to the next level.

Date	Key Milestones	Result
2016	Indigenous and Municipal leaders in the Kenora Area sign a formal resolution in ceremony to address the areas health care issues	All Nations Health Partners are formed to develop All Nations health system
2017	Expanding Indigenous Interdisciplinary Primary Care Teams proposal (WNHAC, KCA, Physicians, FHT partners)	Funding granted to WNHAC to expand interdisciplinary teams (insufficient MD funding)
August – November 2019	Participatory Action Primary Care Research Study (9 First Nations) – KCA and Dr. Retson	Identified large gaps in primary care for FNs on reserve and provided recommendations
December 2019	ANHP/OHT Primary Care Working Group is formed (WNHAC, FHT, FHN, KCA, physicians, NPs, pharmacist, physician/health professional recruiter)	Goal to develop a fully integrated primary care system on and off reserve and to immediately expand primary care for FNs communities to address inequities
January 2020	Meeting with ISC and MOHLTC with ANHP in Toronto	Presentation of data from primary care research study and request for funding for physician services on reserve and system costs
March – June 2020	First Wave COVID (KCA, WNHAC, FHT, ANHP)	Mobile testing teams Pandemic planning further highlights gaps in primary care
May 2020	Chiefs resolution on Primary Care	KCA mobilizes to recruit MDs and Primary care nurses for FNs
July 2020	Implementation of expanded MD and primary care nursing services in FN communities	Every FN community has at least one MD Two dedicated primary care nurses' services for coordination of care
October 20202	Meeting with MOH to explore physician engagement and possible pathways for advancing physician compensation models	Gained greater understanding of MOH approach for advancing models
November – December 2020	Primary Care Engagement sessions with population, patients, and providers Design Event to create vision of overall fully integrated Primary Care model on and off reserve Submission to the MOH for interim transitional funding to support equitable access to primary care for First Nations	185 people/providers engaged Development of Fully Integrated service deliver model in progress

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Acknowledging Providers, Patients & Families Request for Change

Over 185 stakeholders were engaged inclusive of the Primary Care Working Group (14), KCA WNHAC Elders & Youth (14), Seniors stakeholders (4), Shelter/Vulnerable stakeholders (18 – Survey), Kenora Metis Council (10), Sioux Narrows & Nestor Falls stakeholders (4), Kenora Region stakeholders (8), Chiefs, Patient & Family Advisory stakeholders (8), Physicians (8), Nurse Practitioners (6), Home & Community, Interprofessional Stakeholders (48), Hospital (4), Long Term Care & Palliative Care (5), Home & Community Care (13), Public Health (2), and Indigenous Health Leads (4).

To build a primary care system that supports all people within the region, stakeholders identified many change priorities. These priorities have been grouped into the following five themes of Access, Roles, Services, Collaboration and Enablers. The following pages identify clear tactics and strategies for addressing these changes as the ANHP-OHT seeks to improve the region's primary care system.

Timely Access	Right Roles	Appropriate Services	Effective Collaboration	Supporting Enablers
▪ "Access points we know and can get to" ▪ "Patients can access one main Primary Care Provider" ▪ "Pathways that connect patients to their providers" ▪ "Clear inventory of services available" ▪ "Expanded service hours" ▪ "Double down on virtual care" ▪ "Access to traditional medicine & healers" ▪ "Get to see the doctor in 48hrs" ▪ "Urgent clinic available 7 days/week"	▪ "Use different types of roles based on needs – NPs, PAs" ▪ "Elder knows how to practice medicine" ▪ "Support providers who are Indigenous" ▪ "Understand the roles of providers" ▪ "Challenge - remuneration is not on parr" ▪ "Patient liaison in every community" ▪ "Look at new ways to monitor health" ▪ "New tools to get medications – Kiosk" ▪ "Build our pipeline to resources"	▪ "Support under-served populations" ▪ "Traditional healing accessible" ▪ Focus on "equity, inclusion, diversity" ▪ "Frequent access to specialist locally" ▪ Key Services: "Easier access to mental health care", "mobile outreach", "palliative care" ▪ "Culturally appropriate care" ▪ "Good after care - connecting people with good primary care follow-up after leaving hospital"	▪ "Improved connections and collaborations across PCPs" ▪ "Do warm transitions" ▪ "Improve communication with home care" ▪ "Put everyone under primary care model" ▪ "Improve sharing of information across providers" ▪ "Let go of territorialism" ▪ Create "common protocols" ▪ "Pathways that connect patients to their providers"	▪ "Tools to connect providers together – scheduling system" ▪ "Tools to improve info sharing - EMR" ▪ "Appropriate space and locations for care" ▪ "Collect data to measure/evaluate the system" ▪ "Address transportation issues" ▪ "Need to attract doctors" ▪ "Invest in education for provides and patients" ▪ "Enable self-management"

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03 Designing an ANHP Vision for Primary Care

To guide all future planning and design efforts, it was critical to establish an ANHP vision that all stakeholders could work towards in a collective fashion. The vision must respect the importance of traditional healing; focus on individuals and their family through every step of their life; and support the delivery of Quadruple Aim (e.g., improving health of the population, enhancing experience of care for individuals, reduce the per capita cost of health care, and attaining joy, pursuing equity, team well-being).

The future ANHP Primary Care Model is grounded in the College of Family Physicians of Canada's Patient's Medical Home (PMH) Model (see Figure 1). The ANHP Patient's Medical Home (PMH) model is a *family practice defined by its patients as the place they feel most comfortable to discuss their personal and family health concerns. The PMH seeks to address the health needs of both the individuals and the populations served by incorporating the effects that social determinants of health such as poverty, employment, culture, gender, shelter, education, financial and social status, personal health practices, social supports, and access to health services. The goal is to have the patient's family physician, the most responsible provider of their medical care, work collaboratively with a team of health professionals to coordinate comprehensive healthcare services and ensure continuity of patient care. The PMH enables the best possible outcomes for each person, the practice population and the community served.*

The original PMH is broken down into three themes: Foundations; Functions; and Ongoing Development and includes 10 pillars. However, to ready the model for ANHP, one additional theme was added – Equity to ensure care is equitable, inclusive, diverse and anti-racist.

Themes	Pillars
Equity	▪ Care that is Equitable, Inclusive, Diverse and Anti-Racist
Foundations	▪ Appropriate Infrastructure ▪ Connected Care ▪ Administration & Funding
Functions	▪ Comprehensive Team-Based Care with Family Physician Leadership ▪ Community Adaptiveness & Social Accountability ▪ Accessible Care ▪ Patient & Family-Partnered Care ▪ Continuity of Care
Ongoing Development	▪ Measurement, Continuous Quality Improvement & Research ▪ Training, Education & Continuing Professional Development

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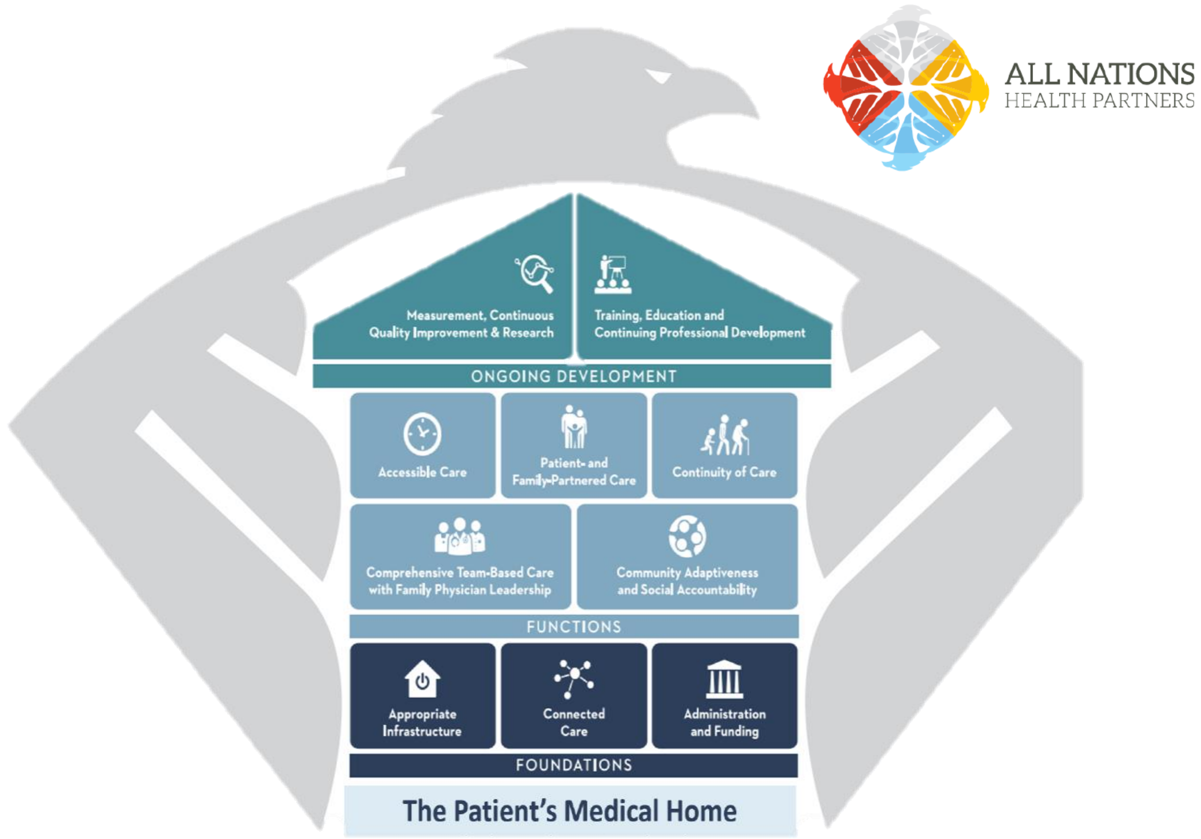
Figure 1. ANHP Patient's Medical Home



ANHP Patient's Medical Home – What it Means to Providers, Patients & Families?

The ANHP Patient's Medical Home model is described by four Themes and 11 Pillars and is summarized by the following description of focus and experiences from the patient's, family's and provider's perspectives.

Themes	Pillars	Focus	Experience of Patients, Families & Providers
Equity Equity is a critical anchor to any care delivery system	**Care that is Equitable, Inclusive, Diverse and Anti-Racist**	Culture and practices that ensure organizations function and deliver care and services with a focus on equity, inclusion, diversity and anti-racism.	▪ Respecting and valuing "culture and language", "Cultural safe" ▪ "Providers reflect the community they serve" ▪ "Valuing both traditional healing and Western medicine" ▪ "I see myself in the system – my input, goals, vision" ▪ "Strong and equal voice" ▪ "Meeting people where they are at"
Foundation These foundations are necessary to enable the PMH practices to thrive within their communities	**Administration & Funding**	Practices need financial support delivered through appropriate remuneration models that enable governance, leadership, and management.	▪ "People know their job and roles" ▪ "The system is funded right" ▪ "Remuneration models that support team-based primary care" ▪ "Improved connections to the MOH to support advocacy"
	Appropriate Infrastructure	Physical space, staffing, electronic records and other digital supports, equipment, and virtual networks facilitate the delivery of timely, accessible, and comprehensive care.	▪ "Attract physicians, health sector providers, admin, support staff" ▪ "Right spaces and infrastructure to give people what they need" ▪ "Ensure staff have training & supports" ▪ "Right roles working to full scopes" ▪ "Inclusion of other roles (e.g., healers, paramedics)" ▪ "Focus on physician & health sector remuneration"
	Connected Care	Practice integration with other care settings and services across the health care system, a process enabled by effectively integrating health information technology	▪ "Access to clear protocols and relationships amongst providers" ▪ "Care the way I want it" ▪ "Record follows patients" ▪ "Effective communication between facilities" (e.g., EMR, virtual care) ▪ "Innovate processes to be more effective" (e.g., filling scripts)

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Themes	Pillars	Focus	Experience
Functions Care provided in a PMH is characterized by the following functions	**Accessible Care**	Advanced and timely access, virtual access, team-based approaches ensure care that's there when it's needed.	▪ "Everyone has a primary care team" ▪ "Easier to get care we need", "tools to make it easier" ▪ "Care as close to home", "Virtual care available" ▪ "Seamless transitions from hospital to going home" ▪ "Barrier-free". "No barriers in attitude"
	Community Adaptiveness & Social Accountability	A PMH responds to the needs of a community it serves on the patient, practice, community, and policy level.	▪ "Our helpers need to be in the know" ▪ "Need to be included" ▪ "Knowledgeable of the community and the resources" ▪ "Need to accept and recognize" traditional health partners, "Need to be working on the same page"
	Comprehensive Team-Based Care with Family Physician Leadership	A broad range of services is offered by a well-connected interprofessional team.	▪ "Patients are part of care team" ▪ "Safe care for all; Best experience & outcomes" ▪ "Care delivered efficiently and effectively" ▪ "Processes are more standard across providers" ▪ "Knowledgeable about different types of medicine"
	Continuity of Care	Patients live healthier, fuller lives when they receive care from a provider who knows them and how their health changes.	▪ "Seamless transitions with good communications that is timely" ▪ "Not having to tell your story over again" ▪ "Not having to re-do a test" ▪ "Continuity of the providers to reduce duplication" ▪ "One-stop" referral hubs, Community/service hubs ▪ "Integrated service models across providers"
	Patient & Family-Partnered Care	Family practices respond to the unique needs of patients and families within the context of their environment, involving them as active partners in care.	▪ "As population ages, see more need for navigation – and more people will need to be involved in the plan of care for the patient" ▪ "Enabling, respecting and listening to people's choices" ▪ "Focus on prevention" ▪ "Listen to what the patient/client needs" ▪ "Honour people's confidentiality"

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Themes	Pillars	Focus	Experience
Ongoing Development Commitment to these ongoing development areas keep PMH practices constantly growing and improving	**Measurement, Continuous Quality Improvement & Research**	Family practices strive for progress through performance measurement and CQI. Patient safety is always a focus, and new ideas are brought in through patient engagement.	▪ "Need to continually improve our primary care system" ▪ "Must measure how effective and efficient the system is" ▪ "Must support physicians and health professional" ▪ "Address social determinants of health"
	Training, Education & Continuing Professional Development	Emphasis on training and education ensures that the unique knowledge and expertise of family physicians can be shared with the broader health care community, while ongoing development ensures constantly staying at the forefront of best practice.	▪ "Providers train and work together effectively" ▪ "EMRs and other tools like scheduling support care delivery" ▪ "Providers are able to easily share information" ▪ "Providers are supported to continually improve"

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04 BUILDING THE FUTURE PRIMARY CARE SERVICE MODEL

To realize the future ANHP Primary Care Service Model, the Primary Care Co-Design Group identified 42 priorities to align to 11 Pillars.

Pillar	Priorities
Equity: Enhancing Equity, Inclusion, Diversity & Anti-Racism	☐ **Design and Implement an Equity, Inclusion, Diversity, Anti-Racism Framework** to ensure services provided and the organization of service providers support a culture focused on equity, inclusion, diversity, anti-racism, and Indigenous cultural safety that builds and nurtures a healthy workplace and care space. *See Ontario Health's Equity, Inclusion, Diversity, Anti-Racism Framework.* ☐ **Develop Training, Education and Mentorship Programs** to advance and support our providers and future providers to ensure they have the required skills and supports necessary. Initial work includes taking stock of current programs, and identifying a multi-year plan with investments required to deliver on the plan ☐ **Build a Training Pipeline** to ensure a diverse resource profile amongst providers that is reflective of the community served through mid term efforts to change the types of providers entering and leading our health care system. Initial work to launch programs in partnership with High Schools, Colleges, Universities will increase the diversity of people entering the health care system – across all roles and professions. ☐ **Create a Provider Recruitment, Retention, Succession Planning** to ensure a focused, multi-year health human resource plan will be established to ensure appropriate recruitment of resources to support the needs of the community (e.g., recruitment of resources from outside the region, retention strategies, and strategies to build more locally-focused human resource strategies). This effort must be linked to a fair and appropriate remuneration model that supports greater equity across the system as opposed to having providers compete against one another.
Foundation: Administration & Funding	☐ **Ensure Clarity of Governance, Administration and Management Roles and Responsibilities** that develop clarity of roles, processes and accountability across system leaders and providers ☐ **Build Funding models for Traditional Health Services** to ensure Traditional services are available to meet the needs of the community through the development of funding models and resources. Initial focus should assess existing models and resource availability and explore what a Traditional service funding model will look like. ☐ **Establish Focused Physician Service Agreements to Fill Gaps & Remuneration Models** to address existing physician service gaps. Initial focus will be to quantify the need and impact of filling these service gaps through the continued review of physician funding models. ☐ **Ensure Connections & Advocacy with the Ministry of Health** are an ongoing focus to ensure alignment with the government strategies and priorities. The ANHP OHT will always aim to set the standard for Northern communities. The initial priority will be to work with the Ministry to confirm the primary care physician compensation model.

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Foundation: Appropriate Infrastructure	☐ **Build Appropriate Physical Infrastructure** to ensure the necessary and appropriate space and equipment is available. Initial focus should include an inventory of all primary care spaces across the region, prioritize needs for space changes, and identify and address high priority space and equipment issues. ☐ **Create Space & Resources for Traditional Ceremonies** to ensure culturally appropriate space is available. Initial focus should include an inventory of all primary care spaces to identify requirements for traditional space needs. ☐ **Build Health Promotion/Prevention Space** to establish a focused area/location where health promotion and prevention space can be recognized and promoted. ☐ **Electronic Patient Record that Follows the Patient Across the Continuum** is a priority for the government with the focus on digital solutions. Providers across the continuum will explore opportunities to streamline and leverage electronic tools to communicate and share information and support coordination and handoff of patient information. To support the advancement of an EPR, providers will need to explore opportunities to build information transfer protocols to support sharing of information across the continuum, resolve privacy and circle of care issues, advance digital tools to enable communication, and explore integrated communication tools between providers. ☐ **Internet Access Across All Regions/Communities Served** will be required to provide a communication backbone to connect providers across the region. Initial focus will be to explore opportunities the OHT and/or Ontario Health/Ministry may be advancing. ☐ **Administrative Supports & Services** will be required to support necessary administrative work required for the newly defined primary care service model. Initial focus should explore the specific need for administrative support and estimate the expected budget.
Foundation: Connected Care	☐ **One-Stop Primary Care Service Referral Hub(s)** will create a central and known point of access for referrals and queries for both providers as well as for patients and families. The Hub(s) will be staffed with resources and supporting technologies to link people in need of care to the right services. Initial work may centre on identifying if there is a "natural" choice for creating a referral hub within the current system. ☐ **Specialty Service Referral Hubs** will create central and known points of access for the referral of focused needs (e.g., cancer, MHA, palliative, chronic disease management). Initial focus will be to select a "lead" organization to serve as the specialized referral hub and assess the feasibility and impact. ☐ **Community Service Navigation Hubs** will create a point (e.g., virtual/physical location) for patients and families to go to receive navigation and information to help answer their questions (e.g., Patient Liaison, Community Health Reps). These hubs could be geographically located within communities to ensure access, and hubs across the region can be connected to provide coverage and supports. ☐ **Service Inventory for the Region** will be critical to help providers and patients to identify the most appropriate services available and support timely referral to these services. Ideally, the inventory will be electronic, and will include patient and provider views. Initial focus: Identify strategy to collect, maintain accuracy, and explore tools to share information.

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Functions	Items
Functions: Accessible Care	☐ **Aligning Access to Primary Care + Core Priority Services and Exploring Continuum-Wide Pathways** focuses on ensuring primary care providers have timely access to core services in another sector (e.g., community or hospital). This may include the development of pathways that span the continuum for key services in chronic care management. Initial focus should include identification of priority pathways that need to be developed. ☐ **Access to Equipment/Supplies/Services** ensures providers in primary care have access to necessary equipment, supplies and/or services (e.g., laboratory, imaging, pharmacy) including results/reports. Initial focus should include identifying key gaps in access to materials/services and quantification of impact. ☐ **New and Alternative Service Options** and **Extended Service Capacity** focuses on identifying the need and impact of new, extended and alternative service options, and determining the best approach to deliver these services under the proposed system approach to primary care. This should create new potential locations and providers for these services.
Functions: Community Adaptiveness & Social Accountability	☐ **Work with Partners to Advocate and Address the Social Determinants of Health Relevant to the Population Served.** This work should start with the collection of relevant data to understand the population served and under-served and assess the impact on the health of the population. ☐ **Use data about marginalized/at-risk populations to tailor care, programming, and advocacy** to meet needs of the population with an early focus on the most marginalized or at-risk
Functions: Comprehensive Team-Based Care	☐ **Primary Care Physician Team Model (Always a Back-Up)** establishes a new team-based model across providers where there is always a primary care provider available to support urgent primary care needs. It is recognized that new ways of working and funding services will be required, and this will require a significant shift in practices, resourcing and supports. ☐ **Inclusion of Traditional Medicine Models** will ensure Traditional providers (e.g., Healers) are recognized, funded, and available to support the needs of the community. Initial focus will be on developing a case to advance care access to Traditional medicine and confirm funding sources. Explore development of a Centre that brings Traditional healing and & Western medicine together, an area/location where the alignment and support for Traditional and Western medicine is brought together to increase awareness, understanding and support for how these two medicines can work and exist together. ☐ **Interprofessional Team Access Available to All** builds on existing resources and seeks to expand access to an interprofessional care team by enabling providers that have limited access to resources be able to contact providers (e.g., FHTs) to gain access to services on an as needed basis while remaining their provider. ☐ **Modify the Mix of Interprofessional Team Members** ensures key resources like paramedics, personal support workers, physician assistants are available and can complement the care team model. Initial focus will be to assess availability, acceptance and feasibility of exploring an extended interprofessional team.

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Functions: Continuity of Care	☐ **Detailed Roles, Processes, Policies Across Primary Care Providers** to ensure clarity for how work is completed, understanding of specific roles and responsibilities, and supporting use of information and technology. Initial focus should be on documenting current state and identifying key proposed changes. ☐ **Detailed Roles, Processes, Policies with Other Continuum Providers** to ensure clarity for how work is completed, understanding of specific roles and responsibilities, supporting use of information and technology. Initial focus should be on documenting current state and identifying key proposed changes. ☐ **Rationalized/Integrated Service Delivery Models Across Providers** explore opportunities for providers to work together to identify the most effective strategy for delivering services (e.g., foot clinic). This may include growing or consolidating a service at one provider to serve a larger client base. Initial focus should explore opportunities for rationalizing selected services to improve access, efficiency or service sustainability.
Functions: Patient & Family-Partnered Care	☐ **Establish Patient, Family, Caregiver Representation & Leadership Communication** to ensure key stakeholders are communicating critical information in a format that they understand and can access. Communication must be standardized wherever possible across primary care providers. Initial focus should identify key messages and communications that key stakeholders identify as most important. ☐ **Patient & Self-Management Supports** are fundamental to ensure individuals are able to participate in the planning and delivery of their own care. Initial focus should include identifying key areas and priorities for self-management. ☐ **Patient & Family Education to build capacity, tools and supports** to ensure patients and their families have access to educational tools about how to access care, what they should expect from the care and services, and what is their role in their own care. Initial work should focus on an inventory of resources. ☐ **Provider Education & Communication** to ensure provides have access to educational supports and information about how to access care and know who to contact when they need supports from other providers. Initial work should focus on an inventory of resources. ☐ **Structured Communication & Engagement Tools with Patients** will ensure patients and families have timely and appropriate access to information and can communicate effectively with providers (e.g., portals to support scheduling or review results). Initial focus should explore if there are any existing communication tools that can be spread across providers in the region and/or if the OHT will advance specific tools/technologies. ☐ **Structured Communication & Engagement Tools With Other Sectors/Providers** will ensure providers are able to communicate effectively and efficiently. Initial focus should explore adoption of existing technologies and/or explore opportunities from advancing the ANHP OHT.

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Ongoing Development: Measurement, CQI & Research	☐ **Establish an Evaluation Framework and Continually Improve Performance** to assess the impact of changes in the primary care service model and quantify the benefits. Initial focus must include the development of the evaluation framework and confirmation of outcome and process metrics. Collection of Data/Metrics to Support Decisions & Monitor Performance and access to Continuous Improvement Capacity will be required to support the evaluation of the changes to the primary care model. The OHT should also invest in resources and supports to collect patient and provider equity data to build a more equitable, inclusive and diverse care delivery system. ☐ **Support Primary Care Related Research** ☐ **Support Development of CQI Capacity & Initiatives**
Ongoing Development: Training, Education & CPDE	☐ **Serve as Teaching Sites for Learners** ☐ **Support Provider Professional Development** ☐ **Provider Training & Support** will be required to support necessary training to work within the newly defined primary care service model. Initial focus should explore the specific needs for provider training and estimate the expected budget. ☐ **Create opportunities for Family Physicians to Share Their Knowledge with the Broader Health Community**

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05 SETTING A ROADMAP FOR MOVING FORWARD

To assist the All Nations Health Partner OHT advance Primary Care within the region, the Blueprint defines a vision that is grounded in a modified Patient's Medical Home (PMH) Model and identifies 42 priorities that support achievement of the ANHP Primary Care vision. To assist with moving forward, the following four actions are proposed for the consideration of the Primary Care Working Group.

Step 1 Endorsing the Blueprint	Step 2 Prioritizing Actions	Step 3 Inventorying Efforts	Step 4 Confirming & Approving a Plan
The first step in moving forward will include the ANHP Primary Care Working Group's approval and endorsement of the Primary Care Blueprint.	The second step includes a prioritization based on the impact and implementation challenge of advancing the recommendations to ensure immediate work centres high ranking priorities.	The third step will ensure current and planned efforts will be identified as part of a region-wide inventorying to ensure efforts moving forward will build on existing strengths and supports.	The final step will be the development of a detailed workplan including resource requirements that can be taken forward to the ANHP OHT for approval and support for moving forward.

Step 1: Endorsing the Blueprint

The ANHP Primary Care Working Group's first action upon receiving the report should be a full review of the report and formal signoff on the report as part of the approval and endorsement process. Appendix B provides a ANHP PCWG Primary Care Blueprint Endorsement page.

Step 2: Prioritizing Actions

To help identify key activities to move forward, activities should be prioritized based on Impact (High, Medium, Low) and Implementation Challenges (High, Medium, Low) to determine the ranking of each priority. As an initial step, PCWG members completed the ranking process resulting in the following summary initial prioritization. See Figure 2 for Proposed Near and Mid-Term Priorities.

Step 3: Inventorying Events

To ensure the Blueprint builds on existing and planned initiatives, an inventorying of efforts from the region is recommended. To support this process, a sample outline of the inventory has been included in Appendix C. Specifically, for each priority, the PCWG should work with other partners to identify:

- Relevant Initiatives
- Project Lead
- Project Status

Using the findings from the inventory, the PCWG should work with other key stakeholders to identify which specific efforts could be leveraged in rolling out the Primary Care Blueprint.

Step 4: Confirming & Approving a Plan

The final step will be the development of a detailed workplan including resource requirements that can be taken forward to the ANHP OHT for approval and support for moving forward. The PCWG should develop a multi-year plan with work divided into specific phases including the development of supporting resources and a detailed budget. Once finalized and approved by the PCWG, it is recommended that this plan be brought forward to the ANHP OHT for review, approval and endorsement.

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Figure 2. Proposed Near and Mid-Term Priorities

Themes	Pillars	Near Term Priorities	Mid-Term Priorities
Equity	Enhancing Equity, Inclusion, Diversity & Anti-Racism	☐ Training, Education, Mentorship Programs ☐ Design and Implement an Equity, Inclusion, Diversity, Anti-Racism Framework ☐ Provider Recruitment, Retention, Succession Planning	☐ Build a Training Pipeline
Foundation	Administration & Funding	☐ Clarity of Governance, Administration and Management Roles and Responsibilities ☐ Connections & Advocacy with the Ministry of Health	☐ Funding models for Traditional Health Services ☐ Focused Physician Service Agreements to Fill Gaps & Remuneration Models
	Administration & Funding	☐ Administrative Supports & Services ☐ Space & Resources for Traditional Ceremonies ☐ Appropriate Physical Infrastructure	☐ Internet Access Across All Regions/Communities Served ☐ Electronic Patient Record that Follows the Patient Across the Continuum ☐ Health Promotion/Prevention Space
	Connected Care	☐ Community Service Navigation Hubs ☐ Service Inventory for the Region	☐ One-Stop Primary Care Service Referral Hub(s) ☐ Specialty Service Referral Hubs
Functions	Accessible Care	☐ Access to Equipment/Supplies/Services ☐ Aligning Access to Primary Care + Core Priority Services and Exploring Continuum-Wide Pathways	☐ New and Alternative Service Options and Extended Service Capacity
	Community Adaptiveness & Social Accountability	☐ Use data about marginalized/at-risk populations ☐ Work with Partners to Advocate and Address the Social Determinants of Health	
	Comprehensive Team-Based Care	☐ Interprofessional Team Access Available to All ☐ Primary Care Physician Team Model (Always a Back-Up) ☐ Modify the Mix of Interprofessional Team Members ☐ Inclusion of Traditional Medicine Models	
	Continuity of Care	☐ Rationalized/Integrated Service Delivery Models Across Providers ☐ Detailed Roles, Processes, Policies Across Primary Care Providers	☐ Detailed Roles, Processes, Policies with Other Continuum Providers
	Patient & Family-Partnered Care	☐ Provider Education & Communication ☐ Structured Communication & Engagement Tools with Patients ☐ Establish Patient, Family, Caregiver Representation & Leadership Communication	☐ Patient & Self-Management Supports ☐ Structured Communication & Engagement Tools with Other Sectors/Providers ☐ Patient & Family Education
Ongoing Development	Measurement, CQI & Research	☐ Support Development of CQI Capacity & Initiatives ☐ Establish an Evaluation Framework and Continually Improve Performance ☐ Serve as Teaching Sites for Learners	☐ Support Primary Care Related Research ☐
	Training, Education & CPDE	☐ Support Provider Professional Development	☐ Provider Training & Support ☐ Create opportunities for Family Physicians to Share Their Knowledge

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Appendix A – Engagement Overview

Appendix A1: Primary Care Working Group

- Anita Cameron
- Dr. Zahra Jaffer
- Dr. Brad Kyle
- Connee Badiuk
- Colleen Neil
- Cheryl O'Flaherty
- June Dearborn
- Dr. Jennifer Wesley
- Karen Parker
- Dr. Laurel Snyder
- Shannon Wiebe
- Dr. Buzz Pedersen
- Tracy Bennett
- Dr. Jillie Retson
- Daphne Armstrong
- Laura Loohuizen

Appendix A2: Interviews & Focus Groups

- Primary Care Working Group (14)
- KCA WNHAC Elders & Youth (14)
- Senior's stakeholders (4)
- Shelter/Vulnerable stakeholders (18 – Survey)
- Kenora Metis Council (10)
- Sioux Narrows & Nestor Falls stakeholders (4)
- Kenora Region stakeholders (8)
- Chiefs, Patient & Family Advisory stakeholders (8)
- Physicians (18)
- Nurse Practitioners (6)
- Interprofessional Stakeholders (48)
- Hospital (4)
- Long Term Care & Palliative Care (5)
- Home & Community Care (13)
- Public Health (2)
- Indigenous Health Leads (4)

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Appendix A3: Co-Design Group

- Gale Black, SNNF
- Billy Boucher, FN youth
- Liz Boucher, Metis Council
- Catherine Fobister, Elder
- Dora Henry, NW37 Health
- Lillian Henry, Elder
- Emily Hildebrand
- Wanda Kabel, SNNF
- Tommy Keesick, Elder
- Barbara Kejick, SL39 health Councillor
- Kathy Kishiqueb, KCA
- Dr. Brad Kyle, physician
- Mike Limerick
- Laura Loohuizen, ANHP/KCA
- Charlene Melillo
- Alfred Oshie, Elder
- Agnes Paul, Elder
- Alexis Peplinskie
- Candace Pitura
- Dr. Jillian Retson, physician
- Lynn & Lucien Skead, Elders
- Joelle Touchette, nurse
- Allan White, Elder
- Andy White, Elder

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Appendix B – ANHP Primary Care Working Group Endorsement Page

Daphne Armstrong
Director of Strategy and Innovation, Kenora Chiefs Advisory

Connee Badiuk
Clinical Services Manager, WNHAC

Tracy Bennett
Nurse Practitioner, Waasegiizhig Nanaandawe'iyewigamig (WNHAC)

Anita Cameron
Executive Director, WNHAC

June Dearborn, BScPharm, RPH, CRE
Pharmacist, Sunset Country Family Health Team (SCFHT)

Dr. Zahra Jaffer, MD
WNHAC

Dr. Brad Kyle, MD
Kenora Medical Associates; Lake of the Woods District Hospital, President of Lake of the Woods Education Group – NOSM, Lead Physician FHN, Lead Physician SCFHT

Laura Loohuizen
All Nations Health System Planning – Community Coordinator; Kenora Chiefs Advisory

Colleen Neil
Executive Lead, All Nations Health Partners Ontario Health Team (ANHP OHT); Executive Director, SCFHT

Cheryl O'Flaherty, CPA, CGA
VP Corporate Services and Chief Financial Officer, Lake of the Woods District Hospital (LWDH)

Karen Parker
Healthcare Professional Recruiter, ANHP

Dr. Sven Pedersen, MD
Lake of the Woods District Hospital

Dr. Jillie Retson, MD
Primary Care Lead Kenora Chiefs Advisory; Lake of the Wood District Hospital, Chair- ANHP OHT Primary Care Working Group, NOSM Lake of the Woods Education Group Board Director

Dr. Laurel Snyder, MD
WNHAC, Lake of the Woods Education Group – NOSM, Lake of the Wood District Hospital

Dr. Jennifer Wesley, MD
Kenora Medical Associates, Lake of the Wood District Hospital

Dr. Shannon Wiebe
Keewatin Medical Clinic, Lake of the Woods Education Group – NOSM, Board Co-chair SCFHT, Lake of the Wood District Hospital

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Appendix C – Blueprint Building Blocks Inventory Template

Themes & Pillars		Priorities	Relevant Initiatives	Project Lead	Project Status
Equity	Equitable, Inclusive, Diverse & Anti-Racist Care	☐ Designing and Implementing an Equity, Inclusion, Diversity, Anti-Racism Framework ☐ Training, Education, Mentorship Programs ☐ Building a Training Pipeline ☐ Provider Recruitment, Retention, Succession Planning			
Foundation	Administration & Funding	☐ Clarity of Governance, Administration and Management Roles and Responsibilities ☐ Funding models for Traditional Health Services ☐ Focused Physician Service Agreements to Fill Gaps & Remuneration Models ☐ Connections & Advocacy with the Ministry			
	Appropriate Infrastructure	☐ Appropriate Physical Infrastructure ☐ Space & Resources for Traditional Ceremonies ☐ Health Promotion/Prevention Space ☐ Electronic Patient Record that Follows the Patient ☐ Internet Access Across All Regions/Communities ☐ Administrative Supports & Services			
	Connected Care	☐ One-Stop Primary Care Service Referral Hub(s) ☐ Specialty Service Referral Hubs ☐ Community Service Navigation Hubs ☐ Service Inventory for the Region			
Functions	Accessible Care	☐ Aligning Access to Primary Care + Core Priority Services ☐ Access to Equipment/Supplies/Services ☐ New/Alternative Service Options + Extending Capacity			
	Community Adaptiveness & Social Accountability	☐ Work with Partners to Advocate and Address the Social Determinants of Health Relevant to the Population Served ☐ Use data about marginalized/at-risk populations to tailor care, programming, and advocacy to meet needs			
	Comprehensive Team-Based Care	☐ Primary Care Physician Team Model ☐ Inclusion of Traditional Medicine Models ☐ Centre of Traditional & Western Medicine ☐ Interprofessional Team Access Available to All ☐ Modify Mix of Interprofessional Team Members			
	Continuity of Care	☐ Detailed Roles, Processes, Policies Across Primary Care ☐ Detailed Roles, Processes, Policies - Other Providers ☐ Rationalized/Integrated Service Delivery Models			
	Patient & Family-Partnered Care	☐ Establish Patient, Family, Caregiver Representation & Leadership Communication ☐ Patient & Self-Management Supports ☐ Patient & Family Education and Communication ☐ Structured Patient Communication/Engagement Tools ☐ Structured Provider Communication/Engagement Tools			
Ongoing Development	Measurement, CQI & Research	☐ Establish an Evaluation Framework to Continually Improve Performance ☐ Support Primary Care Related Research ☐ Support Development of CQI Capacity & Initiatives			
	Training, Education & CPDE	☐ Serve as Teaching Sites for Learners ☐ Support Provider Professional Development ☐ Create opportunities for Family Physicians to Share Their Knowledge with the Broader Health Community			

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