Primary Care 2025: A Patient Advocate Point of View!

This report represents the beginning of a conversation. While it was created by a group with professional, geographical, and population diversity, more voices are needed. Further engagement with patients and the broader primary care community is necessary. For the full report, please see www.primarycare2025.com

Top Ten Reasons Why I Support This Report (David Letterman Format)

Reason #10:

- For my 17 years of advocacy, I have read hundreds of reports that primarily focus on a sector approach to healthcare and although this is driven by Primary care, it is at the heart of the community discussion we need to have and develop across Ontario. The time is here and the fundamental structure with the Ontario Health Agency, Ontario Health Teams and the Ontario Health Regions are in place to operationalize a Provincial strategy.

Reason #9

- We have a window of opportunity presented with the world pandemic which has forced the system to act quickly and react in a positive way with voluntary integration of services across all sectors and have demonstrated that it is time to make this the norm, not the exception for pandemics. The Provincial response has been amazing but still sector driven, and we can use this framework to look at the completion of community hubs for healthcare wrapped around holistic health (Primary and Community Care Hubs).

Reason #8

- This type of approach could, in the long term strategy or at maturity, meet the goal of 100% coverage for all Ontarians and not just for reactive healthcare, but for complete coverage birth to death healthcare in all communities...a very lofty goal but on target to what a community needs.

Reason # 7

- This paper has identified the need for significant education and professional development of the practitioners to adapt to the new models of practice which will take them out of their comfort zone but is necessitated with the expansion of their role within the community. I will not comment on the funding model required to do this as this would cut across most sectors as

re-alignment occurs. It is not just the existing practices but addressing the new graduates who would envision the generalist role as a key element in their early years after graduation.

Reason #6

- "Enable Social Prescribing". It is about time we stopped talking about this and act as this is a fundamental right for the community to expect one-stop service and stop being bounced from organization to organization. Public health, social services and municipalities need to be at the table as this work takes place and not a "re-direct" by healthcare. This gets at the prevention methodology required in every community and focus on marginalized groups who also intersect healthcare as we know it today.

Reason # 5

- Capitation and a blended model. The report identifies the percent of physicians in each category and it is time to consolidate an approach that meets the needs of the community and not necessarily the business model of fee for service. I am aware of the opposition from sole practitioners, but their practices could be aligned to community hubs under a blended model. I am a big supporter of the services provide, in my limited experience, of a capitation model in providing my community (and family) full healthcare support with this model. This heads towards the 100% coverage model and begins to address the need for special incentives for practices that have marginalized communities or complex older adults or complex pediatric families within their community and practice.

Reason #4

- I found it quite remarkable that this group acknowledges the past issues and culture that have caused complexity within Primary care but the discussion , base on the COVID experience, provides the time to re-think a common Primary care approach rather than simply default back to the past as we deal with complex issues including compensation, EMR usage, digital supports and virtual care, silo driven practices and the re-positioning of fundamentally expanded mission as generalists within the community hub model. My big question here is "who will lead this dialogue to operationalize?"
- This is NOT found in the paper but is a result of the paper. I genuinely believe that the COVID pandemic has fostered a dialogue on health and community and that the health literacy of the public has increased ten-fold around family health needs both care wise and all the social aspects around healthcare. This is one of the areas that, as this group engages the community voice, needs to be explored so we do not go back to simply expecting healthcare when needed but begin to develop our own family plans. This is mentioned in the paper as "not all family members consider themselves patients" and this is the approach we need to embellish.

Reason # 3

- This discussion paper aligns with what I have seen in many key areas including the operational model for the Ontario Health Agency, the development of Ontario Health Teams by design and too numerous previous LHIN driven efforts around the province. It is time to consolidate a new approach and I am delighted with the view of short term and long term as this matches the OHT work of "in year one" and "at maturity" as an approach. This is a major re-design encompassing

all sectors, but this framework provides such key elements to a broader Provincial effort to determine what is short term to start but do not loose sight of the overarching long-term objective for at maturity.

Reason #2

- This discussion is decoupled from the political need for elections every four years that drive a new strategy to healthcare as experienced over my involvement with the Ministry. I fondly remember the $1 Billion Aging at Home strategy of George Smitherman which became a focus on ALC/Wait Times and the creation of CCACs and co-opetition for home care and LHINs plus. Even today, solving Hallway Medicine does not cut to the fundamental of healthcare reform but I am delighted to be advocating within the operationalizing side with the new structures in place. Enough about politics.

Reason #1 (drum roll please)

- The paper hit a home run by acknowledging up front, as a key tenant, the need to engage the patient, caregiver, and family community. It goes further into identifying this component as co-design partners going forward including being on key operational Boards across the Provincial structures being set in motion. Our voice has been so fragmented by organization, by sector, by LHIN, by Ministry, by specialized work Groups that seldom is our voice used to look at the Province in a comprehensive manner and then, all the way down to individual organizations within a community. There are thousands of us who have invested time to learn all aspects of healthcare from specialized needs to high level strategies and it is this comprehensive voice that needs to have a forum for discussions like this paper. This is probably the role of the Ontario Health Agency to start but is reinforced within this discussion paper. I need to be clear here as well. All levels of PFACs and PFAs within our existing structure are important, especially at the community level, but the Province needs a comprehensive Provincial view as well to table this type of effort.

My two cents worth and please feel free to circulate widely!

Randy Filinski

Pickering Resident and Healthcare Advocate

filinski2@sympatico.ca

905 509-1708

Appendix 1 -Current Advocacy Roles

- Member of the Ontario Health Agency PFAC
- Steering Committee Member of the Durham OHT
- Co-Chair of the CE LHIN PFAC
- Member of the Ontario Agency Primary Care Quality Advisory Committee
- Member of the SE Health Advisory Committee
- PFEA with Lakeridge Health Durham
- Member of PAN (Patient Advisory Network) supporting the CDHE and WIHV on digital assessments
- Patient representative with the eHealth Conference team/Canada Health Infoway