‘Scotland - New Scotland Integrated Primary Care Initiative’: Report of the Inaugural Meeting

28-30 September 2017

Executive Summary

nova scotia health authority

Scottish School of Primary Care

Scotland – New Scotland Integrated Primary Care Initiative

Inaugural Meeting, September 28th-30th, 2017

Executive Summary

"Courage, compassion, and social justice – these values must guide our work. We have a shared passion to do good for the people that we deliver care to each day in our respective places"

Background

Besides our shared history and culture, Scotland and Nova Scotia hold a shared set of values and goals for health and social advancement. A three day Scotland-New Scotland knowledge sharing and relationship building programme was organized by the Faculty of Health, in collaboration with the Faculty of Medicine, Dalhousie University, the Nova Scotia Health Authority and the Nova Scotia Department of Health and Wellness. Three senior primary care experts from Scotland attended at the invitation of Dalhousie University.

Aim

This was the first meeting of the newly formed Scotland-New Scotland Initiative, which grew out of previous discussions in Scotland with representatives from Dalhousie University and the Nova Scotia Health Authority. Our goal was to meet to share knowledge about the organisation of primary care services and ongoing changes and challenges in both jurisdictions. Our aim was to identify common areas of policy and practice where collaborative research, training and other initiatives may be of mutual future benefit.

Meetings

Events included meetings with the Organizing Committee, the Deputy Minister of the NS Department of Health and Wellness, Dalhousie researchers and leads of two research institutes the Healthy Population Institute and Dalhousie Family Medicine and SPOR research network, Nova Scotia Health Authority, and NS Department of Health and Wellness administrators from policy, implementation of primary care and research. There was a public lecture given at Dalhousie by the Scottish guests and visits to two primary care centres in Halifax (Mumford Dal Family Medicine) and Chester (Our Health Centre). In addition, there was a day long Think Tank with local experts and guests sharing knowledge and perspectives on collaborative/integrated primary care.

Key Outcomes and Opportunities:

A richer and deeper understanding of both primary care systems, the underpinning values and models being developed, the delivery systems and the implementation challenges in both Scotland and Nova Scotia was achieved during the three days.

Knowledge and ideas about current and potential research and research training programs were also shared and generated. There was an agreement to develop a collaborative plan starting in 2018.

Key opportunities included:

- **Building on collaborative relationships between Scotland and New Scotland**
- **Identifying what is working well or not working well in integrated primary care, and why, in both jurisdictions**
- **Developing complementary research and evaluation projects to inform primary care policy and practice**
- **Sharing coaching, mentoring, and leadership training in academic and policy areas**
- **Sharing approaches to engage effectively with local communities**

Conclusions

The first meeting of the Scotland-New Scotland Initiative was deemed a success by all who attended, and highlighted many of the key common issues in primary care integration and transformation facing both jurisdictions. There is a genuine interest to carry on the initiative including the potential of a health and integrated primary care focused trip to Scotland in May, 2018.

Scotland – New Scotland Integrated Primary Care Initiative

Inaugural Meeting, September 28th-30th, 2017
Hosted by the Faculty of Health, Dalhousie University
September 28th-30th 2017

Full Report

'Courage, compassion, and social justice – these values must guide our work. We have a shared passion to do good for the people that we deliver care to each day in our respective places'

Background

The availability of high quality primary care within healthcare systems is known to improve outcomes in a cost-effective way [1]. Universal coverage of high quality, integrated primary care is an ambition worldwide [2]. There has been substantial progress in designing, testing, and implementing new models of integrated primary care to prevent chronic disease, manage it better and improve outcomes in many countries around the world. However, **every country and locale working to implement integrated primary care confronts substantial challenges with implementation**. This is complicated work. Examples of key barriers include: clarity and agreement on models, funding challenges, top-down vs. bottom-up approaches and engagement of stakeholders, tensions between economic and health goals, and evaluating the impact of complex interventions, especially for populations with complex, multiple health issues. **How might we invest our limited human and financial resources for optimal outcomes?** Interestingly, small nations and regions such as Scotland and Nova Scotia have been leading sites of innovation are also good places to both understand and address barriers to implementation of healthcare reforms that are being faced globally [3].

Besides our shared history and culture, **Scotland and Nova Scotia hold a shared set of values and goals for health and social advancement**. A three-day Scotland-New Scotland knowledge sharing and relationship building programme was organized by the Faculty of Health, in collaboration with the Faculty of Medicine, Dalhousie University, the Nova Scotia Health Authority and the Nova Scotia Department of Health and Wellness. Three senior primary care experts from Scotland attended at the invitation of Dalhousie University.

These ideas formed the basis of a number of Scotland-New Scotland knowledge sharing and relationship building events, Sept. 28- Oct. 1, 2017.

Aim

This was the first meeting of the newly formed **Scotland-New Scotland Integrated Primary Care Initiative**, that grew out of previous discussions in Scotland [3] with representatives from Dalhousie University and the Nova Scotia Health Authority. Our goal was to meet to share knowledge about the organisation of primary care services and ongoing changes and challenges in both jurisdictions. Our aim was to identify common areas of policy and practice where collaborative research, training and other initiatives may be of mutual future benefit.

Meetings

Events included meetings with the Organizing Committee, the Deputy Minister of the NS Department of Health and Wellness, Dalhousie researchers and leads of two research institutes the Healthy Population Institute and Dalhousie Family Medicine and SPOR research network, NS Health Authority, and NS Department of Health and Wellness administrators from policy, implementation of primary care and research. There was a public lecture given at Dalhousie by the Scottish guests and visits to two primary care centres in Halifax (Mumford Dal Family Medicine) and Chester (Our Health Centre). In addition, there was a day-long Think Tank with local experts and guests sharing knowledge and perspectives on collaborative/integrated primary care.

The three Scottish guests were:
Dr. Gregor Smith, Deputy Chief Medical Officer for Scotland
Professor Stewart Mercer, University of Glasgow and Director of the Scottish School of Primary Care (a multi-university collaboration on research in primary care in Scotland)
Professor John Gillies OBE, University of Edinburgh, Deputy Director of the Scottish School of Primary Care, and former Chair of the Royal College of General Practitioners (RCGP) Scotland.

Appendix 1 gives a full list of participants in the September 29th Think Tank sessions.

What We Did

The focus was to meet each other, gain understanding of our respective research and policy/practice environments, and begin discussions about how we might collaborate for mutual benefit. We shared information about our particular populations and their health issues, goals and organizational structures, payment systems, change processes, policies and programs, research and innovation, and challenges to the implementation of integrated primary care. As a result of these first meetings there was considerable interest among attendees from government and academe to get to know more and develop an agenda for working together. See Appendix 2 for the slide presentations from participants.

The organizers and Scottish guests of course fully understand the limitations of a short visit and the fact that not all voices of interested and knowledgeable Nova Scotian's could be heard. This was simply a start.

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Key opportunities included:

- **Building on collaborative relationships between Scotland and New Scotland**:
- **Identifying what is working well or not working well in integrated primary care, and why, in both jurisdictions**

- **Developing complementary research and evaluation projects** to inform primary care policy and practice

- **Sharing coaching, mentoring, and leadership training** in academic and policy areas

- **Sharing approaches to engage effectively with local communities**

Other issues

Many other important points emerged and ideas on how these could be developed. These are listed below. For full details see appendix.

- **The importance of values in policy, research and clinical care:**

Identify how values (e.g., compassion, courage and boldness, honesty, being humble, social justice) play roles in both care and strategic investments in integrated primary care, including engaging in public conversations about what we choose as investments in healthcare and treatments. Both NS and Scottish health systems are constrained financially. We need a courageous response and we need to stop doing the things that do not add value, that patients don't want, and that lead to unexplained variations in care. Policy initiatives that are aiming to do just this include:

  - Choosing Wisely Canada https://choosingwiselycanada.org/.
  - Realistic Medicine in Scotland
    http://www.gov.scot/Resource/0049/00492520.pdf
    https://beta.gov.scot/news/realising-realistic-medicine/

- **Fostering Innovation:**

Spreading a climate of innovation in the health system**.** Scotland and Nova Scotia both have good examples of innovation; e.g., doctors working with coast guard, ambulance service etc.

  - How does government in both localities support innovation at the local level?
  - Could we design a "Best Brains" Forum (http://cihr-irsc.gc.ca/e/43978.html) on Integrated Primary Care in Halifax and have participants from Scotland attend?
  - Could we apply a CIHR 'Listening for Direction' http://www.cihr-irsc.gc.ca/e/20461.html process to help understand implementation of integrated primary care; the conditions needed for success – complex intervention basics?

- **Capitalize on current projects:**

Compare and contrast findings from ongoing research and evaluation in both countries.
Examples could include the;

  - In Nova Scotia, Building Research for Integrated Primary Healthcare (BRIC-PHC) NS Strategy for Patient Oriented Research Network in Canada. With over 100 people involved BRIC NS is one of 11 Primary & Integrated Health Care Innovations (PIHCI) Networks across the country. As part of the SPOR initiative BRIC NS is focused on integrating health research more effectively into care in order to engage patients as partners in research, to focus on patient-identified priorities and to improve patient outcomes.
  - In Scotland, the Scottish School of Primary Care (SSPC) is leading the National Evaluation of Primary Care Transformation Pilots, which involves scoping the key activities in primary care integration and transformation in all Health Boards across Scotland, and carrying out 'deep dive' case studies in 5 Health Boards, as

well as nationally for Advanced Nurse Practitioners and MSK Physiotherapy. The School, in collaboration with the CMO and Deputy CMO has also proposed a 5 year programme of 'middle-ground research' to fill the evidence-gaps that are emerging [5].

- **Build Linkages and Relationships:**
  - Foster linkages among individuals (researchers and public servants) to share insights and develop joint initiatives. Help to foster connections
  - Using both virtual and face-to-face visits for policy and practice, research and training
  - Develop a list of people, themes, and projects to identify linkages - what's happening; what are the common interests?
  - Share information about national and international projects, linkages and initiatives such as the work of the EU Committee on Integrated Care
  - Develop learning networks on specific issues
  - Visit to Scotland to further discussions, visit innovative sites, meet with government leaders in primary and integrated care, practitioners, build collaborative research and evaluation projects, Spring 2017
  - Share tools and other resources – policy and practice, research, strategies and tools
  - Invite each other to conferences and training events
  - Government to government collaboration (does it need a neutral convener?)
  - Develop a policy interest group for implementing integrated care
  - Support visiting scholars
  - The NS Government has a cooperation agreement with Scotland in the Arts. Could we develop such an agreement in health policy and research?

- **Develop Project Proposals and Knowledge Syntheses**

Develop project proposals and knowledge syntheses on topics of common interest; e.g. payment systems and contracts with health professionals that align with collaborative, integrated care. Central to joint proposals would be collaborative funding models that leverage partner funding across agencies. Develop a list of researchable questions.

- **Investigate Data and Big Data Opportunities**

We need to be able to access and use good data to identify the lack of efficiencies in the health system. What data and databases do NS and Scotland have that can be useful? Examples include; Atlantic PATH http://atlanticpath.ca/. Maritime Strategy for Patient Oriented Research (SPOR) Support Unit http://www.spor-maritime-srap.ca/ ;Health Data Nova Scotia https://medicine.dal.ca/departments/department-sites/community health/research/hdns.html . In Scotland SPIRE (Scottish Primary Care Information Resource) www.spire.scot is being introduced in 2018.

  - Can we use these data sets to make comparisons and look at the effects of health care utilization?
  - Longitudinal studies on multi-morbidity – we know very little about this e.g. which combinations of conditions can lead to which outcomes?

- **Write and Publish Papers Together**

Develop joint papers comparing and clarifying how Scotland and New Scotland engage integrated primary care, including work in strategic areas such as *ehealth* and medications

management. This exercise would also contribute to building relationships and increase understanding about services and policies, potentially engage trainees.

- What are the policy papers influencing government?
- What policy papers have influenced both countries?
- Can we organize papers to be written across the most important themes? There are papers from Scotland School of Primary Care on their website, examples:
- Bruce Guthrie - Prescribing Safely: http://www.sspc.ac.uk/media/media_484725_en.pdf
- Adrian Rohrbasser - Collaborative Quality Improvement in General Practice Clusters http://www.sspc.ac.uk/media/media_543940_en.pdf
- Health Reform Observer is looking for papers (3 Pages) about innovation for decision makers (Ingrid Sketris) https://escarpmentpress.org/hro-ors
- Scotland Intercollegiate Guidelines Network (SIGNS) – objective is to improve the quality of health care for patients in Scotland by reducing variation in practice and outcome, through the development and dissemination of national clinical guidelines containing recommendations for effective practice based on current evidence. Guidelines are single disease focused not multi-morbidity. First guideline on multi morbidity in world ever developed. Guideline developers will have to take into account that people have multi morbidities. http://sign.ac.uk/

❖ **Analyze complex systems and complex system change as applied to integrated/collaborative primary care:**

- Develop and test practical methods of evaluating integrated primary care to examine approaches to implementing complex health systems change and optimizing impacts
- Investigate sites of innovation and the conditions that foster innovation and spread of innovation
- Compare integrated primary care implementation over time and Scotland and NS: processes, enablers, impact, lessons learned. Apply a "listening for direction" approach to understand more clearly the implementation of integrated primary care and conditions for success.

❖ **Share approaches to advance collaboration, teamwork, and shared decision-making:**

Innovative team-based models, bottom-up vs. top down, flexibility in implementation across regions, engagement versus negative relations across professions and government, patients and families, communities versus central authorities. How do we work together most effectively to create sustainable and effective primary care? Are there some tools that can assess and foster collaboration across sectors? Geographic clusters as learning organizations.

❖ **Pursue health system coaching**

Are there possibilities to develop mentors to support implementation of integrated primary care (as per the program of the International Foundation for Integrated Care)? Could such as program be designed and tested?

❖ **Pursue Opportunities to involve students and trainees**

For example, Meaghan Sim (NS) has been awarded a one-year post doc (CIHR health system impact fellow) that is shared across Dalhousie and government. Could funding be sought to

extend the postdoc for another year to support research and evaluation across Scotland and Nova Scotia? This model of policy and academia sharing a post-doc would be new to Scotland. Dalhousie could share its CIHR grant application with Scotland.

Conclusions

The first meeting of the Scotland-New Scotland Initiative was deemed a success by all who attended, and highlighted many of the key common issues in primary care integration and transformation facing both jurisdictions. There is a genuine interest to carry on the initiative including the potential of a health and integrated primary care focused trip to Scotland in May, 2018.

References

[1] Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Q2005;83:457-502.

[2] The World Health Report 2008 - primary Health Care (Now More Than Ever). http://www.who.int/whr/2008/en/

[3]. The Scottish School of Primary Care. Learning Together: sharing international experience on new models of primary care; policy, delivery, and evaluation http://www.sspc.ac.uk/media/media_538658_en.pdf

Appendix 1

Participant List for the Friday September 29th 2017 Think Tank

Scottish Delegates

Dr. John Gillies, Honorary Professor, Department of Family Practice and Population Health, University of Edinburgh and Deputy Director, Scottish School of Primary Care (john.gillies@ed.ac.uk)
Dr. Stewart Mercer, Professor of Primary Care, University of Glasgow; Director, Scottish School of Primary Care (stewart.mercer@glasgow.ac.uk)
Dr. Gregor Smith, Deputy Chief Medical Officer, Scottish Government (gregor.smith@gov.scot)

Nova Scotia Delegates

Ms. Meredith Campbell, Director Programs, Nova Scotia Health Research Foundation (Meredith.Campbell@novascotia.ca)
Dr. Nancy Carter, Director REAL Evaluation Services, Nova Scotia Health Research Foundation (Nancy.Carter@novascotia.ca)
Ms. Tricia Cochrane, VP Nova Scotia Health Authority delegate for Janet Knox, CEO and President of NSHA (tricia.cochrane@nshealth.ca)
Ms. Krista Connell, CEO Nova Scotia Health Research Foundation(Krista.Connell@novascotia.ca)
Ms. Lynn Edwards, Senior Director for Primary Health Care and Chronic Disease Management, NSHA (Lynn.Edwards@nshealth.ca)
Dr. Charmaine McPherson, Executive Director, Risk Mitigation - Primary and Acute Care Branch
Department of Health & Wellness delegate for Denise Perret, Deputy Minister of Health, NS Government (Charmaine.McPherson@novascotia.ca)
Dr. Tara Sampalli, Director Research & Innovation, Primary Health Care, NSHA (tara.sampalli@nshealth.ca)
Ms. Sandra Crowell, Program Leader, Research Development Research and Innovation, NSHA (Sandra.crowell@nshealth.ca)

Dalhousie University and Affiliates

Dr. Alice Aiken, Vice President Research, Dalhousie University (Alice.Aiken@dal.ca)
Dr. Fred Burge, Co-Lead, Collaborative Research in Primary Health Care, Researcher FoM (Fred.Burge@dal.ca)
Dr. Jacqueline Gahagan, Professor (Health Promotion), School of Health and Human Performance, FH (Jacqueline.gahagan@dal.ca)
Dr. Sara Kirk, Professor (Health Promotion), School of Health and Human Performance, FH and Scientific Director Healthy Populations Institute (Sara.Kirk@dal.ca)
Dr. Cheryl Kozey, Associate Dean Research FH (Cheryl.Kozey@dal.ca)
Dr. Renee Lyons, Professor Emeritus FH; Senior Scientist, Emeritus, Lunenfeld-Tanenbaum Research Institute, Sinai Health System; Professor (Status) Dalla Lana School of Public Health & Institute of Health Policy, Management & Evaluation, University of Toronto (renflyons@gmail.com)
Dr. Ruth Martin-Misener, Co-Lead, Collaborative Research in Primary Health Care, FH &Director of the Centre for Transformative Nursing and Health Research (ruth.martin-misener@dal.ca)

Ms. Suzie Officer, Director Research Services, FH (Suzie.officer@dal.ca)
Dr. Ingrid Sketris, Associate Director Research College of Pharmacy**,** University Professor and Director of IMPART (ingrid.sketris@dal.ca)

Dalhousie/NSHA
Dr. Meaghan Sim, HSPR Post-Doctoral Fellow, Dalhousie Faculty of Health and NSHA

Appendix 2

Key Websites for Additional Information

Dalhousie University Faculty of Health https://www.dal.ca/faculty/health/about.html

Dalhousie University Healthy Populations Institute https://www.dal.ca/dept/hpi.html

Nova Scotia Department of Health and Wellness
https://beta.novascotia.ca/government/health-and-wellness/

Nova Scotia Health Authority Primary Health Care
http://www.cdha.nshealth.ca/primary-health-care

Nova Scotia Health Research Foundation https://www.nshrf.ca/

Scottish School of Primary Care www.sspc.ac.uk

Chief Medical Officer (Scotland) Annual Reports 2014-15 and 2015-16:

http://www.gov.scot/Resource/0049/00492520.pdf

https://beta.gov.scot/news/realising-realistic-medicine/

Scottish Government Primary Care Strategy:
http://www.gov.scot/Topics/Health/Services/Primary-Care/Strategy-or-Primary-Care

Healthcare Improvement Scotland iHub:
http://ihub.scot

Appendix 3

Presentations

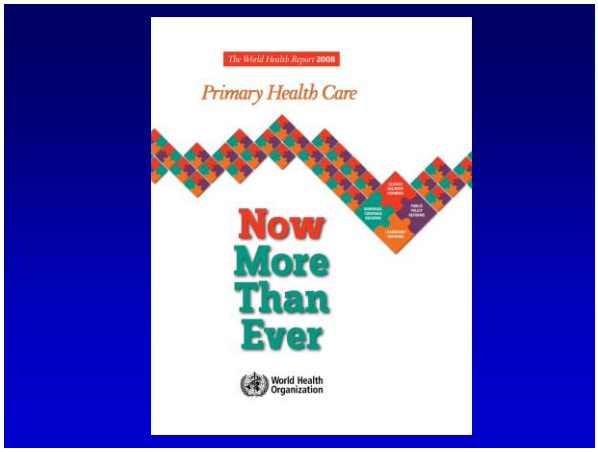
Table of Contents, Slides

Scottish School of Primary Care

SSPC: evidence, evaluation and policy

John Gillies
Deputy Director, Scottish School of Primary care
Honorary Professor of General Practice
Senior Advisor, Global Health Academy
Co-director, University of Edinburgh Compassion Initiative
SSPC_News
www.sspc.ac.uk
University of Edinburgh
Scottish School of Primary Care

GPs at the Deep End



THE UNIVERSITY of EDINBURGH
Global Health Academy

Universal health coverage based on primary care

Gostin *L. Global Health Law.* 2014. Harvard University Press. pp22-25.

'Active' Public Health'

Action on socio-economic determinants of health

www.globalhealthacademy.ed.ac.uk

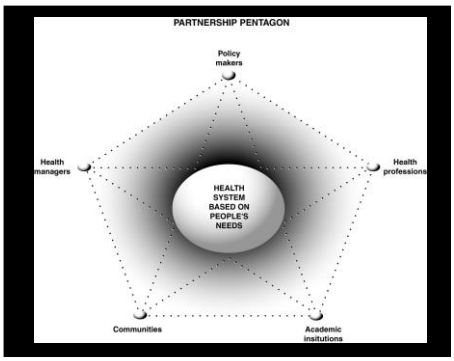
Dr Margaret Chan, World Health Organisation

THE UNIVERSITY of EDINBURGH
Global Health Academy

'Specialised models of care are not ideal to manage ageing populations. *Family doctors who cultivate long term relationships with patients are uniquely placed to help people age in good health, stay at home as long as possible and find the right mix of specialised care when needed.'* Dr Margaret Chan. WONCA World conf Prague. June 2013.

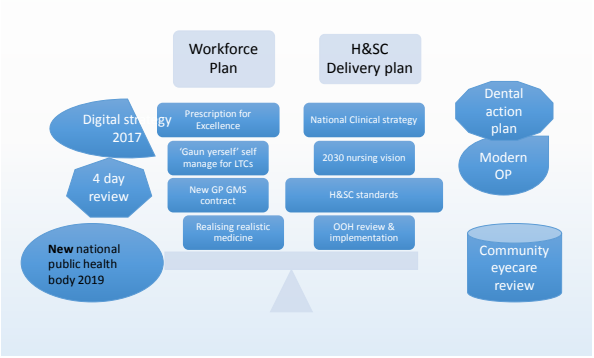
One world. One health. One medicine. Together, we can make Life better
www.globalhealthacademy.ed.ac.uk

Towards Unity for Health 2000



www.the-networktufh.org

Scottish Government: active change!



SSPC Vision is for:

Sustainable and equitable high quality primary care that meets the needs of the people of Scotland.

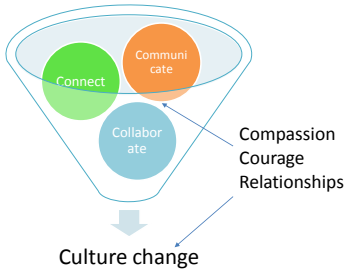
Within this, we aspire to be:

- Relevant
- Credible
- Respected
- Trusted

SSPC current strategic objectives

- ***Inform*** our key stakeholders by collating relevant available national and international evidence, as well as actively contributing to the evidence base.
- ***Support*** the continuing growth of Academic Primary Care in Scotland.
- ***Promote*** Scottish Academic Primary Care internationally.

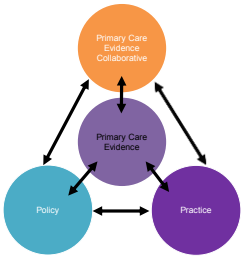
Realising realistic medicine Scotland 2017



Primary Care Evidence Collaborative Members

Healthcare Improvement Scotland
Scottish School of Primary Care
NHS Health Scotland
NHS Education for Scotland
ALLIANCE
The Scottish Government
NHS National Services Scotland

Primary Care Evidence Triangle



Primary Care Evidence Collaborative Members	
HSCA	Health and Social Care Analysis, Scottish Government
SSPC	Scottish School of Primary Care
NHSHS	NHS Health Scotland
HIS	Healthcare Improvement Scotland (including Scottish Health Council)
ALLIANCE	Alliance for Health and Social Care Scotland
NES	NHS Education for Scotland
NSS	National Services Scotland

SSPC: what we're up to…..

- ***International workshops***
  - ***Quality after QOF; Evaluability assessment methodology (2016)***
  - ***Learning together: sharing international experience of new models of primary care: the Edinburgh consensus statement (2017)***
- ***Briefing papers for GP clusters, literature reviews on Quality, GP clusters***

Edinburgh consensus statement May 2017

The Edinburgh Consensus Statement

*"The population challenges facing primary care in Scotland and other countries require **leaders who take a collaborative approach**, and who are proactive in wider roles such as advocacy and social activism. General practitioners will work closely with other health and social care professionals **in multidisciplinary teams** where roles and contributions are understood and respected. **Patients' goals and preferences elicited through shared decision -making** will guide the direction and amount of their healthcare. The **resourcing** of primary care will reflect the growing needs of older people and those with premature multimorbidity in deprived communities. These represent major cultural shifts. As new models of primary care develop and evolve, retaining and building on **core values, such as mutuality, respect and compassion, will be essential to staff and patients alike**. A strong focus on developing and **maintaining trust** among all involved is essential and consideration for staff wellbeing must be evident. **Generalism** must remain at the heart of primary care. **Rapid access to high quality data** to produce intelligence for transforming care will be essential. **Collaboration between policy makers and academics in primary care research** could quickly improve quality and value, achieving greater health gain for citizens, by filling in current evidence gaps and guiding the adoption and delivery of policy directives."*

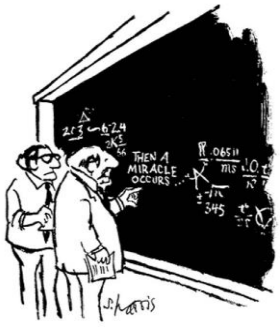
Scottish School of Primary Care National Evaluation Framework for Primary Care Transformation

- The Primary Care Transformation Fund (PCTF) has £20 million designated to new models of care in primary care, which is part of a £60 million fund covering additional aspects of care such as mental health, community pharmacy, and out-of-hours care
- The Scottish School of primary Care (SSPC) has been awarded £1.25 million to help evaluate these new models of primary care

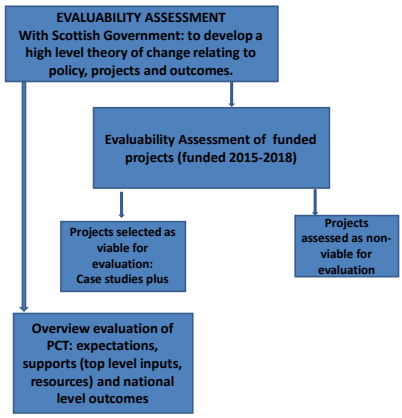
What is Theory of Change?

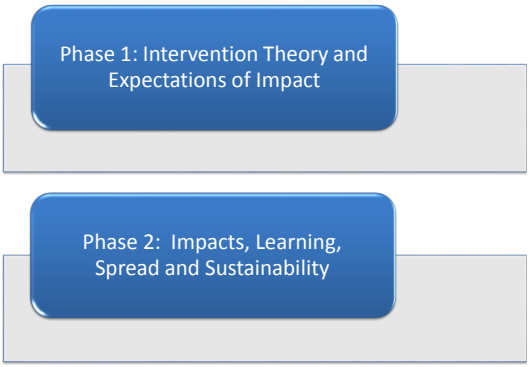
"Theory of Change is essentially a comprehensive description of how and why a desired change is expected to happen in a particular context. It is focused on "filling in" the "missing middle" between what a program or change initiative does (its activities or interventions) and how these lead to desired goals being achieved."

http://www.theoryofchange.org/what-is-theory-of-change/



"I think you should be more explicit here in step two."





This approach is drawn from the evaluability literature, and in particular from the 'ten steps' approach described by the Evaluation Centre for Complex Health Interventions at the University of Toronto, an recognised International centre of excellence in evaluating complex interventions.

Phase 1: Intervention Theory and Expectations of Impact:

The key questions include:

- What is the planned intervention/project and how does this build on previous work?
- What are the key components of the intervention/project?
- Are these likely to change over the life of the intervention?
- What are the expected impacts in the short, medium, and long-term?
- How do the stakeholders think these impacts are going to be achieved?
- What is the evidence to support this?
- Who are the key stakeholders in terms of future sustainability and spread and what evaluation information do they require?

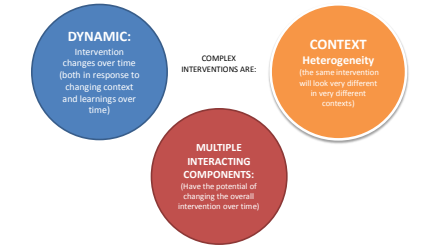
Phase 2: Impacts, Learning, Spread and Sustainability

The key questions include:

- What impact(s) has the intervention/project/programme had, in relation to the expected impacts?
- Has the intervention, and the expected impacts changed over time?
- Have there been any unintended negative consequences?
- What is the key learning that needs to be shared?
- Which interventions seem worth scaling up and spreading?
- How easily can these be implemented?
- How sustainable are these likely to be in the long-term?

Features of complex interventions

Slide from Sanjeev Sridharam with permission



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REALISTIC MEDICINE

Integrated Primary Care in Scotland

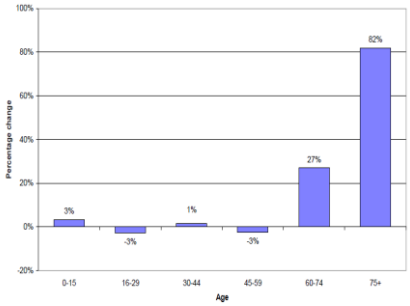
Dr Gregor Smith
Deputy CMO for Scotland

Don't find fault, find a remedy; anyone can complain.
Henry Ford

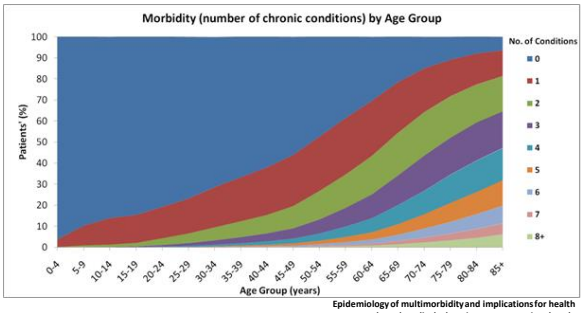
NHS SCOTLAND

Population 5.4 million
Devolved Parliament
Universal healthcare
Integrated delivery system
£12.4 billion budget
14 + 8 NHS Health Boards
31 Integration Authorities
Free personal care for 65+

Projected % change in Scotland's population by age group, 2010 - 2035

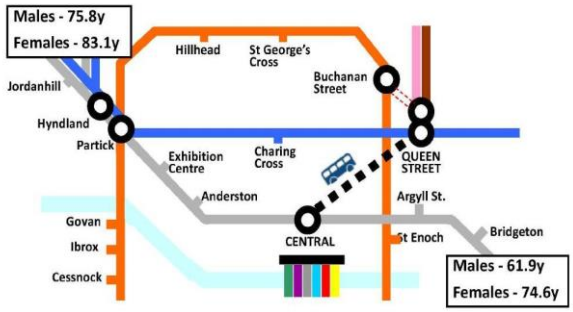


Multimorbidity in Scotland



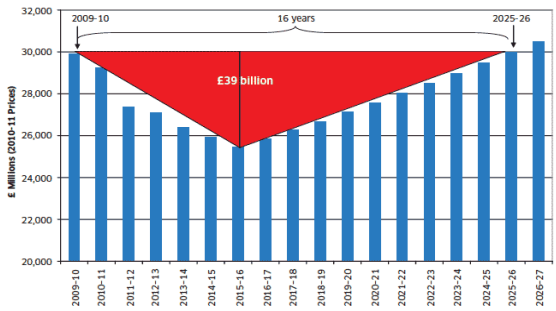
Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study
Karen Barnett, Stewart W Mercer, Michael Norbury, Graham Watt, Sally Wyke, Bruce Guthrie
***Lancet* 2012; 380: 37–43**

Each stop on the Argyll line travelling East represents a drop of 1.7 years in male life expectancy

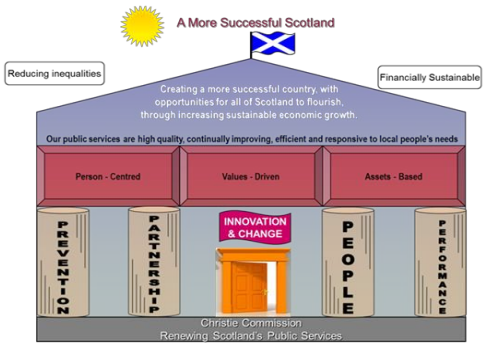


Life expectancy data refers to 2001-5 and was extracted from the GCPH community health and well-being profiles. Adapted from the SPT travel map by Gerry McCartney.

Public Finances – Fall in Government Expenditure



Public Service Reform



Vision

People should be supported to live well at home or in the community for as much time as they can

People should have a positive experience of health and social care when they need it

Learning from successful integrated systems

Four common characteristics:

- Plan for populations, not delivery structures
- Pool resources – money and people
- Embed clinicians and care professionals in service planning, investment and provision
- Strong local leadership

Integration Authorities – minimum functions

Adult hospital care

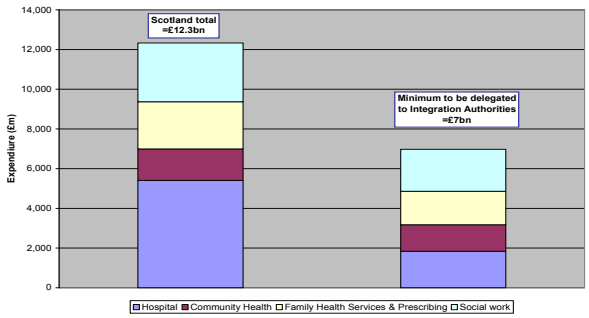
- A&E
- Inpatient beds:
  - general medicine
  - geriatric medicine
  - rehabilitation medicine
  - respiratory medicine
  - psychiatry of learning disability
  - palliative care
  - palliative care
  - addictions and dependencies
  - mental health services, except secure forensic mental health services
  - addictions and dependencies
  - GP beds

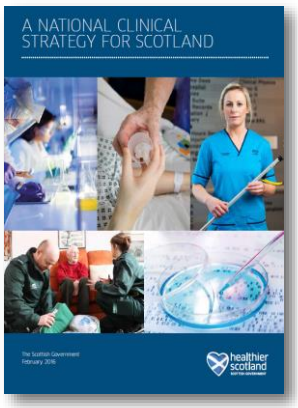
Adult social care

Adult primary and community healthcare

- Primary medical services
- Out-of-hours services
- District nursing services
- General dental services
- Public dental service
- Community ophthalmic services
- Community pharmaceutical services
- Community and outpatient AHP services
- Community addiction and dependency services
- Community geriatric medicine
- Community palliative services
- Community learning disability services
- Community mental health services
- Community continence services
- Community dialysis services
- Services provided by health professionals that promote public health

Integrated Resources - Minimum to be delegated

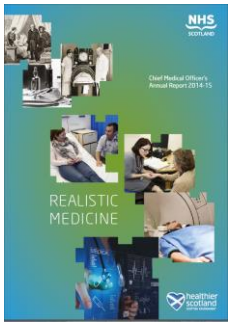


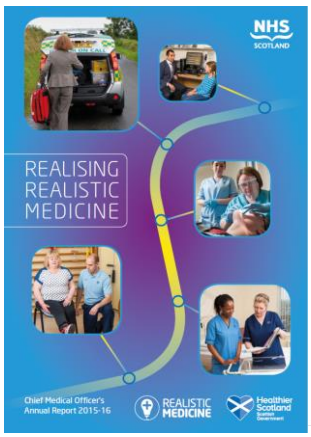


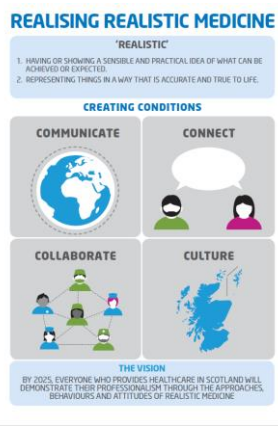
"A focus on **supporting people**, rather than single disease pathways

with a solid foundation of **integrated health and social care** services

based on new models of **community-based provision**."







"Silver City" Aberdeen

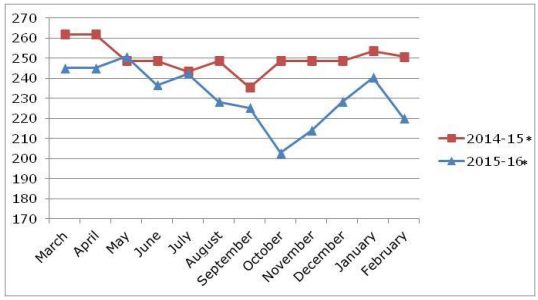


Figure: Emergency hospital admissions per 1000 population aged Silver City MDT meeting commenced March 2015.
**Chi-squared test : p=0.012*

Transforming Primary Care

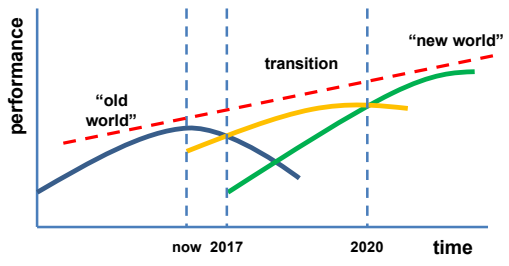
"My vision puts primary and community care at the heart of the healthcare system, with highly skilled multidisciplinary teams delivering care both in and out of hours, and a wide range of services that are tailored to each local area.

That care will take place in locality clusters, and our primary care professionals will be involved in the strategic planning of our health services. The people who need healthcare will be more empowered and informed than ever, and will take control of their own health. They will be able to directly access the right professional care at the right time, and remain at or near home wherever possible."

Shona Robison, Scottish Parliament (15th December 2015)

NATIONAL OUTCOMES			
Our children have the best start in life and are ready to succeed	We live longer, healthier lives	Our people are able to maintain their independence as they get older	Our public services are high quality, continually improving, efficient and responsive
We start well	**We live well**	**We age well**	**We die well**
PRIMARY CARE VISION	Our vision is of general practice and primary care at the heart of the healthcare system. People who need care will be more informed and empowered, will access the right professional at the right time and will remain at or near home wherever possible. Multidisciplinary teams will deliver care in communities and be involved in the strategic planning of our services.		
HSCP OUTCOMES	People can look after own health	Live at home or homely setting	Positive Experience of Services	Services improve quality of life
Services mitigate inequalities	Carers supported to improve health	People using services safe from harm	Engaged Workforce Improving Care	Efficient Resource Use
PRIMARY CARE OUTCOMES			
We are more informed and empowered when using primary care	Our primary care services better contribute to improving population health	Our experience as patients in primary care is enhanced	
Our primary care workforce is expanded, more integrated and better co-ordinated with community and secondary care	Our primary care infrastructure – physical and digital – is improved	Primary care better addresses health inequalities	

Transforming primary care



Role of the GP Cluster

Intrinsic

- Learning network, local solutions, peer support
- Consider clinical priorities for collective population
- Transparent use of data, techniques and tools to drive quality improvement – will, ideas, execution
- Improve wellbeing, health and reduce health inequalities

Extrinsic

- Collaboration and practise systems working with CMDT and third sector partners
- Influence priorities and strategic plans of IJB
- Provide critical opinion to aid transparency and oversight of managed services
- Ensure relentless focus on improving clinical outcomes and addressing health inequalities

"Improving Together"

"Congratulations on the new framework. I cannot recall seeing a more sophisticated approach to overall improvement, contemplating authentic leadership from the profession. It has many strengths. For example, I love the "Value" framework that appears early on, and the "Extrinsic/Intrinsic" construct us extremely useful. Most important, this provides hope for the kind of "learning nation" that can make real progress."

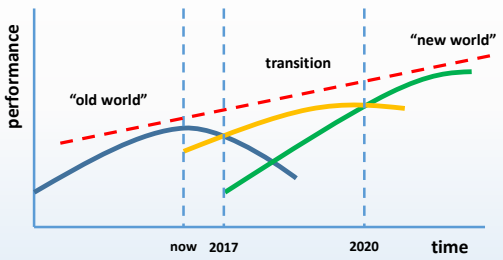
- Don Berwick

Scottish School of Primary Care

Evidence-Based Realistic Medicine for Integrated Primary Care

Stewart Mercer
Director of the Scottish School of Primary care
Professor of Primary care Research
University of Glasgpw
SSPC_News
www.sspc.ac.uk

Transforming primary care

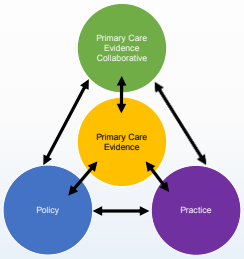


From a prescriptive contract to an enabling contract

Primary Care Evidence Collaborative Members

Healthcare Improvement Scotland
Scottish School of Primary Care
NHS Health Scotland
NHS Education for Scotland
ALLIANCE
The Scottish Government
NHS National Services Scotland

Primary Care Evidence Triangle



Primary Care Evidence Collaborative Members	
HSCA	Health and Social Care Analysis, Scottish Government
SSPC	Scottish School of Primary Care
NHSHS	NHS Health Scotland
HIS	Healthcare Improvement Scotland (including Scottish Health Council)
ALLIANCE	Alliance for Health and Social Care Scotland
NES	NHS Education for Scotland
NSS	National Services Scotland

This type of evaluation is necessary but not sufficient…….

The key principles of realistic medicine, as set out in the CMO's 2015 report are:

- Moving towards shared decision-making
- Building a personalised approach to care
- Reducing harm and waste
- Reducing unnecessary variation in practice and outcomes
- Managing risk better
- Becoming improvers and innovators

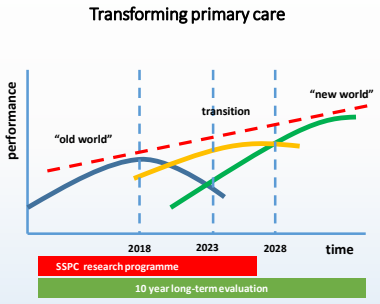
Realistic Research for Realistic Medicine….

"NHS professionals and academics all too often work in their individual silos with limited translation of research into practice, and limited evaluation of practice to maximise effectiveness. However, each group has complementary strengths and weaknesses, so collaboration on the right terms can be of great mutual benefit….."

	Frontline clinicians and managers	Academics
Creating interventions and new models of care	Normal business for NHS innovators. Strong on feasibility but often don't draw on strongest existing theory and evidence.	Normal business for health services researchers. Strongly based on existing theory and evidence but often inadequate attention paid to feasibility.
Evaluating interventions and new models of care	Often not focused on from the start, tend to use weaker evaluation designs that have significant risks of bias.	Emphasise pre-planned, 'as strong as possible' evaluation design to minimise bias.
Translating new ideas into practice and ensuring spread and sustainability	The experts in real-world implementation but often don't draw on existing theory and evidence.	Often under-estimate the complexity of real-world implementation and many perceive translation to be someone else's responsibility.
Evaluating widespread implementation	Often not focused on from the start, tend to use weaker evaluation designs that have significant risk of bias.	Have relevant methodological expertise but not commonly engaged in real-world evaluation. REF requirements to demonstrate impact.

Delivering the Evidence-Base for Realistic Medicine in Primary Care

- There is a **compelling need to fill the many 'evidence-gaps'** in integrated primary care.
- There is an **important innovative 'middle-ground'** that sits between the current remit of national research funding bodies and service evaluations.
- A focus on this **'research middle-ground'** – working closely with the NHS and social care partners – could provide evidence within a relatively short time frame to inform **primary care transformation** and to help realise **Realistic Medicine**.



The Scottish School of Primary Care

Multimorbidity in Scotland

The Scottish School of Primary Care's
Multimorbidity Research Programme

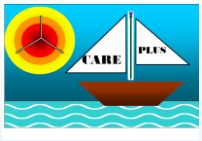
Programme lead: Professor Stewart Mercer

University of Glasgow | Institute of Health & Wellbeing

University of Dundee

Chief Scientist Office

Living well with multimorbidity: the Care Plus Study



Stewart Mercer
Bruce Guthrie
Elizabeth Fenwick
Bridie Fotzpatrick
Alex McConnachie
Rosalind O'Brien
Graham Watt
Sally Wyke
NHS and Deep End General Practices

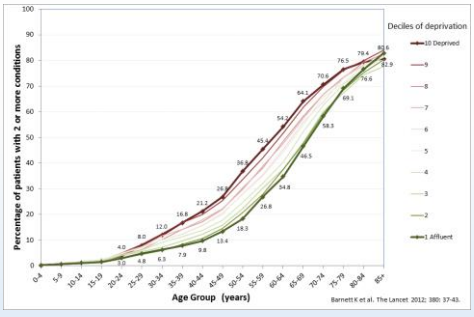
2009- 2014

Chief Scientist Office

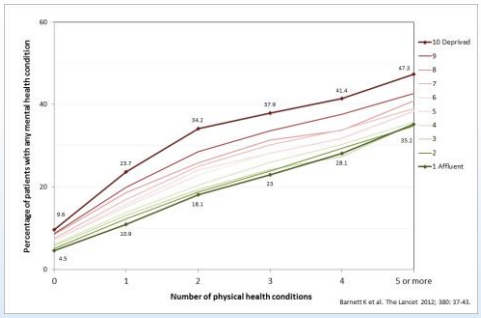
Living well with multimorbidity

The extent of the problem	• 310 general practices -1,754,133 patients • Qualitative interviews - 19 HCPs and 14 patients • Economic analysis: Scottish Health Survey
Developing and optimising the intervention	• First iteration – 6 Focus Groups • Second iteration – Pilot Study in 2 practices
Exploratory cluster RCT	• 8 general practices: GPs and practice nurses • 152 patients • Economic analysis: in-trial and modelling

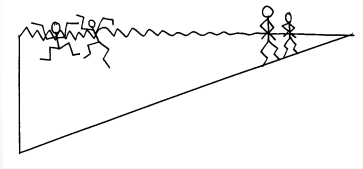
People living in more deprived areas in Scotland develop multimorbidity 10-15 years before those living in the most affluent areas

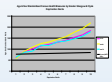


Mental health problems are strongly associated with the number of physical conditions that people have, particularly in deprived areas in Scotland

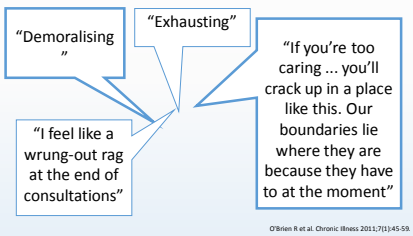


GENERAL PRACTITIONERS AT THE DEEP END

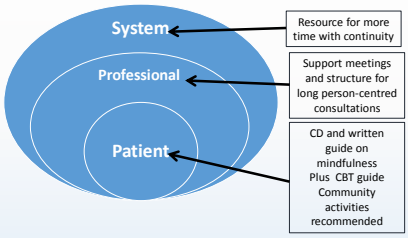




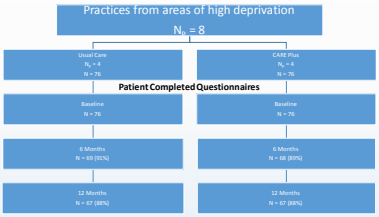
General practitioners and practice nurses in deprived areas struggle to support people with multimorbidity

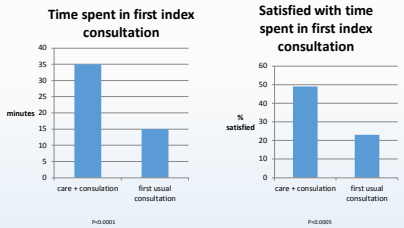


O'Brien R et al. Chronic Illness 2011;7(1):45-59.

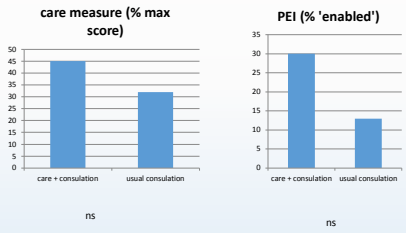


Would GPs and patients participate in a RCT?

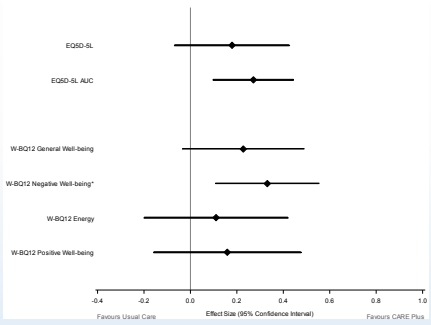




Are consultations 'better'?



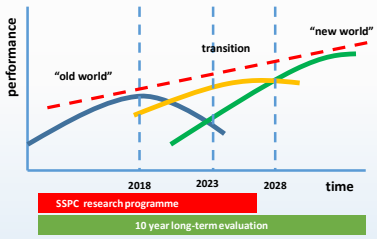
Patients in the CARE Plus group had improvements in quality of life and wellbeing at 12 months

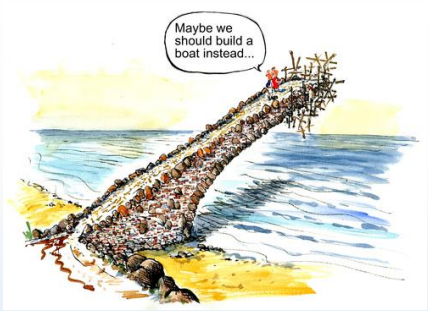


CARE Plus is also very cost-effective

- Cost-effective:
  - Cost < £13,000 per QALY
  - NICE currently supports a cost of £20,000 per QALY

Transforming primary care

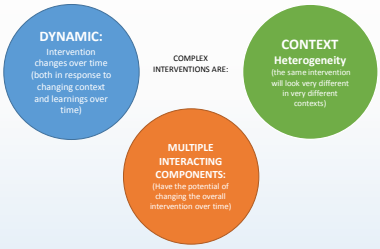




Thank you

Features of complex interventions

Slide from Sanjeev Sridharam with permission



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Nova Scotia Based Academic Primary Health Care Research Entities

Scottish Visit to Nova Scotia

September 29, 2017

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CoR-PHC

- Interdisciplinary group of primary health care researchers
  - Originally funded by and located at Dalhousie
  - A Primary Health Care Research Collaborative
- Created to respond to health system needs
  - Members from Faculties of: Health (nursing, pharmacy, occupational and physical therapy, health promotion), Medicine (family medicine, community health and epidemiology, geriatrics) Dentistry, Computing Science, Engineering and Arts and Science
  - Nova Scotia Health Authority
  - Nova Scotia Department of Health and Wellness

http://www.dal.ca/sites/cor-phc/home.html

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CoR-PHC Objectives

- Focus strategic directions of researchers on the needs of decision makers
- Create and synthesize existing knowledge on effectiveness of the new approaches to PHC
- Build research capacity
- Capture national funding for PHC research and improvement
- Build new collaborations to leverage skills and potential for PHC research (SPOR, CRCs, donor support)

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CoR-PHC Research Focus

- Strategic policy oriented projects influencing design, evaluation, and scaling new models of interdisciplinary team-based PHC
  - Wellness promotion, risk factor management
  - Chronic disease prevention and management, self-management
  - Access to routine and urgent care
  - Collaborative interdisciplinary approaches to PHC
  - PHC health service delivery quality
  - System coordination/integration across health sectors
  - Translational research
- Alignment with strategic priorities of Dalhousie, Faculties, Health Authority and Department of Health and Wellness

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Successes

- Inter-faculty collaboration growth
- Learner support: events, partnering with TUTOR-PHC
- Nova Scotia Health Authority collaboration expansion
- Annual Nova Scotia Primary Healthcare Research Day
- Visiting Scholars and annual retreats
- Brewing ideas
- Grant successes- CIHR SPOR PIHCI Network: BRIC NS
- Increasing focus on patient/citizen participation
- Wave 2

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Building Research for Integrated Primary Healthcare (BRIC NS)

BRIC NS Management Team	
Fred Burge **(Science Lead)**	Dalhousie Faculty of Medicine, Department of Family Medicine
Rick Gibson **(Clinical Lead)**	Nova Scotia Health Authority, Primary Health Care
Lynn Edwards **(Policy Co-Lead)**	Nova Scotia Health Authority, Primary Health Care
Charmaine McPherson **(Policy Co-Lead)**	Nova Scotia Department of Health and Wellness, Acute and Primary Care
Ruth Martin-Misener	Dalhousie Faculty of Health, School of Nursing, Centre for Transformative Nursing and Heath Research
Lois Jackson	Dalhousie Faculty of Health, School of Health and Human Performance, Healthy Populations Institute
Sara Kirk	Dalhousie Faculty of Health, School of Health and Human Performance, Healthy Populations Institute
Tara Sampalli	Nova Scotia Health Authority, Research and Innovation, Primary Health Care
Meredith Campbell	Nova Scotia Health Research Foundation
Emily Gard Marshall	Dalhousie Faculty of Medicine, Department of Family Medicine
Beverley Lawson (Director)	Dalhousie Faculty of Medicine, Department of Family Medicine
Sara Wuite (Manager)	Dalhousie Faculty of Medicine, Department of Family Medicine

What is SPOR?

- A CIHR initiative focused on integrating health research more effectively into care
- Patient-Oriented Research:
  - engages patients as partners
  - focuses on patient-identified priorities and improves patient outcomes
- The SPOR Strategy is carried out through the work of **SPOR Networks** and **SPOR SUPPORT Units** and several national working groups.

BRIC NS

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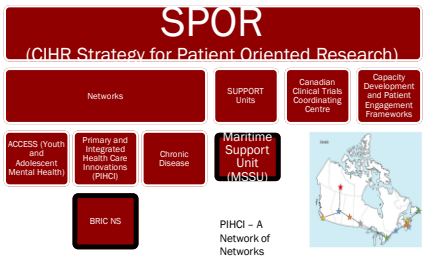

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What is BRIC NS?

- BRIC NS is our provincial **Primary and Integrated Health Care Innovations Network**
- Part of the Canadian Institutes of Health Research (CIHR) Strategy for Patient Oriented Research (SPOR)
- Co-funded by the Nova Scotia Health Research Foundation and CIHR.

Nova Scotia Health Research Foundation CIHR IRSC SPOR Putting Patients First BRIC NS

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BRIC NS

Overall goal:

To support evidence-informed transformation and delivery of more cost-effective primary and integrated health care to improve patient experience. To improve health, health equity, and health system outcomes for individuals with, and at risk of developing, complex health needs.

BRIC NS

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Priorities

- Focus on populations with complex needs
  - 'high system users
  - across the life span
- Integration health promotion & addressing the social determinants of health in care delivery: preventing future complex needs
- Using innovative tools & strategies to identify patients with complex needs & to understand their needs
- Redesigning service delivery to meet the needs of complex patients
- Enabling the primary health care workforce to meet the needs of complex patients & future demands for a range of services.

BRIC NS

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BRIC NS – Network functions

- Provide research infrastructure
  - BRIC NS has no funding for projects
- Provide opportunity to apply for CIHR targeted calls dedicated to primary & integrated health care research
- Facilitate researcher, provider and knowledge user connections within NS and across the country
- Build capacity in primary & integrated health care research
- Develop a 'rapid-learning' environment responding to the real-time needs of PHC stakeholders for evidence to inform policy and practice innovations
- Bring together researchers, policy makers, clinicians and patients.

BRIC NS

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Patient Engagement in BRIC NS

Support patient-oriented research

BRIC NS involves patients like Kylie Peacock in shaping the primary care research agenda. As a person with type 1 diabetes, Kylie has been intensely involved with the health care system for many years, as a patient, advocate and fundraiser. She jumped at the chance to join the BRIC NS advisory council.

"BRIC NS research covers such a broad spectrum, from prevention to chronic disease management, across the lifespan," she says. "It's exciting to see the researchers in academia working with the decision makers in the health care system, and involving people like me, to develop research initiatives that will make a real impact."

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Learner Support in BRIC NS

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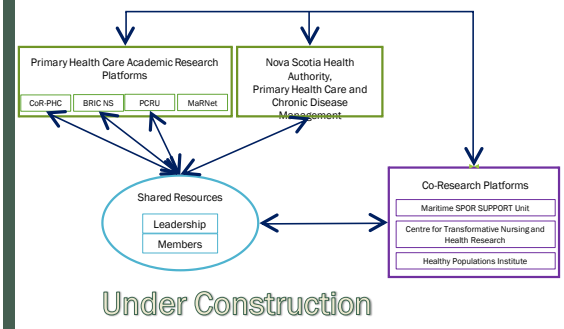
MaRNet

- Maritime Research Network for Family Practice
- Has Electronic Medical Record data from participating practices
- Originally set up for chronic disease surveillance
- Part of the Canadian Primary Care Sentinel Surveillance Network (CPCSSN)
  - *80 practices: family doctors and nurse practitioners: 100,000 patients*
  - *National network of 10 networks with > 1 million patient records*
  - *Focus on care for patients with chronic disease*

MaRNet Objectives

- To develop a network of Family Practices across Nova Scotia, New Brunswick and Prince Edward Island that can collaborate on research projects to improve health care in the Maritimes.
- To enable community Family Physicians and Nurse Practitioners to combine their relevant questions, skills and resources with the expertise and resources of academic family physicians to conduct Primary Care research.
- To conduct and support primary care research in practice-based settings that addresses questions of importance to Family Medicine and improve health care delivery to, and the health status of, patients and their families in the Maritime provinces.



Under Construction

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Exemplar Projects

Integrating Paramedic and Primary and Palliative Care Teams to Optimize Patient Time in the Community at the End-of-Life

- Led by Dr. Alix Carter
- $125,000 from CIHR SPOR PIHCI Comparative Program and Policy Analysis Grant; In NS, matched funds from NS Emergency Health Services, MSSU, Dalhousie
- Evaluating training course that teaches paramedics to deliver palliative and end-of-life care in the community
- Partnered with British Columbia

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Exemplar Projects

Evaluating the Involvement of Patient and Family Advisors in Quality Improvement and Safety Teams in NS

- Led by Dr. Ruth Martin-Misener
- $50,000 from CIHR SPOR PIHCI Comparative Program and Policy Analysis Grant; In NS, matched funds from NSHA, Dalhousie
- 3 patients on study team
- understand how best to involve Patient and Family Advisors (members of NSHA Primary Health Care Quality and Safety Teams) so that patients have a stronger voice and meaningful impact on the primary health care system in Nova Scotia

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Primary Health Care in Nova Scotia

09-28-2017
Lynn Edwards
Senior Director, Primary Health Care & Chronic Disease

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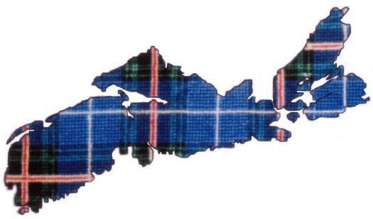
Challenges & Opportunities



VISION	MISSION	VALUES
Healthy people, healthy communities - for generations.	To achieve excellence in health, healing and learning through working together.	Respect, Integrity, Innovation, Courage, Accountability

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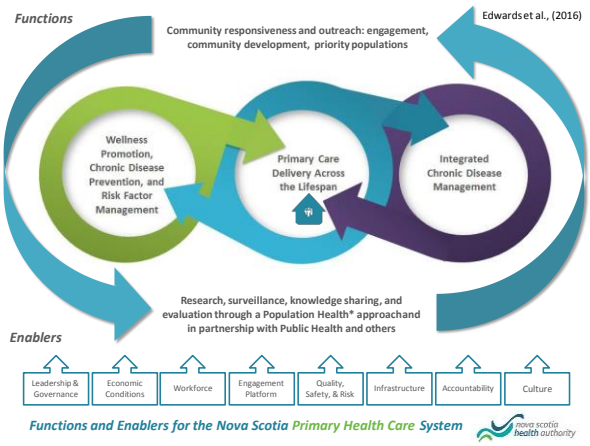
High Performing Health Systems

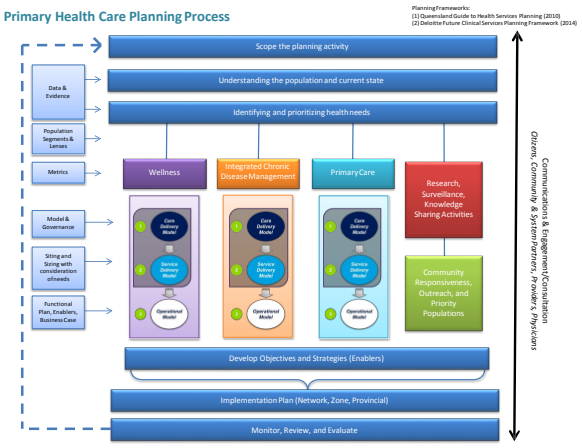
- ***Strong primary health care and robust primary health care teams are the foundation of the health care system*** *(Baker & Denis, 2011).*
- ***Primary care improvement is viewed as a critical starting point for transforming health care systems and improving access and quality of care***
  (Starfield et al., 2005; Hutchison, 2008; Health Council of Canada, 2009; as cited in Baker and Dennis, 2011).

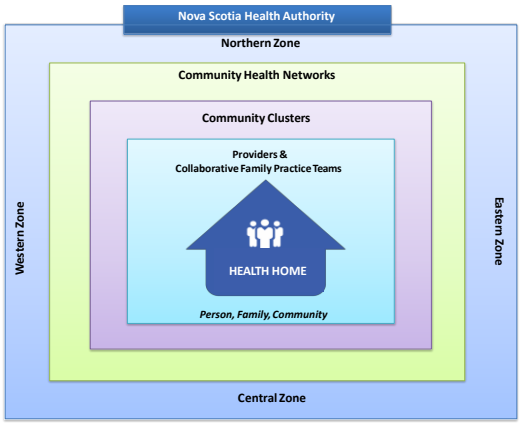
nova scotia health authority *Healthy people, Healthy communities — for generations*

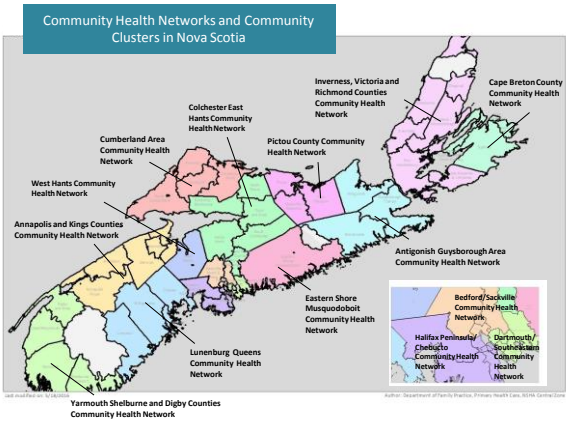
PRIMARY HEALTH CARE **AIM**

- Keep people healthy
- Prevent and/or delay Illness
- Support individuals to improve their management of chronic (complex) conditions
- Reduce unnecessary emergency room usage
- Reduce unnecessary hospital utilization







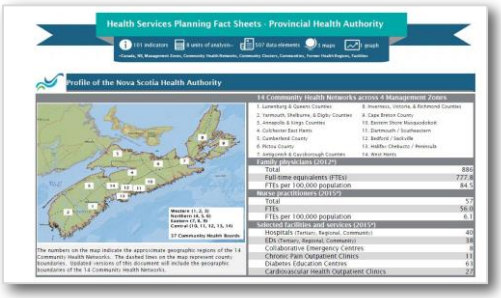


Community Health Networks

Zone	Community Health Networks	Population[1]	# of Clusters
Western (194,501)	Lunenburg & Queens Counties	57,544	4
	Yarmouth, Shelburne, & Digby Counties	58,550	4
	Annapolis & Kings Counties	78,507	5
Northern (150,597)	Colchester East Hants	73,352	6
	Cumberland County	31,344	4
	Pictou County	45,901	3
Eastern (163,217)	Guysborough Antigonish Counties	27,315	3
	Cape Breton County	102,397	4
	Baddeck, Richmond, Inverness Counties	33,305	6
Central (412,068)	Dartmouth/Southeastern	115,610	5
	Halifax Chebucto/Peninsula	169,461	8
	Bedford/Sackville	87,838	4
	Eastern Shore Musquodoboit	18,203	1
	West Hants	20,956	1

[1] **Census 2011** updated December 2015

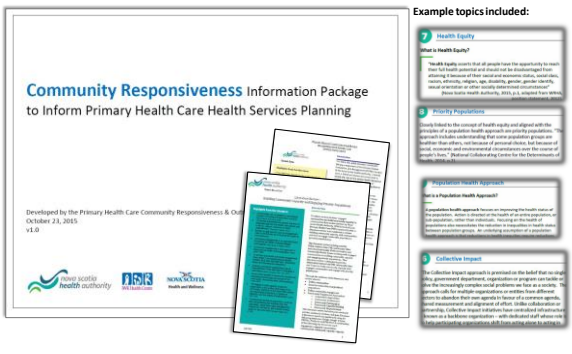
Review of Local Community Data



Census Information, Canadian Community Health Survey, Priority Populations, CHB Engagement and Consultation Reports, etc

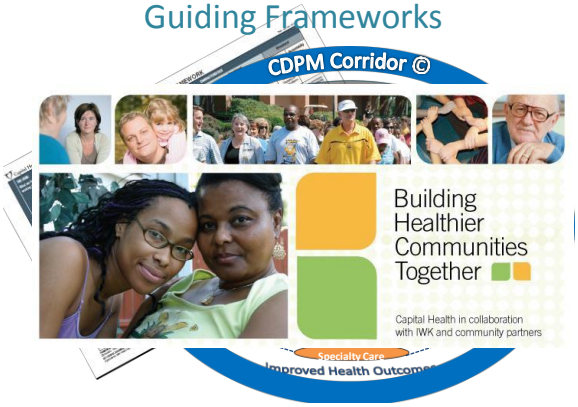
http://healthatlas.ca/

Community Responsiveness Document



Example topics included:

Guiding Frameworks



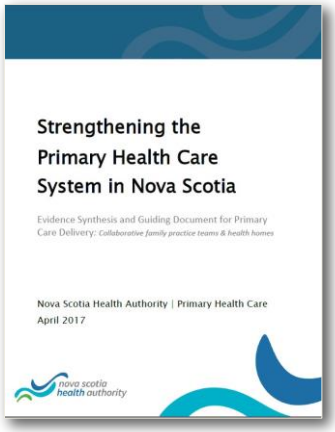
Evidence Informed

Work to date has been informed and guided by evidence:

- 28 literature reviews, frameworks and best practices scans
- Experience to date in NS, 2003 Report
- Community responsiveness guiding document
- Guiding models and frameworks (e.g., Triple Aim, Patient-Centred Medical Home, etc.)
- What our citizens are telling us
- What our providers are telling us

Full references available upon request.

Evidence to Support Future Recommendations



Current Landscape

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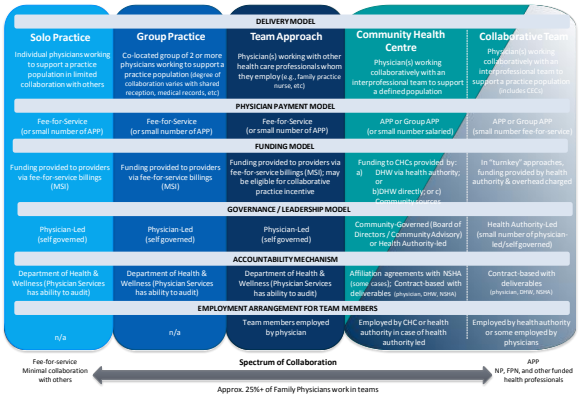
Current State: Practice Models (2016 Estimate)

Practice Model	% Family Physicians Practicing in each Model
Solo Practice	15%
Co-located/ Group Practice	54%
Collaborative Team (in various stages of development)	27%

Primary Care Delivery, Payment, and Governance Models

CURRENT STATE OVERVIEW IN NOVA SCOTIA



Progression: Solo…Collaborative Teams … Health Homes

Person & Family Centred	Timely Access	Training & Research
Accountability, Quality, and Safety	Coordination	Comprehensiveness
Most Responsible Provider	Continuity	EMR

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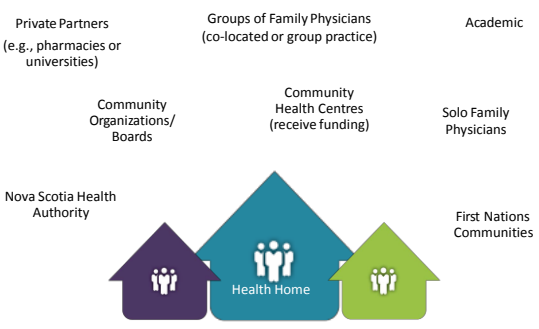
Current State: Practice Models (2016 Estimate)

Practice Model	% Family Physicians Practicing in each Model
Solo Practice	15%
Co-located/ Group Practice	54%
Collaborative Team (in various stages of development)	27%

Current State: Governance Models in Nova Scotia (2016 Estimate)

Governance Model	% of Family Physicians Practicing in each Model	Average Age of the Family Physicians
Physician-led	71%	54
NSHA Turn-key	10%	46
NSHA Co-Leadership	7%	43
Private Partner	4%	45
Community Governed	3%	40
Dalhousie Family Medicine	3%	48
First Nation	1%	45
Grand Total	100%	51

Current Landscape



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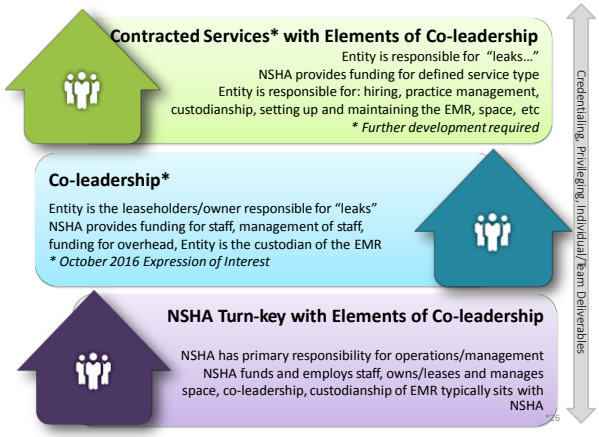

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A Better Tomorrow

Future

Nova Scotians will …

- Have access to wellness programs and initiatives
- Have access to a family practice team that serves as a health home
- Have access to a strengthened and coordinated system of supports to assist them in managing their chronic conditions.

Foundation of Quality

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Thank You

Questions?

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DALHOUSIE UNIVERSITY

HEALTHY POPULATIONS INSTITUTE

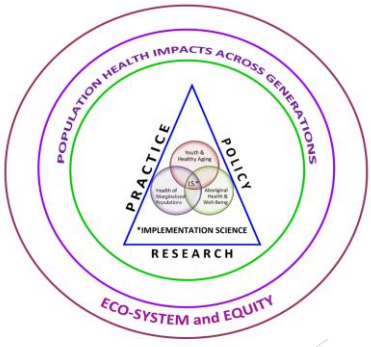
Promoting Healthy Populations through research, policy and practice

Sept 29, 2017

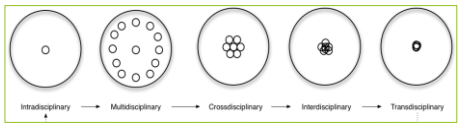
About HPI

- **Multi-faculty research institute**
  - Health, Medicine, Dentistry
- **Formerly the Atlantic Health Promotion Research Centre**
  - Established in 1993
  - Revisioned to ensure sustainability and alignment with university strategic priorities
- **Healthy Populations Institute**
  - New name (Feb 2016)
  - Launch (May 2016)
- **Mission**: *Improving population health and promoting health equity by understanding and influencing the complex conditions that impact the health of communities*
- **Vision**: *Healthy populations throughout the life course*

Conceptual Framework



Our Approach



"Lone Wolf"

"Collective Wisdom"

Research Clusters

- Indigenous health & well-being
- Youth and healthy aging
- Health of Marginalized populations
- Implementation Science
  - cross-cutting theme, applied to population health

Operational Focus:
Building capacity and mentoring
Research development
Knowledge mobilization
Research management and support

Some Highlights

- Implementation Science cluster has worked together to conduct a scoping review on IS methods for population health
  - Received funding from FH
- Student members are working together to establish a framework of core competencies and developing projects/activities to meet them
  - Received funding from CLT
- HPI a partner in BRIC-NS network (Building Research for Integrated Primary Care)
  - Opportunity for capacity building in population health
- Recipe for Health and Learning Project
- Health System Impact Fellowship

Recipe for Health and Learning Project

- 5-year school-university-community partnership to enhance the health and learning of Nova Scotian children and youth
- Funding approved in principle by Public Health Agency of Canada ($5m over 5 years), conditional on matching private sector funding
- Engagement of multiple sectors – DEECD, DHW, NSHA, IWK, school boards, community partners, STUDENTS!
- Opportunity to amplify existing provincial Health Promoting Schools model, plus deliver at scale and 'dose' required for sustainable impact
- Builds on a decade of research and best practice
  - "Made in Nova Scotia"

Health System Impact Fellowship

- CIHR-IHSPR initiative to support experiential learning opportunities in health system (and related organizations) beyond traditional academic pathway
- Partnership between Dal FH (through PhD in Health), HPI and NSHA
- Fellowships are one year, with focus on one major project
- Mentoring provided by senior leadership in both organizations
- Fellow started in September 2017

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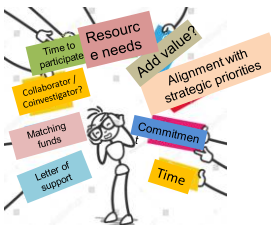
Research Strategy in Primary Health Care

Tara Sampalli
Director of Research and Innovation, Primary Health Care, Family Practice, & Chronic Disease Management

A Research Strategy for the Health System

Gateway
Primary Health Care

= demand to participate in research



How will research integrate and translate into practice?

BRIC NS
NOVA SCOTIA
Health and Wellness
CoR-PHC
Collaborative Research in Primary Health Care
SPOR•SRAP
nova scotia health authority
Research and Innovation
Nova Scotia Health Research Foundation

Research Landscape In Nova Scotia

September 28, 2017

Specific question for the strategy

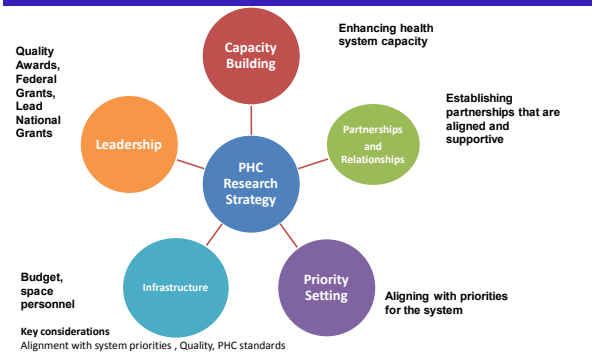
- How will PHC system engage in research?

Provincial Research Strategy in PHC

Co-design of a VISION

"Leading research for a **strong integrated and collaborative** primary health care system" to **meet the fundamental needs and functions of the PHC system** while creating and enhancing research **capacity** in care teams and staff, and developing **strategic partnerships** and collaborations with the focus on the **health of Nova Scotians**."

Guiding Model and Strategy



PHC System Capacity Building

How will we measure success?

- Measuring our planned capacity building activities such as education, training
- Measuring PHC staff and patient participation in key research roles
- Measuring our success rate in local, provincial and federal research budget that aligns with PHC system priorities
- Integration of evidence to practice
- Impact on health outcomes

Showcasing our immediate success stories

- Compared to baseline: 2013 - 2015

Patients and families: 85 % increase in participation as research team members

Decision makers: 80% increase in participation as Co-Is and Co-PIs

Showcasing our immediate success stories

- Compared to baseline: 2013 - 2015

Engagement and partnership sessions and meetings held across the province - > 50 in the last year

Showcasing our immediate success stories

- Compared to baseline: 2013 - 2015

Over 20 funded projects in the last year aligning with PHC system priorities with at least 4 that are federally funded

Thank you
Questions?

Contact: tara.Sampalli@nshealth.ca