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

28-30 September 2017

Executive Summary
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.
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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.

Key outcomes and opportunities:
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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/.

- 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/](http://atlanticpath.ca/) _Maritime Strategy for Patient Oriented Research (SPOR) Support Unit [http://www.spor-maritime-srap.ca/](http://www.spor-maritime-srap.ca/)_; Health Data Nova Scotia [https://medicine.dal.ca/departments/department-sites/community-health/research/hdns.html](https://medicine.dal.ca/departments/department-sites/community-health/research/hdns.html) _In Scotland SPIRE (Scottish Primary Care Information Resource) [www.spire.scot](http://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](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](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](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/](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


[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 Kozy, Associate Dean Research FH (Cheryl.Kozy@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 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:


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

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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
University of Edinburgh
Scottish School of Primary Care

GPs at the Deep End
Universal health coverage based on primary care

‘Active’ Public Health

Action on socio-economic determinants of health


‘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.

Towards Unity for Health 2000

www.thenetworklufh.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

Culture change
Primary Care Evidence Collaborative Members

- Scottish School of Primary Care
- Health and Social Care Analysis, Scottish Government
- Scottish School of Primary Care
- NHS Health Scotland
- Healthcare Improvement Scotland (including Scottish Health Council)
- Alliance for Health and Social Care Scotland
- NHS Education for Scotland
- National Services Scotland

Primary Care Evidence Triangle

- Policy
- Practice

Primary Care Evidence Collaborative Members

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<td>HBCA</td>
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SSPC: what we’re up to.....

- International workshops
  - Quality after QOF; Evaluability assessment methodology (2016)
- Briefing papers for GP clusters, literature reviews on Quality, GP clusters

Learning together
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.”

Dalhousie University, Halifax, Nova Scotia
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?

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**Features of complex interventions**

- **Dynamic:** Intervention changes over time (both in response to changing context and learnings over time).
- **Context:** Heterogeneity (the same intervention will look very different in very different contexts).
- **Multiple interacting components:** Have the potential of changing the overall intervention over time.

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**Integrated Primary Care in Scotland**

Dr Gregor Smith
Deputy CMO for Scotland

*Don’t find fault, find a remedy; anyone can complain.*

Henry Ford
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

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 GCHI community health and well-being profiles. Adapted from the SFT travel map by Gary McCutney.
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 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.”
Scotland-New Scotland Initiative

Scotland - New Scotland Initiative
Sept. 28-30, 2017

Dalhousie University, Halifax, Nova Scotia
“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)
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 practice 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

"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 is extremely useful. Most important, this provides hope for the kind of "learning nation" that can make real progress.”

- Don Berwick

"Improving Together"
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

Primary Care Evidence Collaborative Members

Primary Care Evidence Triangle

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<td>NHS Education for Scotland</td>
</tr>
<tr>
<td>NSS</td>
<td>National Services Scotland</td>
</tr>
</tbody>
</table>
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.....”

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

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.
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

Developing and optimising the intervention
- First iteration – 6 Focus Groups
- Second iteration – Pilot Study in 2 practices
- 8 general practices: GPs and practice nurses
- 152 patients
- Economic analysis: in-trial and modelling

Exploratory cluster RCT

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

"Exhausting"
"Demoralising"
"I feel like a wrung-out rag at the end of consultations"

"If you're too caring, you'll crack up in a place like this. Our boundaries lie where they are because they have to at the moment"

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

CARE PLUS: a whole-system approach

Resource for more time with continuity
Support meetings and structure for long person-centred consultations
CD and written guide on mindfulness
Plus: CBT guide
Community activities recommended
Would GPs and patients participate in a RCT?

Practices from areas of high deprivation

N = 8

CARE Plus

N = 4

N = 76

Baseline

N = 76

6 Months

N = 68 (89%)

12 Months

N = 67 (88%)

Usual Care

N = 4

N = 76

Baseline

N = 76

6 Months

N = 69 (91%)

12 Months

N = 67 (88%)

Patient Completed Questionnaires

0

5

10

15

20

25

30

35

40

minutes

30

60

90

120

150

180

% satisfied

Time spent in first index consultation

Satisfied with time spent in first index consultation

Are consultations ‘better’?

Care measure (% max score)

PEI (% ‘enabled’)

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

EQ5D-5L AUC

Effect Size (95% Confidence Interval)

-0.4

-0.2

0.0

0.2

0.4

0.6

0.8

1.0

Favours Usual Care

Favours CARE Plus

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

W-BQ12 Positive Well-being

W-BQ12 Energy

W-BQ12 Negative Well-being*

W-BQ12 General Well-being

EQ5D-5L

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

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

Dairy, Fruit, and Vegetables

PEI (% ‘enabled’)

Care measure (% max score)

Favours Usual Care

Favours CARE Plus

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

PEI (% ‘enabled’)

Care measure (% max score)
CARE Plus is also very cost-effective

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

Thank you
Features of complex interventions

**Dynamic:**
- Intervention changes over time (both in response to changing context and learnings over time)

**Complex:**
- Heterogeneity (the same intervention will look very different in very different contexts)

**Multiple Interacting Components:**
- Have the potential of changing the overall intervention over time

---

**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](http://www.dal.ca/sites/cor-phc/home.html)

---

**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)
CoR-PHC Research Focus

- Strategic policy-oriented projects influencing design, evaluation, and scalability of 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

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-PHC Network: BRIC NS
- Increasing focus on patient/citizen participation
- Wave 2

Building Research for Integrated Primary Healthcare (BRIC NS)

<table>
<thead>
<tr>
<th>BRIC NS Management Team</th>
<th>BRIC NS Management Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fred Burge (Science Lead)</td>
<td>Dalhousie Faculty of Medicine, Department of Family Medicine</td>
</tr>
<tr>
<td>Rick Gibson (Clinical Lead)</td>
<td>Nova Scotia Health Authority, Primary Health Care</td>
</tr>
<tr>
<td>Lynn Edwards (Policy Co-Lead)</td>
<td>Nova Scotia Health Authority, Primary Health Care</td>
</tr>
<tr>
<td>Charmaine McPherson (Policy Co-Lead)</td>
<td>Nova Scotia Department of Health and Wellness, Acute and Primary Care</td>
</tr>
<tr>
<td>Ruth Martin-Misener</td>
<td>Dalhousie Faculty of Health, School of Nursing, Centre for Transformative Nursing and Health Research</td>
</tr>
<tr>
<td>Lois Jackson</td>
<td>Dalhousie Faculty of Health, School of Health and Human Performance, Healthy Populations Institute</td>
</tr>
<tr>
<td>Sara Kirk</td>
<td>Dalhousie Faculty of Health, School of Health and Human Performance, Healthy Populations Institute</td>
</tr>
<tr>
<td>Tara Sampalli</td>
<td>Nova Scotia Health Authority, Research and Innovation, Primary Health Care</td>
</tr>
<tr>
<td>Meredith Campbell</td>
<td>Nova Scotia Health Research Foundation</td>
</tr>
<tr>
<td>Emily David Marshall</td>
<td>Dalhousie Faculty of Medicine, Department of Family Medicine</td>
</tr>
<tr>
<td>Rodney Jassie</td>
<td>Dalhousie Faculty of Medicine, Department of Family Medicine</td>
</tr>
<tr>
<td>Sara Wuite (Manager)</td>
<td>Dalhousie Faculty of Medicine, Department of Family Medicine</td>
</tr>
</tbody>
</table>
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.

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.

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.
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 – 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.

Patient Engagement in BRIC NS

Learner Support in BRIC NS
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.

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
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

Primary Health Care in Nova Scotia

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

Challenges & Opportunities

<table>
<thead>
<tr>
<th>VISION</th>
<th>MISSION</th>
<th>VALUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy people, healthy communities for generations</td>
<td>To achieve excellence in health, healing and learning through working together</td>
<td>Respect, integrity, innovation, courage, accountability</td>
</tr>
</tbody>
</table>
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; Hutchinson, 2008; Health Council of Canada, 2009; as cited in Baker and Denis, 2011).

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**Primary Health Care**

...is a multidimensional system that has a responsibility to organize care for individuals across the continuum of care (from pre-conception to palliative care) and understand and work with our partners to improve the health of communities.

Primary care is the foundation of our health care system. (adapted from Kringos, 2010; What is Primary Health Care? Annapolis Valley Health Authority Vision for Community Health Centres, 2005)

---

**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

<table>
<thead>
<tr>
<th>Zone</th>
<th>Community Health Networks</th>
<th>Population¹</th>
<th># of Clusters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western</td>
<td>Lunenburg &amp; Queens Counties, Yarmouth, Shelburne, &amp; Digby Counties, Annapolis &amp; Kings Counties</td>
<td>57,544</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>58,550</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>78,507</td>
<td></td>
</tr>
<tr>
<td>Northern</td>
<td>Colchester East Hants, Cumberland County, Pictou County</td>
<td>73,352</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>31,344</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>45,901</td>
<td></td>
</tr>
<tr>
<td>Eastern</td>
<td>Guysborough Antigonish Counties, Cape Breton County, Baddeck, Richmond, Inverness Counties</td>
<td>27,315</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>102,397</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>33,325</td>
<td></td>
</tr>
<tr>
<td>Central</td>
<td>Dartmouth/Southeastern, Halifax Chebucto/Peninsula, Bedford/Sackville, Eastern Shore Musquodoboit, West Hants</td>
<td>115,610</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>169,461</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>87,838</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>18,203</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>20,956</td>
<td></td>
</tr>
</tbody>
</table>

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.

Community Responsiveness Document

Example topics included:
- Primary Care
- Mental Health
- Urban Health
- Healthcare Services
- Community Resources

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

Current State: Practice Models (2016 Estimate)

<table>
<thead>
<tr>
<th>Practice Model</th>
<th>% of Family Physicians Practicing in each Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solo Practice</td>
<td>15%</td>
</tr>
<tr>
<td>Co-located/Group Practice</td>
<td>54%</td>
</tr>
<tr>
<td>Collaborative Team (in various stages of development)</td>
<td>27%</td>
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</table>
Current State: Practice Models (2016 Estimate)

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</tr>
<tr>
<td>Collaborative Team (in various stages of development)</td>
<td>27%</td>
</tr>
</tbody>
</table>

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

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

- **Private Partners** (e.g., pharmacies or universities)
- **Groups of Family Physicians** (co-located or group practice)
- **Community Organizations/Boards**
- **Community Health Centres** (receive funding)
- **Solo Family Physicians**
- **First Nations Communities**
- **Academic**
- **Nova Scotia Health Authority**

**Contracted Services** with Elements of Co-leadership
- Entity is responsible for "leaks..."
- NSHA provides funding for defined service type
- Entity is responsible for: hiring, practice management, custodianship, setting up and maintaining the EMR, space, etc.
*Further development required

**Co-leadership**
- Entity is the leaseholders/owner responsible for "leaks"
- NSHA provides funding for staff, management of staff, funding for overhead, Entity is the custodian of the EMR
- October 2016 Expression of Interest

**NSHA Turn-key with Elements of Co-leadership**
- NSHA has primary responsibility for operations/management
- NSHA funds and employs staff, owns/leases and manages space, co-leadership, custodianship of EMR typically sits with NSHA

A Better Tomorrow

- 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
Thank You
-----------------
Questions?

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
  - Revisited 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
Scotland-New Scotland Initiative

Our Approach

- 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

Research Clusters

- Implementation Science cluster has worked together to conduct a scoping review on IS methods for population health
- 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

Some Highlights

- 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

A Research Strategy for the Health System

Gateway
Primary Health Care

= demand to participate in research

How will research integrate and translate into practice?

Research Landscape In Nova Scotia

September 28, 2017
Specific question for the strategy

- How will PHC system engage in research?

“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.”
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

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