Primary Matters

Family & Community Medicine
UNIVERSITY OF TORONTO

A Strategic Planning Primer

Chair’s Note

As we emerge from the pandemic, the largest Department of Family and Community Medicine in the world is beginning the work of developing its next strategic plan.

We are embarking on a process to listen, learn and discuss. Together we will consider our priorities, our options, our big dreams, and our responsibilities. We will think about how we can best work together for the good of our Department, our patients and communities (both local and global), our faculty and learners, and our health care system.

The document that follows is part backgrounder, part proposition. It is meant to help bring us closer to a shared understanding and appreciation of the factors that will influence our conversations about the future of DFCM. We welcome you to help us continue to build the foundation that we are developing here by adding in resources that you think are important and relevant to this exercise.

We are still at the beginning of a thorough process of internal and external engagement, but there are already some themes and issues that have come to light.

The future of education, research and practice in Family and Community Medicine is linked to existential external challenges facing our society more broadly.

Health inequities

We are a department of lifelong learners. If there is a lesson to be drawn from the last 2 years, it is that the opportunities for health are not the same for

everyone. Like every part of society, we must internalize that lesson and build the future of our work in response to that reality.

In the emerging post-COVID landscape, significant health inequities persist which predate the pandemic. Indigenous, racialized and marginalized communities and individuals face consistently worse health outcomes. Some populations (in particular, those experiencing poverty and racialized people - especially Black communities- as well as First Nations, Inuit and Métis peoples) have consistently worse health outcomes[1] including much higher odds of avoidable mortality[2].

The pandemic was of course a case in point. In 2020 "Ontario neighbourhoods with the highest 'ethnic diversity' rates had the worst COVID-19 outcomes": higher hospitalization rates (4x higher), higher intensive care unit (ICU) admission rates (4x higher), and higher death rates (2x higher). In Toronto, racialized communities accounted for 79% of COVID-19 cases while representing 52% of the city's population[3]." For DFCM, this meant that the communities we serve in Scarborough, Mississauga and Humber River were hit especially hard.

The pandemic deeply affected Indigenous people and communities in profound ways as well. Indigenous patients, practitioners and learners are trying to grapple with a colonial healthcare system and health education system that does not embed or consider Indigenous approaches to health. Culturally safe healthcare is an essential component of Reconciliation.[4] This is not solely an issue for rural or northern communities: the GTA is home to a significant Indigenous population (counts range from 60,000 - 100,000[5]), foregrounding the need for the DFCM to develop a more comprehensive Indigenous Health agenda and strong anti-racist practices.

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[1] https://www.canada.ca/en/public-health/services/publications/science-research-data/key-health-inequalities-canada-national-portrait-executive-summary.html

[2] https://link.springer.com/article/10.17269/s41997-019-00270-9

[3] https://www.publichealthontario.ca/-/media/documents/ncov/he/2020/12/COVID-19-environmental-scan-addressing-health-inequities.pdf?la=en

[4] https://dfcm.utoronto.ca/indigenous-health

[5] https://www.cbc.ca/news/canada/toronto/toronto-urban-indigenous-census-1.6192449

These people are our patients; they are also our colleagues, learners, family members, and friends. How do we continue to work with and for them to improve health outcomes and address social and structural determinants?

The role of Technology and Big Data in healthcare

Technologies are continually evolving and need to be carefully evaluated in order to ensure that they are used in ways that improve health and do not exacerbate inequities. Virtual care, once a novelty, is now a mainstay of clinical practice, bringing with it significant convenience in some circumstances, while shifting expectations and introducing new sources of frustration. The way we approach data collection, storage and sharing, and access for research, quality improvement, and clinical care will all be impacted by fast-paced technological advances. Artificial intelligence, IoT, and wearables for monitoring are just a few of the ways that the future is becoming the present[6].

Population shifts and needs:

The populations we serve are not static. The residents of Toronto and across Canada are aging, and there is a continued interest among older people to age in place[7]; mental health needs across the lifespan are shifting[8]; immigration continues to enrich our communities and requires new levels of culturally safe care. All of these factors will have wide-ranging impacts on the locations and costs of care, the types of models needed and the teams we work alongside. The implications of shifting demography for our research and education are substantial.

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[6]https://www.forbes.com/sites/bernardmarr/2022/01/10/the-five-biggest-healthcare-tech-trends-in-2022/?sh=7daa239b54d0

[7]https://www.cihi.ca/en/infographic-canadas-seniors-population-outlook-uncharted-territory

[8]https://www.who.int/news/item/02-03-2022-covid-19-pandemic-triggers-25-increase-in-prevalence-of-anxiety-and-depression-worldwide

Trends and shifts in education:

The ways we learn and teach and the expectations that exist for academic institutions are evolving as well[9]. Online or hybrid learning, the need for faculty that reflect and are responsive to the diversity of the communities we serve, and a deeper focus on learner and faculty wellness are all on the agenda at the highest levels of our institution[10].

Locally we are seeing a greater push for community-responsive medical education, as evidenced by the launch of SAMIH, the new medical campus of our Temerty Faculty of Medicine in Scarborough.

And nationally, the release of the Outcomes of Training report from the CFPC heralds a move towards a 3-year training program for family physicians across Canada, with implementation likely to occur in the next 5-10 years. There are both tremendous opportunities and potential risks to our discipline inherent in this approach, and we expect major changes in the way we think about training as a result.

Internally, at DFCM we also have significant questions to answer.

Community:

We must assess who our "community" is - what is the "C" in DFCM about? How do we build authentic and productive partnerships with community? How do we reach communities with unmet health needs and come to understand what health means to them and what our role is in addressing those needs?

Shifting the System:

[9] https://altusassessments.com/education-program-management/top-5-meded-trends-to-watch-in-2022/

[10] https://www.qs.com/what-will-the-future-of-medical-education-look-like/

With the extensive experience and expertise that we have within our Department we have an opportunity to think critically about how to shift the healthcare system so that it works more effectively. The growing focus on integrated care requires family medicine leadership if it is to be successful, because strong, easily accessible and high-quality primary care is the bedrock of an integrated health system. How can an academic department help to lead health system transformation, so that our graduates can join a system that allows them to fully use their skills?

Planetary Health:

The relationship between Climate Change and healthcare is multifaceted, complicated and essential. From considerations around environmental determinants of health such as clean air, safe drinking water, nutritious food supply and safe shelter to the energy demands of the infrastructure of healthcare, the impacts are significant. How do we ensure that our education and research bring planetary health to the fore? How do we encourage evolving work to both reduce the negative environmental impacts of the healthcare system and train for treatment of health outcomes directly related to climate change?

Encouraging Comprehensive Family Medicine while respecting focused practice:

Every person deserves and needs easy access to relationship-based, comprehensive, longitudinal family medicine and primary care. Ensuring that we equip our trainees to meet that need is the cornerstone of our social accountability mission. Our department also plays an important role in ensuring that family physicians can develop enhanced skills in areas of real need, from emergency medicine to palliative care and beyond. How do we maintain and improve access to continuous, comprehensive primary care, preparing our learners for that work, while also holding space for enhanced skills work from a generalist base? What are the ways in which this work might be synergistic, rather than creating tensions?

Connecting DFCM:

We must also consider how our Department of 1900+ Faculty, 40+ staff, and 1000+ learners can work collaboratively. How do we address our structure, our processes, and our priorities to harness our collective energy towards our big goals? How do we ensure that all of our activities are in service of our patients and our learners? In addition to our size and scope, what other metrics do we want to use to measure our success? What do we want to be known for?

Working on a Global Scale:

Our Department's extensive experience in collaborative partnerships with academic institutions, organizations and colleagues all over the world and our World Health Organization (WHO) Collaborating Centre on Family Medicine and Primary Care allow us to play an important role in the global Primary Health Care community. These important relationships should be bidirectional; we can bring Canadian education, research and expertise to the world scene and we can learn a tremendous amount from our international colleagues. In a world that has changed dramatically over the last several years, what role can DFCM play on the important global issues of our time? What are the right goals to set for our international research, education, policy and leadership work?

While all of these issues (and many more!) are important and deserve consideration, over the course of this process we will have to make trade-offs, determine priorities, and decide where our energy, time and resources can make the most impact.

It is an exciting moment for us to reflect on what the last two years and the decades before them have taught us - and to commit to that stance of being learners, people who collectively draw lessons from important moments and make changes as a result.

So, if we go back to the initial question: What's at Stake? The short answer is a lot. What's at stake is wellbeing: the wellbeing of our patients, our learners, our team, our communities and our healthcare system. What's at stake is our relevance: our claims to excellence in education, research and scholarship, and leadership. What's at stake is our credibility: our ability to live our values and commitments as people who believe in improving health as a noble mission.

The section that follows gives a brief overview of the strategic planning process that we are undertaking and showcases the opportunities available for engagement. This is just the beginning, and we look forward to gaining your input and insights along the way. Please feel free to reach out to the strategic planning team, Sarah, Chim, or Peter with any thoughts or suggestions and visit primarymatters.ca for more information.

Thank you for your time and interest in collectively building the future of the University of Toronto's Department of Family and Community Medicine.

What is this document and how to use it

This document

This What's at Stake document is an overview of information that may be relevant in the development of the next strategic plan. It captures details about the process of creating the plan, background on the DFCM and its

history, a high level environmental scan of comparable institutions and their priorities and structure as well as individuals in the field.

The second half of the document is a broad strokes overview of some of the most pressing issues and themes that are impacting family medicine and family medicine education.

How to use this document

There are three ways to use this document:

1. As a reference and research document to review in order to get high level information and links to more detail.
2. As a repository for constructive comments that can help enrich and provide insights and examples. **Please feel free to add comments** in order to continue to populate the document with appropriate and useful information. (As a commenter please be mindful of maintaining a collegial tone recognizing that all members of the departmental community may be reviewing your words. We would appreciate if comments can be signed.)
3. As a backgrounder and guide in advance of hosting a conversation on priorities, themes and guiding principles for the next strategic plan. (Please refer to the Discussion Questions and Discussion Guide at the end of the document.)

About the strategic planning process

Why have a strategic plan?

- Make choices about opportunities and issues
- Provide clarity regarding organizational priorities
- Renew culture and connections
- Encourage greater cohesion and alignment
- Communicate to external audiences

The previous strategic plan focused on:

- Enhancing health equity in the local and global context through robust family medicine and primary care.
- Advocating for greater health system integration and cost-effective care.
- Increasing impact through enhanced knowledge translation and dissemination.
- Continuing to inspire, engage and focus the collective talents of the department.
- Reflecting and adjusting to a changing environment that was seeing an aging population, greater expectations and reliance on family physicians, and increasing demands for performance measurement, reporting and demonstrating value and impact on investments from the government.

Goals for this strategic planning process are:

- Prepare family doctors of the future AND shape the system for them
- Determine and define our “community”
- Engage broadly and ensure diverse voices are heard
- Learn together about the needs of our communities and the forces shaping our discipline
- Reach agreement concerning our outlook and priorities
- Determine how to transcend individual excellence to build a shared identity and narrative to advance a shared agenda

- Achieve excellence within our programs, sites and initiatives

Our Process/opportunities for engagement:

- Leadership Circles: Four leadership circles are guiding this process, providing feedback and resources, and helping to determine priorities. These are:
    - Internal Leadership Circle composed of Faculty, staff and learners from across the department.
    - External Leadership Circle composed of experts and practitioners in various areas of our work including education, health systems, community medicine and policy.
    - Indigenous Leadership Circle led by DFCM Indigenous Health leadership, building on existing work and engaging others through that structure. This work will aim to embed truth and reconciliation & build Indigenous perspectives, leadership, and self-determination into DFCM's future.
    - Lived Experience Leadership Circle developed together with internal and external colleagues focused on health equity to foreground the perspectives of patients, especially those who experience systemic barriers and are from equity-deserving communities.

- *In-Depth interviews*: One-on-one conversations with internal and external stakeholders conducted by the strategic planning team.
- *Delegated conversations*: Opportunities to take the conversation out wider. Stakeholders, supported by the strategic planning team, will talk to their partners, colleagues and constituents and share findings with the team.
- *Departmental survey*: A broad online survey to capture perspectives and input from across the entire department
- *Community member profile videos*: Personal and varied accounts of experiences with primary care, family medicine and the health care system

- *Webcast events*: Conversations, fireside chats, or panel discussions with experts, leaders and valued opinions within the field and the community
- *Workshops*: Facilitated working sessions with stakeholders to dive deeper into some of the most pressing issues.
- *In-person or virtual events*: Broader opportunities for presentations, conversations and dialogue.

Our Outputs:

- What's at Stake and Discussion Guide (April)
- Soundings: What We Heard (August)
- Draft Plan (September)
- Final Plan (October)

About UTDFCM

People

1952
Faculty Members

377
Family Medicine Residents

1000+
MD Learners

38
Graduate Students

23
Continuing Education Students

40+
Staff

Places

14
Core Teaching Sites

40+
Teaching Practice Sites

4 Integrated Community Streams

Research

$40.5M
In Research Grant Funding 2019

Areas of Focus

- Education & Scholarship
- Research
- Quality & Innovation
- Global Health & Social Accountability
- Family Doctor Leadership

The University of Toronto Department of Family and Community Medicine (DFCM) is the largest academic department of family medicine in the world and home to the World Health Organization Collaborating Centre on Family Medicine and Primary Care.

With over 1,900 faculty, 14 hospital sites, 40+ teaching practices and 1,000+ learners at all levels, DFCM is recognized internationally for excellence in teaching, research and clinical care.

About our faculty | DFCM is home to 1,900+ family medicine care providers, teachers and researchers who train the next generation of family doctors and work to improve primary care in Canada and internationally.

Family doctors are specialists in the health and wellbeing of people, families and communities. We care for the whole person, irrespective of the disease. Our faculty members provide generalist medical expertise across the Greater Toronto Area and beyond, in hospitals and community clinics, emergency departments, congregate and long-term care facilities, the homes of our patients and beyond.

Our faculty are also teachers, researchers and advocates, breaking new ground on issues ranging from emergency medicine, palliative care, addiction medicine, Indigenous health and more. Together we are working to equip the next generation of family doctors to provide the highest quality patient-centred care, advance the discipline of family medicine and shape the future of our health system.

The current DFCM vision, mission and values are articulated as follows:

- Vision – Excellence in research, education and innovative clinical practice to advance high quality patient-centred care.
- Mission – We teach, create and disseminate knowledge in primary care, advancing the discipline of family medicine and improving health for diverse and underserved communities locally and globally.

Core values:

- We are guided by the four principles of family medicine:
    - The family physician is a skilled clinician.
    - Family medicine is a community-based discipline.
    - The family physician is a resource to a defined practice population.
    - The patient-physician relationship is central to the role of the family physician.

- We are also guided by the following values:
    - Integrity in all our endeavours
    - Commitment to innovation and academic and clinical excellence
    - Lifelong learning and critical inquiry
    - Promotion of social justice, equity, diversity and inclusion
    - Advocacy for access and quality patient care and practice
    - Multidisciplinary, interprofessional collaboration and effective partnerships
    - Professionalism
    - Accountability and transparency within our academic communities and with the public

Who are the people of DFCM?

- Leadership and Structure
- Faculty Organizational Chart
- Administrative Organizational Chart

Department history and achievements

What follows below is a condensed version of Looking Back at 50 Years: A Timeline.

Please add in any milestones that you feel are missing and important.

- In the spring of 1969, local family physician, Dr. Reg Perkin, was appointed the inaugural Chair of the newly established Department of Family and Community Medicine (DFCM) at the University of Toronto. One year later, in June of 1970, DFCM's new family medicine residency program enrolled 24 first-year and six second-year residents. Though small compared to our residency program today, at the time it was the largest family medicine training program in Canada and quickly,

through the leadership of Dr. Perkin, Dr. Fred Fallis (his successor as Chair), and many others, DFCM grew to become one of the largest and most respected academic family medicine departments in the world.

- In 1972, with the support of the Sunnybrook Group, DFCM, College of Family Physicians and the Canadian International Development Agency (CIDA), Dr. Paul Roberts led Project Ecuador; a residency project curriculum was developed and an ambulatory teaching facility was established in Quito.
- Dr. Palmer, who chaired the department from 1982-1991 set departmental research as a high priority. His 1986 Strategic Plan represented novel ideas including: 1) Establishing the fellowship program; 2) New collaborative program to train family physicians in Malta; 3) Identifying 5 main areas of departmental research: education, obstetrics, clinical decision making, prevention, information systems & data collection; 4) DFCM started developing computerized Cumulative Patient Profile at the hospital units. This will form a large database for clinical research.
- In 1984, the Undergraduate Standardized Patient Program was created. Co-ordinated by Dr. Barbara Stubbs, this program grew exponentially and moved out of DFCM in 1999. It is now a resource for the whole university and many external clients. The program won the W.T. Aikens Award in 1985.
- In 1990, the department expanded to include three more family medicine teaching units: The Scarborough General (Dr. Barney Giblon physician-in chief), St. Joseph's (Dr. Michael Szul physician-in-chief), and Toronto East General (Dr. Dan Mallin department head).
- In 1994, Drs. Walter Rosser and Yves Talbot introduced "Curso Básico" in Curitiba, Brazil. Today more than 5000 primary health care workers (physicians, nurses, dentists, health promoters) have been trained in this country.
- In 1998, the Rural Residency Program began.
- In 2000, a community-based multidisciplinary primary care research development network in North Toronto called Nortren launched. It was led by Neil Drummond, Ross Upshur, David White, and Walter Rosser.
- In 2003, the Centre For Effective Practice launched. It was created to address the growing gap between best evidence and current primary

care practice. Produced clinical toolkits, practice aids. It was co-directed by Jamie Meuser and Bart Harvey.

- 2003 also saw the first Primary Care Today event. This event (now known as Pri-Med) for the primary care medical community started in 2003. The conference has enhanced the reputation and profile of DFCM among primary care practitioners across Ontario and Canada.
- In 2006, The Rural Northern Initiative Program (RNI) was established to provide medical care in small northern Ontario communities facing a physician shortage and expose DFCM residents to the exciting and rewarding work available in northern Ontario.
- In Spring 2008, the Family Medicine Longitudinal Experience (FMLE) Initiative was piloted and the program started in Fall 2008 under the direction of Dr. Kymm Felman.
- In 2011, UTOPIAN (University Of Toronto's Practice-Based Research Network) launched. The network is a living laboratory that brings together researchers, family medicine physicians and patients to improve the care of patients.
- Also in 2011, the Quality Improvement Program was established. Under the direction of Dr. Philip Ellison, the focus was to equip a new generation of quality-focused professionals with the knowledge, skills and drive to lead quality improvement initiatives. In the Fall of 2011, first-year family medicine residents began training in quality improvement.
- The Ontario Ministry of Health and Long-Term Care has provided $7.7 million dollars of funding between 2011 and 2015 for a joint initiative of the DFCM and the Departments of Medicine and Psychiatry. The BRIDGES initiative is a project incubator that supports and studies innovative models of health service delivery that incorporate hospitals, primary care and community services to provide integrated care for patients with complex chronic diseases.
- In 2018, the World Health Organization (WHO) designated DFCM as the World Health Organization Collaborating Centre on Family Medicine and Primary Care. The Centre is the first of its kind in the world to have a specific focus on family medicine, and one of few in the world with a focus on primary care and primary health care. The WHO Collaborating Centre on Family Medicine and Primary Care will assist the WHO in

researching, evaluating and strengthening family medicine and primary care at a global level and in countries around the world. The Centre's primary WHO regional partner is the Pan-American Health Organization (PAHO), which is responsible for health across the Americas.

Last strategic plan:

- Strategic Plan 2015-2020: Advancing Family Medicine globally through scholarship, social responsibility and strategic partnerships.
- UTDFCM is committed to leveraging its expertise to enhance health equity in the local and global context through robust family medicine and primary care. In order to achieve a positive impact and our vision, this commitment will be embedded within the five strategic directions' goals and actions.

Achieving Impact

- We improve the lives of vulnerable populations locally and globally
- Our research changes practice and improves the health of individuals and populations
- Our education scholarship advances family practice across the globe
- We transform the future of primary care
- Our faculty and staff are highly engaged and effective academic, clinical and health system leaders

Institutions

Below are the top six departments of Family and Community Medicine in the United States and comparable health systems. Many of these institutions are engaged in EDI initiatives to further connect with their communities and have identified areas such as collaboration as strategic priorities.

Which institutions are highly regarded internationally for their Family and Community Medicine Education Programs?[11]

U.S. Schools

[11] Interim_Report_Chapters_High Impact Research Programs in Family and Community ...

- Harvard University, Department of Primary Care
- John Hopkins University
- University of California San Francisco, Department of Family and Community Medicine
- University of Washington- Seattle
- University of Michigan, Department of Family Medicine
- University of North Carolina, Department of Family Medicine

Non- U.S. schools

- University of Oxford, Primary Care Health Sciences
- University College London, Population Health and Primary Care
- University of British Columbia Department of Family Practice
- University of Ottawa, Department of Family Medicine
- University of Melbourne, Department of Family Medicine
- Karolinska Institute, Department of Family Medicine and Primary Care

What are the primary missions of the foremost international FCM institutions?[12]

- Promoting Equity, Diversity, and Inclusion in research
- Strategic Intramural Research
- Funding of clinician-researchers (i.e. investigators, scientists, and Ph.D. researchers)
- Foster Collaboration internationally, nationally, locally
- Mentorship
- Methodological and statistical support
- Site research readiness
- Seed Grants
- Research training and capacity building, including supervision of graduate students

[12] Interim_Report_Chapters_High Impact Research Programs in Family and Community ...

What are the strategic directions of the foremost international FCM institutions?

- Documents provided indicated that a *collaborative* organizational model was one most likely to foster high impact research in FCM
- Ecosystem of Collaboration
    - The need to create an "ecosystem of collaboration" is imperative as a strategic focus
    - The goal is to "Promote, incentivize, and support a new level of collaboration among faculty, staff, learners, academic health science partners, and community"
        - Helps to facilitate exponential impact
    - Calls for coordination of projects across DFCM and creation of a centralized location where researchers can see new projects, a list of co-investigators for collaboration, and opportunities to work with recruiting sites
- Diverse Development Opportunities
    - Internal documents showed that there is a large opportunity for DFCMs to amplify research through structures such as
        - Cross appointments in School of Graduate studies and hospital based research institutes
        - Alliances with other clinical departments

What is the organizational design/structure of these institutions?

- There were many commonalities in the organizational structure of the institutions researched. Examples include:
    - University of California San Francisco Org Chart
    - University College London Org Chart
    - Laval University

    - Laval integrates several unique/innovative committees in it's organizational design including the "Teacher's Assembly" and the "Intellectual Independence Committee"

Actors/Individuals

There are a number of individuals who have been instrumental in advancing the study and practice of Family and Community Medicine. Below are some of the top thought leaders in Family and Community Medicine globally as suggested by the Research Program team and the Education team. **Please feel free to add in others!**

Who are the foremost practitioners of Family and Community Medicine, globally?

- World Organization of National Colleges, Academies, and Academic Associations of General Practitioners/Family Physicians (WONCA) Five Star Doctors
    - Dr. Mariolis Anagiros (Greece)
    - Dr. Veronica Casado Vicente (Spain)
    - Dr. Vikesh Sharma (United Kingdom)
    - Dr. Austin O.Carroll (Ireland)
    - Dr. Louis Ferrant (Belgium)
- Ontario's family Physicians of the Year over the past several years
- Joanne Reeve. Lead, Advancing generalist Expertise Interest Group, North American Primary Care Reserach Group
- Val Wass. Chair of WONCA Working Party on Education
- Nancy Fowler. Executive Director, Academic Family Medicine, College of Family Physicians of Canada

Who are the foremost educators of Family and Community Medicine, globally?

Canada

- Dr. Maureen Topps, Executive Director of the Medical Council of Canada
- Preston Smith, Dean, University of Saskatchewan
- Nick Pimlott, Editor of Canadian Family Physician
- Jane Philpott, Dean Queens University Faculty of Health Sciences
- Glen Bandiera. Executive Director, Office of Specialty Education, Royal College of Physicians and Surgeons of Ontario
- David Price. Previous Chair (2006 - 2021) of Family Medicine at McMaster University.

Globally

- Norbert Donner-Banzhoff (Germany). Grandfather of German family medicine
- Anne Marie Cunningham (UK). Associate Medical Director for Primary Care, Digital Health and Care. Cardiff Wales
- Miriam Haki (Qatar). Assistant Deputy of Health
- Haipin Hathirat (Thailand). Grandmother of Thai family medicine
- Krishnan Suvarnabhumi (Asia Pacific). Secretary General of the Royal College of Physicians
- Hiro Hayashi (Japan), Dean, Tokyo Ariake University of Medical and Health Sciences

Who are the foremost researchers of Family and Community Medicine, globally?

Canada

- Glenn Regehr. Associate Director, Centre for Health Education Scholarship, University of British Columbia

- Kathryn Parker. Senior Director, Academic Affairs and Simulation Lead Holland Bloorview Kids Rehabilitation Hospital

United States

- David Irby. Education scientist at the Center for Faculty Educators at University of California San Francisco Parnassus Campus
- Janet Corral. Associate Dean, Curricular Affairs, University of Arizona
- Cindy Haq. Clinical Professor and Chiar, Family Medicine at UC Irvine
- John Frey. Professor emeritus, University of Wisconsin

United Kingdom

- Clare Morris. Reader in Medical Education, Research and Development, Institute for Health Sciences Education, Barts and the London School of Medicine and Dentistry, Queen Mary University London. (That's her official title but for simplicity, she's a professor at Cambridge University and Queen Mary University London)

Australia

- Liz Malloy. Professor of Work Integrated Learning in the Department of Medical Education, Melbourne Medical School, at the University of Melbourne

Netherlands

- Olle Ten Cate. Professor of medical education at University Medical Center Utrecht, the Netherlands.
    - The leading researcher on Entrustable Professional Activities (EPAs)

Issues/Themes

The themes and issues discussed below have been identified through dialogue with leaders in DFCM as well as independent research by the Strategic Planning team. **Is something missing? Inaccurate? Please feel free to add in or let us know.**

What are the current trends in education and pedagogy in Family Medicine and Primary Care?

(Trends below identified by the Education team)

- Generalism
    - Academic family medicine was founded on the belief that Generalism in itself, was a specialization in medicine. This value has been lost amidst growing dominance of technology and specialization. Despite this, there has been a growing movement to reintegrate the principles of Generalism back into all medical education programs in Canada.
- Impact and integration of new technologies in clinical practice and education
    - Well designed and deployed, digital tools have the potential to improve the quality and efficiency of primary care. Academic family physicians are uniquely positioned to understand the potential of health technology and shape how the tools transform primary care practice and medical education. Digital literacy for learners and faculty is essential so that we train future practitioners who are tech savvy when they graduate.
- Big data-informed education, evaluation, and decision making

    - Data sharing across institutions has been a growing trend domestically and internationally reflecting the need for closer integration of education and clinical practice data.
- Virtual Care
    - While Virtual Care has been an instrumental tool in navigating health care during the COVID-19 pandemic, it has highlighted the gaps of virtual learning. As patient virtual care becomes more entrenched, FCM institutions have an opportunity to lead ongoing research on virtual teaching implementation and evaluation. The opportunity for greater access, especially for learners and faculty in more rural, remote and isolated communities, is significant and must be considered in future education plans.
- Evolution of competency-based education models
    - It is imperative that FCM departments stay ahead of emerging concepts and trends and their impact on medical training. Engaging in research and staying abreast changing frameworks and accreditations will help FCMs lead the future of medical education.
- Move to incorporate Entrustable Professional Activities
    - Entrustable Professional Activities, assessment tools for Royal College specialties, are now mandated for undergraduate programs. This new requirement will allow opportunities to inform undergraduate and postgraduate medical education.
- Recognition of the responsibility to develop learning experiences in social accountability, cultural safety, health equity, care for indigenous and IDEA disadvantaged groups, and climate change
    - IDEA (Inclusivity, Diversity, Equity, and Accessibility) principles have increasingly been integrated into learning experiences at FCMs. Approaches such as ones that centre critical self-reflection must be adopted to advance social justice and reduce health inequities.
    - Incorporating more Patient and Public Involvement in how we develop our training and our faculty will be important.
    - Mental health and addiction counseling and services need more attention as well.
- Interprofessional skills and competencies

    - As family medicine shifts towards interprofessional collaborative practice, future physicians must be adequately prepared to navigate these methods of health care. FCM graduates must have interprofessional practice experience in primary care that models teamwork and collaborative practice skills.
- Academic leadership
    - The main goal of FCMs are to educate and train the next generation of healthcare professionals. The department must continue to display academic leadership in emerging trends and research and our education programs must deliver exceptional programs that are creative, innovative, evidence-informed, and rigorously evaluated on the local, national, and international levels
- Quality improvement
    - The College of Physicians and Surgeons of Ontario has developed several QI initiatives aimed at the improvement of quality of care for patients. FCMs must prepare students to meet evolving QI standards as well as show leadership through evolving research and educational practices in QI.

How are FCM Departments responding to the shifts, trends, and health outcomes that COVID has produced?

The COVID-19 pandemic has changed the landscape of primary care. Physician burnout, disinformation, and pandemic-driven innovation are all challenges that FCM departments must work to address. Institutions are working to prepare for the post-pandemic world through a number of targeted initiatives.

- The pandemic highlighted the demands and challenges on family medicine practitioners and learners. One of the outcomes of this is a renewed focus on wellness and managing burnout.
- As misinformation and disinformation about COVID and vaccines run rampant, family physicians have remained a trusted source of

information for patients and their families. The longstanding relationships between family physicians and their patients contribute to this trust and place an added duty on family physicians to stay current on their local COVID situation in order to educate and communicate clearly with their patients and communities.
- While we are still struggling with COVID, we know that we need to work now to prepare for the next waves and the next pandemic. Family Medicine has a role to play in determining how and when primary care physicians can and should be engaged in pandemic response. This work is ongoing.
- What we know about COVID is continuously evolving as more science and research emerges along with new variants and vaccines. Over the next few years we will inevitably continue to care for acute COVID patients and patients dealing with long COVID symptoms. The long term implications of the virus on patients, healthcare providers and the healthcare system are unclear.

How are FCM Departments working to address health inequities?

The health disparities that affect the most marginalized communities have become more prevalent in recent years. FCM Departments across the world are working to address these historical inequities in their practices and the communities they serve through meaningful community partnerships and initiatives to promote diversity within their learners and faculty. Acknowledging and addressing social and structural determinants of health is another essential piece of this work.

- To ensure that the diversity in Family and Community Medicine reflects the communities they serve, FCM Departments have undertaken initiatives such as mentorship programs aimed at increasing FCM applications from marginalized youth, and expansion of admissions criteria beyond academic excellence to allow admissions to better

reflect the community. Organizational and cultural shifts within FCM departments are essential to prioritize social accountability.

- Oxford's Nuffield Department of Primary Care Health Sciences conducted an "Evaluation of Ethnic Diversity in Departmental Research" to address barriers of inclusion and diversity in their research and patient and public involvement (PPI). The report identifies key recommendations for the department including measures such as diverse representation in research teams, challenging the University's own assumptions of vulnerable groups, and public engagement work.
- Patient engagement and involvement as well as "authentic and equitable community partnerships, rooted in cultural humility are core elements that support social accountability approaches" and work towards improving health equity. This involves rebalancing power, updated concepts of ownership, and seeing community as educators for learners.
- Building trust and personal relationships are crucial to reducing health disparity and increasing access for marginalized patients. FCMs are taking steps to build this trust by incorporating trauma-informed care and anti-racism curricula in training and diversifying hiring practices.
- Around the world, health leaders are conducting research and employing strategies to reduce health inequities both within the system and by addressing social and structural determinants of health. Preparing future generations of family physicians with a renewed focus on the role of social and structural determinants of health in wellness is critical to both the health of our communities and the future of our family medicine.
- University of Ghent has undertaken several initiatives to mitigate health inequities such as their programs aimed at educating Health Professionals to address the social determinants of health, as well as their research series on the "Accessibility of preventative care"
- University of Oslo hosts a research group for "Global Health and Health Equity" (GHE), an interdisciplinary group comprised of scholars from medicine, public health, medical anthropology and other disciplines to investigate global health challenges and promote health equity worldwide.

How are FCM Departments working to respect and support their teams (Faculty, Staff, Learners, etc.)?

The size and breadth of expertise in the University of Toronto's DFCM is one of the department's greatest assets. To ensure that the department is continuing to deliver high-quality education and research, the wellbeing of the FCM teams must also be prioritized. Many institutions have undertaken efforts in order to set the best working conditions for their staff and learners and place significant importance on prioritizing wellness.

- Concerns around burnout and maintaining balance are consistent in all health care settings. A study out of the UK looks at "What Matters to You" as a framework to understand how best to support team members. "Three primary domains of **communication, support, and safety** were used to analyze and tag qualitative data from individuals, teams, and listening sessions."
    - Asking team members "what matters to you and other action-oriented questions allows organizations to get to the root of the wants, needs, and desires of employees" and helps the individuals feel they are valued and listened to.
- Studies have shown that shifting work from a physician-centric model to one of a shared, team-based model (through integration) can result in improved professional satisfaction and greater joy in practice.
    - Has also shown to decrease physician burnout in addition to increasing health outcomes for patients.

What health system strategies and methods lead to integrated, high quality, equitable care?

Trends in Family and Community Medicine are leading towards integrated health teams as the new standard. To ensure that future physicians are

prepared for this new landscape, the department needs to engage students in these updated strategies and methods. Below are some of the innovative methods in primary care that result in high quality integrated care.

- Primary Care Networks allow for economies of scale, sharing of best practices, and improved quality of care.
- Successful integrated models of care have identified primary care leadership and organizations as essential contributors, especially in community response to COVID.
    - Multi-sectoral distributed leadership models that include public health, primary care, and acute care can be valuable and effective if given time to build trusting relationships across organizations and government support that facilitates these collaborations.
    - "Even in regional geographies where relationships might not yet exist between different sectors and organizations, identifying a burning platform, being inclusive and welcoming to new partners, agreeing on shared goals that benefit the community and stating a common, larger vision might act as enablers to work together."
    - A method of publicly funded organized primary care could be considered "for more effective health system planning and integrated care delivery".
- Building health systems based on people's needs with a five-way partnership between policy makers, health professionals, academic institutions, communities, and health administrators is one way to bring collective action into the healthcare arena with a patient/community focus.
    - Digital infrastructure, such as E-health records, create opportunities for improving care coordination and person centredness. Standardization and aggregated patient data

systems can benefit the integration and coordination between local, provincial, and federal partners.

- System research of the best practices and delivery of primary care will result in further improvement, new discoveries, and cutting edge innovation. While research in the field is conducted regularly, it is primarily focused on disease and conditions. Through increased funding of primary care research infrastructure academics can study and compare various novel approaches and build a primary care learning health system.
- The United States-based "Institute for Patient- and Family Centered Care" is a coalition formed by the Association of American Medical Colleges. The body's recommendations included actions such as:
  - Early and comprehensive involvement of patients and families in educational programming at all levels.
  - Provide opportunities for faculty development to learn how to partner with patients and families.
  - Create opportunities to learn how to conduct teaching rounds in the room with the patient and family and to model patient- and family-centred communication.
  - Factor patient needs and perspectives into the design of health care processes, creation and use of technologies, and the training of clinicians.

- "School-Based Health Center Partnerships" in the United States are an example of effective partnerships between community organizations, educational institutions, and primary care. They provide students with access to care from an interprofessional team of clinicians, including primary care and mental health clinicians, in collaboration with the school community.
  - Often the partnerships are created are between a school and a community health organization

    - Generally also provide services to individuals outside of enrolled students, including:
        - Faculty and school personnel
        - Family members of students
        - Out of school youth
        - Broader community
    - Has resulted in enhanced access to primary care and reduced health disparities for marginalized communities.
- An investment and focus on primary care research can help provide the data and direction to redesign the system to achieve "improved health outcomes, increased value, better patient and clinician experience, and health equity".

What are the major trends shaping the practice of family medicine?

Technology, collaboration, career trends, and other factors are shaping the landscape of family medicine for current and future physicians. Technological innovation has resulted in a reduction of doctor visits and need for more diverse skill training. The lack of students enrolling in primary care and the growing trend of specializing upon graduation has contributed to a significant shortage of family physicians.

- There is a growing trend that graduates of medical schools are not choosing comprehensive family medicine as a discipline."The Association of American Medical Colleges predicts a shortage of between 21,100 and 55,200 primary care physicians by 2032[13]."

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https://khn.org/news/american-medical-students-less-likely-to-choose-to-become-primary-care-doctors/

- The below chart shows the year over year increase in unfilled family medicine positions in Canada in the first iteration of the CARMS match.

Table 1. 2022 CaRMS Match – First Iteration Basic National Statistics for Family Medicine

	2022	2021	2020	2019	2018	2017	2016	2015	2014
Total Number of Family Medicine Positions (all streams)	**1569** +6	1563 -10	1,573 +21	1,552 +24	1,528 -3	1,531 +10	1,521 +9	1,512 +25	1,487
Total Filled	**1344**	1356	1,403	1,414	1,370	1,375	1,390	1,400	1,387
Total Unfilled	**225**	207	170	138	158	156	131	112	100
Fill Percentage	**85.7**	**86.7**	**89.2**	**91.1**	**89.6**	**89.8**	**91.4**	**92.6**	**93.3**

- More data on the 2022 Match can be found here.
- The use of electronic medical records (EMRs) in primary care has been an advance in many ways, but in some cases, has ended up creating a bigger workload rather than empowering physicians to spend more time with their patients to improve their health outcomes.
- The OMA's "Prescription for Ontario: Doctors' 5-Point Plan for Better Health Care" appreciates that "primary care is the foundation of Ontario's health-care system. But at least one million Ontarians don't have a family doctor. Family doctors help patients stay healthy, prevent disease by identifying risk factors, manage chronic disease and get their patients access to specialists and other health-care services when needed."
- They list 7 recommendations to address doctor shortages, especially in rural and remote areas:
    - #1: Creating a detailed analysis based on high-quality data that accounts for the types and distribution of doctors to meet population needs.
    - #2: Establishing a set of best practices around physician supports to help ensure Ontario has the right doctors in the right places at the right times.
    - #3: Using best evidence regarding forecasted population need, increasing the number of medical student and residency positions.

    - #4: Supporting students from remote, rural and racialized communities to go to medical school, aligned with populations in need.
    - #5: "Letting doctors be doctors" whereby they spend more time with patients doing the things that only doctors can do and less time on paperwork or other tasks.
    - #6: Helping doctors trained in other jurisdictions become qualified to practise in Ontario.
    - #7: Investing in more training and educational supports for practicing doctors.
- The United States has seen a steady decline in visits to Family doctors and primary care physicians. This can be attributed to a variety of factors such as successful continuum of patient care, longer appointment times which result in fewer follow-ups, and the integration of technology. Other systemic factors include the declining supply of family physicians, geographical disparities, and increased use of emergency/urgent clinics.
- Integrating the voices of people with lived experience in health care planning and advisory groups has been a growing trend in recent years. Physicians are recognizing that their expertise and personal interactions with the healthcare system aren't representative of the patient experience as a whole.
    - The College of Family Physicians in Canada began this journey through engagement in their strategic plan, working groups, patient e-panels and developing relationships with representative groups.
- Interprofessional training of FCM physicians has been a growing trend in the United States following the founding of the "Interprofessional Education Collaborative" in 2009.
    - Most healthcare care disciplines now have interprofessional competencies as an expectation for their graduates
    - Case studies:
        - VA Centres of Excellence in Primary Care Education focus on development and implementing models for interprofessional team-based learning and practice.

        - American College of Physicians created a standing committee to advise on “plans and strategies to promote high quality education incorporating interprofessional, interdisciplinary, and patient perspectives and promoting partnership with all members of the healthcare team”.[14]

How are FCM Departments connecting with their communities?

Connecting with the communities they serve has been at the heart of family and community medicine. Reflecting this, many institutions have continued to prioritize patient engagement at all levels, integrated care in the community, and unique clinical placements.

- Case Study: South Central Foundation’s Nuka System of Care
    - An Alaska-indigenous-owned not-for-profit that integrates community relationships into its core. They offer multiple opportunities for feedback from patients (“customer-owners”) and operate in a structure based on Indigenous Alaskan values and needs.
- “With a greater focus on care received outside of the hospital, there is growing emphasis on the role played by community-based care sectors and, in particular, family medicine.”... “Family medicine is an adaptive and evolving field that meets the needs of patients and communities.”
    - “...as we look to the future of family medicine in Canada, we can expect the role of family physicians to continue to evolve, playing a greater role in the delivery of primary care, strengthening integration with public health and secondary care, and increasing accessibility through the use of technology[15].”

[14] Implementing High-Quality Primary Care_2021.pdf, 200
[15] https://www.cfp.ca/content/67/9/647?rss=1

    - "... we expect Canadian family physicians to learn lessons from global colleagues about how to implement task shifting and interdisciplinary care better to expand service delivery without compromising quality or increasing costs[16]."
    - This shift allows for greater community participation, and relies on settings that are contextualized in a person's daily life.
    - This flexibility in delivery settings for primary care has been underscored by the COVID-19 pandemic (i.e. Telehealth adoption in primary care increased 50%).[17]
- Clinical learning opportunities in settings that resemble the communities whom practitioners will serve has been fundamental in ensuring the department is connecting with their communities. These include opportunities such as rural clerkships, inner-city practicums, and immersive placements in Indigenous communities.
- Accreditation in social accountability via the Association of Faculties of Medicine of Canada (AFMC) provides FCMs with an unified, formal mechanism to maintain awareness of the changing needs of communities and develop sustainable healthcare systems.
    - This process provides the community with the opportunity to guide curriculum development by sharing their healthcare priorities in workshops, stakeholder meetings, and other engagement junctures
- UTDFCM has been making active attempts at patient engagement through spaces such as the Patient and Family Advisory Committee (PFAC) or ad-hoc client engagement efforts. These opportunities call for patient partnership in several areas such as:
    - Sharing easily accessible health information
        - I.e. COVID-19 updates on social media
    - Consultation
        - i.e. Feedback surveys in waiting rooms, targeted follow-ups, focus groups
    - Involving patients in solutions

[16] https://www.cfp.ca/content/67/9/647?rss=1

[17] Implementing High-Quality Primary Care_2021.pdf

        - i.e.Patients working with residents to identify health gaps for quality improvement (QI) projects
    - Patient Partnership
        - I.e. Peer support to other patients, the patient-led redesign of the Mt. Sinai Family Health Team waiting room, and patient and family engagement strategy committee
- University of Ghent's "Community Coach, Nieuw Gent" pilot project (2019-2020), explored how community sport programs could be used to improve the health of youth in historically excluded population groups. The project included a series of small, low threshold community sports activities to help promote health in marginalized populations. The pilot has found that, when applied with a strong EDI framework, it can be quite effective in promoting group connectivity and individual health.
- The Nuffield Department of Primary Care Health Sciences has implemented a Patient and Public Involvement (PPI) in research program aimed at creating partnerships between researchers and those who use health services. The PPI contributors work with researchers to identify new topics for researchers, ensure their content is clear and understandable for the public, and add input on ongoing research projects.
    - The Centre is in the process of producing an updated strategic plan for the PPI initiative

How are FCM Departments considering and planning for the use of new and evolving technologies in health care?

- The Undergraduate Education Comittee of the College of Family Physicians of Canada outlined several ways that growing technology can be used to enhance learning for FCM students

    - Computerized simulations for learning procedures and for learning clinical reasoning skills
    - Computer based- virtual reality (i.e. for learning anatomy)
    - Virtual patients
    - Skills labs for learning procedural skills
- While technology-enabled care has expanded significantly it has also highlighted additional barriers to high quality care. Technology-enabled care can only be used by those who have access to the necessary infrastructure, often excluding those most marginalized. As well, the use can facilitate burnout of physicians, as they need to be equipped with the skill set to manage the technology. FCM departments are working to address this issue.
    - There have been calls for more research on how to establish the framework and training for digital care and how it can be used to effectively provide culturally relevant and integrated care to marginalized groups.
- The Nuffield Department of Primary Care Health Sciences at the University of Oxford recently launched the Bennett Institute for Applied Data Science. This will serve as a hub for academics from a range of disciplines including clinicians, software engineers, policy experts and statisticians to develop and use new tools and methods to improve the lives of patients and citizens.
- Scotland's technology-enabled care program showed how video consultation can be used for a wide range of clinical problems in addition to outpatient monitoring. Investment in material and technological infrastructure, staff training, and professional and public engagement were all essential components of the success of the program. This type of virtual care can be an effective tool to reach people in rural and remote areas and work towards reducing inequalities.

What are the major issues affecting the GTAA region?

Recovering from the COVID-19 pandemic has been the underlying factor for many of the most pertinent issues in the city. Pandemic response highlighted pre-existing challenges of health and social inequities experienced by many residents. Addressing these disparities while developing an economically robust and resilient post-pandemic city is a top priority for the GTAA.

- RecoveryTO has categorized '6 for the 6ix" Recovery themes. These are:
    - City Building and Mobility
        - City building describes activities that guide the growth and revitalization of Toronto, including improving the built and natural environments, ensuring desirable development, integrating land use and transportation, enhancing access to community services and facilities, and conserving heritage resources.
        - Mobility is critical to the City's recovery, and Council has prioritized addressing the loss of transit revenue due to the COVID-19 pandemic, enhancing the affordability and accessibility of transit, and promoting active transportation options for all Torontonians.
    - Business and Economic Recovery
        - In addition to supporting the immediate economic needs of residents and businesses, the COVID-19 pandemic has increased the City's focus and attention on economic renewal and increasing broad-based economic participation. While economic outcomes are shared with other governments and sectors, the City has put significant attention into programs and advocacy that advance short and long-term objectives and that target the sectors and communities that have been most impacted.
    - People, Housing and Neighbourhoods
        - COVID-19 has had more significant impacts on some Torontonians, including racialized residents, women,

seniors, young people, Indigenous communities, residents with disabilities and low-income residents. The City of Toronto is taking action to support equity-deserving communities under its guiding framework, TO Supports: COVID-19 Equity Action Plan

- Climate Action and Resilience
  - COVID-19 is a powerful reminder that the everyday stresses that Torontonians face are significantly exacerbated by external risks emerging from the natural world. The City's TransformTO Climate Action Strategy and Resilience Strategy identify goals and actions to help Toronto survive, adapt and thrive in the face of any challenge, particularly climate change and chronic stresses such as growing inequality, systemic racism, mobility challenges and aging infrastructure, and acute shocks such as pandemics, heatwaves, flooding or blizzards. A resilient city is focused on reducing inequities so that communities are better able to bounce back when they face a shock.
  - 2021 priorities include developing a Net Zero Strategy to reach the City's ambitious target: net zero greenhouse gas emissions by 2050 or sooner.
- A Well-Run City and City Finances
  - The City has a committed, engaged and diverse workforce who provide services that improve the lives of residents, help build trust and confidence in local government and supports the financial sustainability of the City.
  - Since the start of the COVID-19 pandemic, the City has focused on:
    - improving how services are delivered digitally and person-to person engagement virtually
    - securing intergovernmental funding commitments
    - prioritizing resources required for COVID-19 pandemic response and recovery efforts
    - increasing capacity to make decisions and guide outcomes based on data, insights and engagement
- Public Health and Safe Reopening

        - Toronto Public Health continues to guide the City's public health response to the COVID-19 pandemic and provide health guidance to residents and businesses and key data and indicators on a regular basis. Toronto Public Health information also helps guide the safe resumption of City services and reopening of buildings.

- Key themes related to population health that emerged from the city of Toronto's 2019 Population Health Status Report were:
    - The city has a growing population, expecting 3.5 million residents by 2030 and a growing senior population, expecting 19% of the population to be 65+ by 2030.
    - 52% of Toronto residents identify as visible minorities and just under half of all Torontonians are immigrants.
    - Health inequities in Toronto abound.
        - "A history of colonialism resulting in economic, social, and cultural marginalization has had a strong negative impact on the health of Indigenous people in Canada".
        - "As a result of these conditions, Indigenous people face health inequities related to behavioural risk factors, nutrition, mental health, and morbidity and mortality."
        - Poorer health outcomes are common among immigrant sub-groups owing to factors such as stressors experienced from war and violence for refugees and a lack of insurance for those who are undocumented and therefore not able to access the healthcare services they need.
        - Poorer health outcomes are also observed in higher rates for Toronto's racialized communities including higher rates of obesity and reporting of pain from Black people, and higher rates of cardiovascular disease from South Asian people.
        - Trans people and other gender diverse people are frequently targets of stigma, discrimination and violence. "Over half of trans individuals have reported experiencing symptoms consistent with clinical depression [32] while 43% have attempted suicide in their lifetime."

- Social determinants of health such as homelessness, food insecurity, access to healthcare, social inclusion, and violence are all factors contributing to health inequities.
    - In 2019:
        - 1 in 12 Torontonians was unemployed
        - 8700+ experienced homelessness
        - Adults in 1 in 7 households experienced food insecurity
        - 1 in 5 people and more than 1 in 4 children lived in low income
            - "The percent of children living in low-income families in Toronto is higher for racialized, immigrant and lone-parent families. One of the most striking inequities however, is for Toronto's Indigenous children (one to 14 years of age), 92% of whom lived in low income households."
- Additional pertinent health-related statistics from 2019:
    - Air pollution from traffic and other sources contributed to about 1,300 premature deaths and 3,550 hospitalizations each year.
    - On average, 120 people die each year due to extreme heat
    - Approximately 37% of Toronto households experienced housing affordability issues in 2016
    - 23% of Toronto households are not considered adequate, affordable or suitable
    - 1 in 3 Toronto residents have not seen a dentist in the last year.
    - 38% of Torontonians do not have dental insurance
    - Approximately 100,000 emergency department visits due to mental health and addiction-related issues in 2016
    - Approximately 12,000 hospitalizations for mental health and addiction-related issues in 2016
    - Suicide was the leading cause of death for those 18-35
    - Sexually Transmitted Infection rates have increased by 58% between 2008 and 2018
    - Rates of diabetes, chronic obstructive pulmonary disease and dementia were all on the rise, with these and other

chronic conditions existing in higher rates in people with lower income.

Discussion Questions

Overarching Questions

to be addressed by as many stakeholders as possible

1. The current Strategic Plan lists five priorities, how would you rate our progress against these priorities? What would you propose as an additional two or three priorities for the next Strategic Plan?
2. What are the trends or factors that are doing the most to shape family medicine and primary care today?
3. What are the biggest strengths and greatest challenges for the DFCM in general?
4. What are the current trends in research, education and pedagogy in Family Medicine and Primary Care?

Internal Questions

to be addressed by internal DFCM stakeholders

1. How do we build a sense of community and collective action within DFCM and keep our group well?
2. How can the various elements of the DFCM work together more effectively?
3. How can our department work together and in lockstep to embed EDIIA practices internally across all of our areas and teams?

4. What do you value most about being a member of the Department? What do you think others value most?
5. How can the DFCM better support and promote our team?
6. How is DFCM perceived locally? Nationally? Internationally?

Community-related Questions

to be addressed by internal and external stakeholders interested in community connection

1. How is DFCM working to address health inequities? What existing methods should shift? What more can we be doing?
2. How can DFCM be more connected to the communities we serve?
3. How do we build trusted and productive relationships with communities we ought to be serving?

Big Picture Questions

to be addressed by internal and external stakeholders with a strategic focus

1. How can DFCM influence health policy and health systems to promote high quality, equitable care?
2. How do we maintain and improve the value and integrity of comprehensive primary care for our learners to ensure practitioners from our Department work in comprehensive care in the community?
3. What role can and should DFCM play in the International space, and what is the future of our work with the WHO?
4. How should DFCM consider and plan for the use of new and evolving technologies in health care?

Discussion Guide

How-to guide for hosting conversations

Choose 2-3 questions from the Discussion Questions that are most relevant for the group.

Share the questions with your group in advance.

Here is some possible framing to use to set up the discussion:

In this critical moment as we slowly emerge from the pandemic and look to the future of family medicine and family medicine education and research, the University of Toronto's Department of Family and Community Medicine is embarking on the development of our next strategic plan.

We are undertaking an extensive process across our 1900+ family medicine care providers, teachers and researchers to create a plan that will guide us for the next five years and provide a roadmap for the department's choices on opportunities, issues, and areas of focus.

We want to hear what you think. We will spend one hour together discussing these three questions (share questions). We will take notes and share them back to our strategic planning team.

Please take some time in advance of the meeting to think about the questions above and consider what is most important to you and your patients/learners/colleagues as we plan for the future.

Instructions for facilitation

During the meeting start by re-stating the goal and purpose of the meeting.

Share the questions one at a time and allot an appropriate amount of time for each question.

Try to make sure everyone has a chance to speak.

Instructions for capturing the conversation

Take notes that capture the relevant points that each person makes

As soon after the meeting as possible, take some time to review and clean up your notes so that they can be understood by someone who is not familiar with the participants or the details of your conversation. Wherever possible, spell out acronyms. Add in links if/where useful.

Please synthesize the top 1-3 points per question in a summary section.

Instructions for reporting back

Please share your notes as soon as they are cleaned up with Kayte McKnight at kayte@masslbp.com