afhto association of family health teams of ontario

Leading primary care to strengthen a population-focused health system

AFHTO 2016 Conference - October 17 & 18, 2016

Concurrent Theme Descriptions

1. Planning programs and fostering partnerships for healthier communities

Primary care teams are expanding their focus of care beyond rostered patient populations to the entire community. This requires new ways of planning programs and developing partnerships with the aim to care for their communities from a variety of perspectives – *public health, health & social equity, LHIN & sub-LHIN regions, etc.* – and identifying gaps/overlap in services with each.

This stream will focus on how teams are planning for populations, improving health equity and reducing disparities, creating stronger partnerships with local health and community services, collaboration between LHIN and sub-LHIN regions and Health Links.

2. Optimizing access to interprofessional teams

Patients First calls to improve access to interprofessional teams for those who need it the most, focusing on equitable access across the province. Presently, only 25-30% of Ontarians can access interprofessional team-based primary care and only some other groups of physicians have access to certain IHPs for their patients. Primary care teams are trying to understand the needs in their community and their team's capacity to adapt by asking tough questions:

- Can the people who need care the most get it in their community?
- How do primary care providers who don't have access to interprofessional team resources get access for their patients?
- How do we open the team to new patients and providers while still providing a team-based approach to care and without overwhelming existing resources?
- What partnerships and agreements can be set up to open the door to these patients?

This stream will focus on the steps taken so far to explore these questions and initiatives that have started to address this need.

3. Strengthening collaboration within the interprofessional team

Interprofessional primary care teams are designed to combine the expertise of a range of health professionals to provide comprehensive primary care. Creating a strong and high-functioning team dynamic is a challenge when teams are experiencing high turnover, new community partnerships/programs are introduced, and new team members are transitioning from solo to team practice.

This stream focuses on how teams have overcome barriers to engage all team members in providing care, create a healthy team culture, manage conflict within the team, strengthen care coordination internally and in the community, and achieve optimal scope of practice for all team members.

4. Measuring performance to foster improvement in comprehensive care

Primary care teams have made significant progress to advance manageable and meaningful measurement for improved patient care. Early results from Data to Decisions (D2D) are showing that higher quality comprehensive, patient-centered care is related to lower healthcare costs.

This stream will focus on the tools and processes teams are using to measure as well as how they are using the resulting information to improve quality.

5. Coordinating care to create better transitions

Primary care is an anchor for patients and families, providing comprehensive care throughout their lives and guiding them through the health system. Primary care providers offer patients and families a single point of contact to help them manage their own care and access programs and services.

This stream highlights how primary care teams are managing care coordination for their patients whether through Health Links, supporting better integration through shared care models, implementing strategies for specific populations such as seniors or individuals who need access to mental health and addiction programs, or better management of chronic diseases.

6. Leadership and governance in a changing environment

Patients First describes the need for clinical leadership to deliver the system transformation expected in primary care in the coming months and years. The role of a “clinical leader” from a system standpoint denotes a clinician who looks up and out from their individual clinical setting to their wider community and the health system to effect change. Leaders, clinicians and governors in primary care teams will be challenged to fulfill this role.

This stream will focus on sharing resources to strengthen individual leadership competencies, the role of clinical and administrative leaders in primary care teams, and the governance structures needed to foster change.

7. Clinical innovations to address equity

Primary care teams are resourced to care for patients with chronic and complex conditions by offering diverse professional expertise and access to the resources and skills required to manage the “whole patient”.

This stream will focus on how teams are leveraging their resources and organizing care to address gaps, reach special populations and provide better access to care where and when its needed. Specific topics of interest include improving access and outcomes in mental health, palliative care, and diabetes.