afhto association of family health teams of ontario

# Responding to the Ministry's ***Patients First*** proposal:

## Summary of member response from web meetings with FHT/NPLC leaders in each of the 14 LHIN regions.

The Ministry of Health and Long-Term Care released the ***Patients First*** proposal on Dec.17, 2015 and invited feedback from health care providers, patients and caregivers. AFHTO's response is as follows:

1. Jan. 5-15: Web meetings held with leaders of AFHTO member FHTs + NPLCs in each of the 14 LHIN regions to determine priority issues.
2. Jan. 8-15: AFHTO worked with 6 colleague associations in the Ontario Primary Care Council (OPCC) to identify priority topics for which OPCC is aiming to develop a joint response on behalf of all of primary care.

Priority topics that emerged from these meetings are presented below. Details on each topic are presented on pages 2 – 11, including a summary of member comments and proposed next steps (for AFHTO board review on Jan.28). Detail on the poll results from each of the webinars is on the last page (p.12). AFHTO members in each region are also engaging with their LHINs to strengthen their voice and shape implementation in their LHIN. AFHTO has offered support and is working with leaders in regions where requested.

**Overview of priorities from web meeting poll results**:

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| While many said all 12 issues are important,<br>**The top 3 were**:<br>• Accountability and contractual relationships<br>• Support for leadership roles / smooth transitions<br>• Primary care HHR planning<br>**Not far behind was**:<br>• How LHINs and clinical leaders collaborate<br>**The next cluster** gathered roughly half of the total points possible:<br>• Care coordination<br>• Information and data systems<br>• Improve health equity and reduce disparities<br>• Access to interprofessional teams<br>• Performance measurement | The following topics were given **lesser priority** by members:<br>• Performance management<br>• LHIN/sub-LHIN boundaries<br>• Stronger link with Public Health.<br>**Additional topics** identified in discussion were:<br>• Funding: for primary care as a whole, and more equitable resourcing on a LHIN-by-LHIN and team-by-team basis<br>• LHIN understanding of FHTs, in contrast to CHCs & NPLCs: need to ensure they understand complexities arising from physician autonomy, rural vs urban settings, academic status, resource differences between earlier and later waves, etc.<br>• Collaboration with hospitals and other providers<br>• After-hours clinics: how we would work in a shared model |

The table below builds on the document circulated for the regional web meetings.

- Column 1 identifies key issues for primary care teams raised in *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*.
- Column 2 presents AFHTO's existing position on this issue.
  - First 2 columns are the same as distributed to leaders of AFHTO member organizations for the 14 regional web meetings.
  - Order has been changed to reflect priorities from polling results on these calls – in four clusters.
- Column 3 summarizes input on the topic from the regional web meetings.
- Column 4 presents updated action suggested for province-wide response from AFHTO membership.

| | Issue | AFHTO's current position / activity in this topic area | Member comments (themes) | DRAFT - Action at provincial level |
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| **HIGHEST priority cluster** (scores = 924-973 out of 1300) | | | | |
| 2 | **Accountability and contractual relationships**<br>*Patients First* states:<br>• "We must create a responsive health system where someone is accountable for ensuring that care is coordinated at the local level." (p.7)<br>• "make LHINs responsible and accountable for all health service planning and performance" (p13), although for primary care, this would be "in partnership with local clinical leaders" (p15)<br>• "physician compensation and primary care contracts would continue to be negotiated by the government and administered centrally" (p.16)<br>• "What accountability measures need to be put in place to ensure progress is being made in integrating health care services and making them more responsive to the needs of the local population?" (p23) | Governance principles for primary care teams states that boards "Are accountable to the patients, funders and members of their organization."<br><br>To date, AFHTO has not taken a position re accountability to LHINs. | • Continue leading the charge on making sure that we are determining our accountability agreements' content<br>• Concern re potential for conflict and mismatch between expectations at LHIN level and funding coming through from ministry<br>• If not directly linked to the LHIN – how do we achieve true integration and collaboration?<br>• If physicians are funded through Ministry but FHTs accountable to LHIN (for planning aspects) – this could result in challenges unless strong FHT/Physician relations exist.<br>• Funding (money) dictates which organizations operate/control the health care services, therefore, having one organization responsible for health care services in a designated region is the best way to manage these services. We support the LHIN being this organization as long as they have the infrastructure to manage these services effectively<br>• Prefer to deal directly with Ministry | KEY question to explore with members --<br>• FHT accountability to MOHLTC + LHIN, or to LHIN alone: what difference would it make to your team?<br>If members prefer dual-level system:<br>• Need to clarify LHIN and MOHLTC roles and responsibilities (and boundaries around each) to make this workable.<br>If members prefer FHT/NPLC contracts be moved to LHIN:<br>• What other issues would then need to be addressed? |

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| 12 | **"A Path Forward" - support for leadership roles / smooth transitions**<br>*Patients First* concludes with these questions:<br>• How can clinicians and health care providers be supported in leadership roles in continued system evolution?<br>• How do we ensure changes are supportive of and responsive to future service changes that are still being worked on, such as home and community care?<br>• How do we create a platform for further service integration, such as enhanced community mental health and addictions services?<br>• What can be done to ensure a smooth transition from the current system to the one proposed in this proposal?<br>• How would we know whether the plan is working? (p.23) | Report from AFHTO's October 2015 Leadership Session – identifies functions that need to be strengthened in primary care, including leadership, governance & management capacity. (p.3)<br>Pages 4 – 5 present members' hopes and concerns regarding system transformation, and the supportive strategies needed, i.e.:<br>• Advocacy<br>• Manageable, meaningful measurement<br>• Sharing best practice on collaborative practice<br>• Change readiness<br>• Focus on ALL of primary care<br>• Streamlining opportunities | • Concern about LHIN capacity to do the engagement and planning work<br>• Physician and IHP engagement needs to be a central focus for effective change management to occur<br>• Primary Care needs a voice at the implementation table<br>• How is 'leadership' envisioned? Who is speaking on behalf of primary care?<br>• Important to look at leadership structure at sub LHIN level<br>• Need to ensure the LHIN recognizes and understands the important complexities and uniqueness of FHTs – the physician relationship; differences between academic, rural, urban FHTs; and different waves<br>• An effective change management strategy is crucial to support leadership during transition - critical element will be physician & interprofessional engagement<br>• Determine as collective leadership the 'quick wins' we should focus on and be mindful re the pace of change (build on our successes!)<br>• Need to recognize differences in readiness | OPCC is aiming to identify principles, expectations and strategies to support leadership roles in primary care. This will draw from work on this subject by McMaster Forum, OCFP and others.<br><br>This is an initial response only. This is a much longer term issue!<br><br>AFHTO will:<br>Contribute to OPCC development, in consultation with AFHTO board (and more broadly as needed)<br>Continue to work with and support members through AFHTO's Governance + Leadership and QIDS Provincial programs.<br>Advocate on behalf of members for additional support or policy change needed at provincial level. |

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| 6 | **Primary care HHR planning**<br>*Patients First* states:<br>• "LHINs, in partnership with local clinician leaders, would be responsible for recruitment planning, linking new patients with doctors and nurse practitioners, and improving access and performance in primary care" (p16)<br>• "While LHINs would play a greater role in primary care health human resources planning, physician compensation and primary care contracts would continue to be negotiated by the government and administered centrally. Ontario Medical Association (OMA) representation rights would continue to be respected" (p16) | AFHTO's advocacy priority has been to stabilize the workforce and ensure sufficient capacity. | • Concern about impact of the changes ahead and how they will play out in teams – risk of losing staff buy-in/engagement and resulting in further turnover<br>• If FHT HR resources don't increase it may be difficult to meet LHINs performance expectations.<br>• If primary care is foundation of health system, we need to stabilize the work force and deal with wage disparities before it crumbles.<br>• Primary care HHR planning must address the disparity in remuneration et al that currently pervades the primary care sector. If we are to achieve integration, then the levelling of salaries and benefits will need to be neutralized and be respectful of the pay equity legislation currently in place in Ontario.<br>• general inequity across health system - primary care needs to be able to fairly compete.<br>• LHINs playing big role in designated 'underserved' areas – but very inconsistent in how these decisions are being made. AFHTO should make statement about utilizing a consistent, fulsome approach. Many areas are challenged with recruiting the physicians needed to deal with unattached patients | AFHTO will make VERY strong statements on the issue of staff turnover due to uncompetitive compensation, and on inequity in distribution of teams from LHIN to LHIN.<br>Beyond noting our work on « time spent » indicator, should AFHTO make any other comments on LHIN role in Managed Entry? |

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| **HIGH priority** (scores = 805 out of 1300) | | | | |
| 1 | **How LHINs and clinical leaders collaborate** in primary care planning and performance management<br>*Patients First* states:<br>• "Set out clearly the principles for successful clinical change, including engagement of local clinical leaders." (p15)<br>• "LHINs would work closely with primary care leaders, patients and providers to plan and monitor performance within each LHIN sub-region" (p15)<br>• … then asks – "How can we effectively identify, engage and support primary care clinician leaders?" and "How can we support primary care providers in navigating and linking with other parts of the system?" (p.16) | Report from AFHTO's October 2015 Leadership Session – AFHTO members identified they want "To be heard" (p.1), that PC teams should take the lead in collaboration to create partnerships, build capacity, improve data sharing and identify region-specific performance measures and outcomes. (p.2) | • Members of our FHTs & NPLCs should be at the LHIN implementation table as systems changes will directly affect us | OPCC is aiming to define principles, expectations and strategies for collaboration between LHIN and all of primary care.<br><br>AFHTO will contribute to OPCC development, in consultation with AFHTO board (and more broadly as needed) |
| **MEDIUM priority cluster** (scores = 632 - 677 out of 1300) | | | | |
| 7 | **Care coordination**<br>*Patients First* states:<br>• "CCAC employees providing support to clients would be transitioned to and employed by the LHINs.<br>• Home care coordinators would be focused on LHIN sub-regions, and may be deployed into community settings (such as family health teams, community health centres or hospitals)." (p.18) | Transitioning care coordination resources to primary care and Care Coordination in Primary Care | • We need to continue to assert the role of primary care providers to lead care coordination<br>• Bringing CCAC staff into FHTs to coordinate care at a much higher salary could cause issues within the FHT<br>• Need to leverage care coordination role, could allow for opportunity to embed Health Links more into primary care<br>• Needs to be much better coordination with case workers and FHTs – having this integration occur would be very positive but would also include significant 'ramp up'. AFHTO should advocate for this change and for the resources and appropriate time frame to absorb this change. Don't want to be set up to fail! | Continue advocacy on recommendations in these AFHTO documents.<br><br>Continue work with OPCC colleagues to develop more detailed recommendations to Ministry and LHINs on transitioning of care coordination role to LHIN and deployment to primary care |

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| 8 | **Information and data systems**<br>*Patients First* states:<br>• "How do we support improved integration through enhanced information systems, data collection and data sharing?" (p.23) | Report from AFHTO's October 2015 Leadership Session – identifies need to strengthen IT infrastructure + EMR connectivity (p.3) | • Information technology – physicians previously received funding from Ontario MD, but funding has terminated. This will be a challenge if we are to move forward with data sharing, etc. LHIN will have to recognize this. Direction from Ministry is that there is no additional money – have to find through reallocation | Draw attention to these needs in AFHTO response<br><br>Continue advocacy for data infrastructure as part of QIDS provincial program/involvement at eHO, OMD + HQO tables<br><br>Monitor and support regional efforts as needed/requested. |
| 11 | **Improve health equity and reduce disparities**<br>*Patients First* states:<br>• "LHINs would be responsible for understanding the unique needs of Indigenous peoples, Franco-Ontarians, newcomers, and people with mental health and addiction issues in their regions, and providing accessible, culturally appropriate services. At the same time, the ministry would pursue discussions with these partners to determine how best to adapt system structures to provide effective person-centred care" (p.11) | Report from AFHTO's October 2015 Leadership Session – "AFHTO members are hopeful that a transition to population based primary care would lead to improved health equity and access to primary care … Better health outcomes for members in a given community." (p.4) | • Ultimately the highest priority has to be improving health care for our population and health equity.<br>• Note differences in provincial priorities (e.g. diabetes) compared to priorities for specific populations. E.g. for Inuit, respiratory illness is highest priority; diabetes incidence is low. | Monitor developments at provincial level and needs identified by members at regional level, and be prepared to act as needed. |

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| 5 | **Access to interprofessional teams**<br>*Patients First* states:<br>• "Planning would include improving access to inter-professional teams for those who need it most, facilitating care plans and supporting an integrated, coordinated patient-centred experience" (p.16)<br>• "To make it easier for patients to connect with primary care, each LHIN sub-region would have a process to match unattached patients to primary care providers." "Patients … clinicians would retain choice …" (p.16) | Optimizing the value of and access to team-based primary care; and proposal to stabilize the workforce and ensure sufficient capacity. | • Enhancing access to teams presents both a risk and opportunity – all Ontarians would have access to IHPs; but risk losing the dynamic and value of the "team"; also need to weight this against capacity concerns<br>• Enhancing access to interprofessional teams must be balanced with capacity and quality of care; principles and minimum requirements must be put in place for meaningful collaboration and communication to occur<br>• Concern expressed about how teams can provide better care to more patients without increased human resources | AFHTO is aiming to develop a joint response on this issue with OPCC colleagues, drawing from position papers from AFHTO, OMA + AOHC.<br><br>Continue advocacy on recommendations in these AFHTO documents.<br><br>Generally monitor access to teams by LHIN; support regional efforts as needed. |
| 4 | **Performance *measure*ment**<br>*Patients First* states:<br>• "To help drive continuous quality improvement in primary care, the ministry would more methodically measure patient outcomes in primary care to help understand the patient experience accessing primary care, including same-day and after-hours care, and satisfaction with service.<br>• LHINs would collect, assess and publish performance indicators at a sub-region level and share that information with health care providers and managers to support performance improvement, as well as to help inform the organization of primary care in each LHIN sub-region." (p.16) | The Starfield Principles and advancing this through Data to Decisions (D2D).<br>Key to this is engagement of the field to ensure measures are meaningful and measurable, and that patient perspective drives the weighting of the quality roll-up | • Needs for clarity and consistency across LHINs on how they're manage and monitor performance<br>• AFHTO is leading us in right direction with performance measurement (D2D),<br>○ Need to ensure appropriate infrastructure is in place for performance measurement and reporting<br>• QIDS partnership model is an opportunity, but also need to look at HHR planning and the technical infrastructure required (i.e. widespread EMR adoption | Continuing advocacy on approach + measures in provincial framework.<br><br>Respond to govt. on their questions (p.16) -- How should data collected from patients about their primary care experience be used? What data and information should be collected and publicly reported? |

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| **LOWER priority cluster** (scores = 285-472 out of 1300) | | | | |
| 3 | **Performance *manage*ment**<br>*Patients First* states:<br>• "LHINs, in partnership with local clinical leaders, would take responsibility for primary care planning and performance management." (pp.5+15).<br>• In their expanded role, LHINs would:<br>  • Assess local priorities and current performance, and identify areas for improvement.<br>  • Work with providers across the care continuum to improve patients' access to services, and make it easier for both patients and providers to navigate the system.<br>  • Integrate and improve primary care, home and community care, acute care, mental health and addiction services and public health across the entire health care system.<br>  • Drive the adoption of technology to enhance care delivery through, for example, integrated systems or virtual access to care providers through telemedicine.<br>  • Prepare public reports about the patient experience with different health services and other reported outcomes to help drive improvements. (p.13) | AFHTO has a position on accountability (see above) and has made general statements about supporting teams to succeed, but has not gone further to define how performance should be "managed". | • Physician engagement needs to be central focus (especially around accountability and performance) | AFHTO is aiming to develop a joint response with OPCC colleagues on the issue of accountability and performance.<br><br>This work could potentially:<br>Identify principles for performance management, including province-wide standards and targets that may be established.<br>Address issues around "levers" for managing performance, including financial (or other) incentives + disincentives.<br>Advocate for sufficient "enablers" for performance, e.g. HHR, info technology. |
| 9 | **LHIN/sub-LHIN boundaries**<br>*Patients First* states:<br>• "Identify smaller regions as part of each LHIN to be the focal point for local planning and service management and delivery." (p.13) | x | Some members noted sub-LHIN boundary issues they will raise with their LHINs– or lack of LHIN engagement on defining sub-LHINs.<br>One comment noted boundary challenge that spans two LHINs (CE + SE). | No role for AFHTO (except to support regional efforts as needed.) |

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| 10 | **Stronger link with public health**<br>*Patients First* states:<br>• "Where the system's and public health's interests overlap (e.g. surveillance of reportable infectious diseases, documentation of immunizations, smoking cessation programs and other health promotion initiatives) public health would benefit from more in-depth knowledge of the population's health status available through LHINs as well as the LHINs' ability to distribute health resources to address health inequities. LHINs would also benefit from greater access to public health expertise when planning health services." (p.19) | AFHTO's response to Patients First Discussion Paper states "Public health departments must be connected to LHINs" because of their role in understanding populations and health risks, and promoting wellness and illness prevention across the population | • Need to create stronger linkages with public health | AFHTO members support this direction<br><br>OPCC will be advocating for a more consistent and thorough approach to assessing population health needs and risks across the province. |

## Additional topics to consider:

- **Funding:** NOTE: Ontario Primary Care Council is aiming to address issue of appropriate funding for primary care in our joint response.
  - Need to continue to advocate for appropriate funding for primary care and look at opportunities to enhance the funding envelope (e.g. accessing possible CCAC funds)
    - What about the funds that will be available with the change in the CCAC funding - is there an avenue to move some dollars?
      - The challenge may be that CCAC funding is within the LHIN, but Ministry is still funding primary care – unsure about ability to juggle this money to primary care (could be potential barrier)
    - Also need to address inequities in:
      - IHP resource availability across the province
      - FHT funding and resources between waves 1-5
- **LHIN understanding of FHTs**: Not sure they understand the complexities, how we've evolved, and/or the key differences between FHTs and CHCs:
  - For example, physicians are autonomous, independent providers. Following through on performance management, data consistency and other expectations depends on strong boards and physician relationships
  - Complexity of academic FHTs must also be recognized.
    - MULTIPLE layers of accountability (DFCM, Hospital Boards, Accreditation Canada)

        - Don't have volume or availability compared to other colleagues in the community (hoping that work of QIDS program on the 'time spent' indicator may help get a better handle on this)
    - Need to stratify FHTs/NPLCs based on sub-LHIN boundaries but also take into account different waves, urban vs rural, etc.
        - Need to be mindful of the difference between rural areas and urban centres
    - The LHIN must also be aware of financial challenges that some FHTs are faced with (may be related to different waves) – some teams dealing with huge rent costs with no increases in budgets to help with costs and are struggling to keep programs running.

- **Collaboration with hospitals and other providers**:
    - Should focus efforts on collaboration between LHINs and leaders – and also between other organizations and agencies – ensuring that we create common understanding of what true collaboration really means
    - Connection and engagement with community services and more developed partnerships with acute care around primary care also important – need to enhance awareness re. appropriate level of care
    - The unique role of small hospitals and physicians needs to be addressed

- **After-hours clinics**: This needs to be well thought out re how we would work in a shared model with after-hours care.

## Additional comments:

- All priority issues are important; the devil will be in the implementation details.
- The LHINs and clinical leadership (bullet 1) has to be in place before we can easily have a discussion about accountability. Accountability (2) to outcomes/measures is tied tightly to what we choose to measure and how we manage it (3,4). We know that teams improve outcomes, and planning for and coordinating care (5,6,7) will enable better performance (in relation to the point above.) The other points I think are enablers that inform how we do HHR planning and service delivery.
- We are concerned that changes in necessary regulations will not be completed quickly enough to make significant changes meaningful. Momentum will be lost.
- CHCs and FHTs represent a significant portion of primary care delivery, but we must find ways to integrate and communicate successfully with ALL primary care delivery to truly provide coordinated care.
- Regulations and funding should be reviewed which will allow land ambulance staff to be included in primary care, specifically Community Paramedics.
- FHT physicians only represent ¼ of physicians in Ontario. We need to recognize the knowledge and experience of solo physicians and docs in other practice models that don't have a strong voice. AFHTO is working closely with OCFP to develop province wide approach, but at local level need to ensure these voices are getting factored in at LHIN and sub LHIN level. Be mindful of all primary care!
- Another obstacle to better collaboration is the fact that the whole population of primary care physicians are all doing same job, but paid differently (Capitation vs fee for service) and there is a discrepancy for access to resources. FHT physicians have the most access to resources and highest pay scale; solo physicians at other end of spectrum…and bunch of models in between. This is OMA domain – but AFHTO should flag the challenges that this creates.
- Would be helpful if there was an information exchange where those FHTs that are working well with their LHIN could provide others with some helpful "tips"

## Poll results: Priorities identified by FHT + NPLC leaders who participated in regional web meetings

| | Percent of participants on the call who selected this item as a priority for AFHTO to respond to | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | scores above 50% are highlighted in yellow | | | | | | | | | | | | | | total score | range | |
| | 1-ESC | 2-SW | 3-WW | 4-HNHI | 5-CW | 6-MH | 7 - TC | 8-Centr | 9-CE | 10-SE | 11-Cha | 12-NSM | 13-NE | 14-NW | max is 1300) | low | hi |
| 2 Accountability and contractual relationships | 81 | 80 | 89 | 53 | 83 | 78 | 86 | 83 | 80 | 93 | * | 29 | 65 | 73 | 973 | 29 | 93 |
| 12 Support for leadership roles / smooth transitions | 88 | 85 | 100 | 59 | 50 | 78 | 87 | 58 | 50 | 75 | | 63 | 76 | 70 | 939 | 50 | 100 |
| 6 Primary care HHR planning | 63 | 75 | 89 | 53 | 67 | 56 | 67 | 83 | 70 | 69 | | 100 | 52 | 80 | 924 | 52 | 100 |
| 1 How LHINs and clinical leaders collaborate | 63 | 45 | 44 | 71 | 50 | 89 | 86 | 33 | 50 | 93 | | 43 | 74 | 64 | 805 | 43 | 93 |
| 7 Care coordination | 63 | 65 | 56 | 47 | 50 | 42 | 40 | 50 | 80 | 31 | | 75 | 68 | 10 | 677 | 10 | 80 |
| 8 Information and data systems | 88 | 45 | 33 | 29 | 100 | 22 | 73 | 58 | 50 | 63 | | 13 | 60 | 40 | 674 | 13 | 100 |
| 11 Improve health equity and reduce disparities | 56 | 50 | 67 | 41 | 67 | 67 | 67 | 33 | 40 | 50 | | 38 | 52 | 30 | 658 | 30 | 67 |
| 5 Access to interprofessional teams | 31 | 80 | 67 | 53 | 67 | 89 | 73 | 33 | 30 | 50 | | 25 | 28 | 30 | 656 | 25 | 89 |
| 4 Performance measurement | 63 | 65 | 100 | 53 | 33 | 56 | 43 | 42 | 70 | 29 | | 29 | 22 | 27 | 632 | 22 | 100 |
| 3 Performance management | 56 | 50 | 33 | 29 | 33 | 22 | 50 | 33 | 50 | 50 | | 0 | 30 | 36 | 472 | 0 | 56 |
| 9 LHIN/sub-LHIN boundaries | 38 | 40 | 11 | 24 | 33 | 11 | 40 | 25 | 40 | 13 | | 13 | 64 | 40 | 392 | 11 | 64 |
| 10 Stronger link with public health | 13 | 20 | 0 | 12 | 50 | 11 | 40 | 0 | 50 | 25 | | 38 | 16 | 10 | 285 | 0 | 50 |

* For the Champlain region web meeting, participants preferred to send in comments rather than respond to the poll during the call