GOVERNANCE AND LEADERSHIP EDAC PHONE MEETING RESULTS REPORT

Prepared by:
Bryn Hamilton and Jenny Cockram
July 27, 2015

AFHTO Governance and Leadership
EDAC Phone Meeting Results Report

Table of Contents

AFHTO Governance and Leadership
EDAC Phone Meeting Results Report

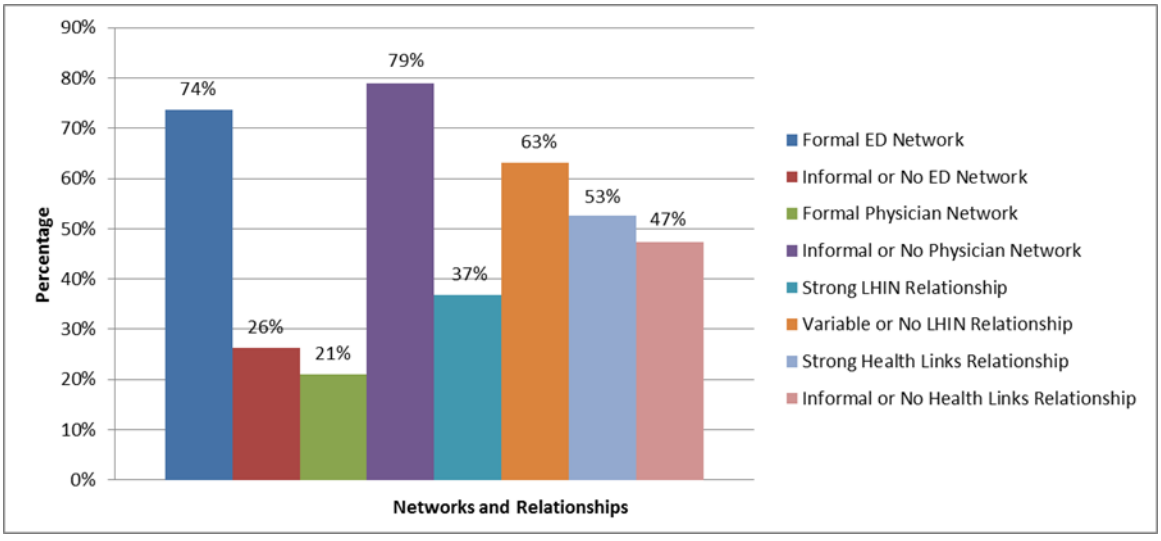
Executive Summary

It is anticipated the Ontario government will introduce important developments in the evolution of primary care over the summer. In order to help prepare FHTs and NPLCs for the changes that lay ahead, AFHTO interviewed nineteen members of EDAC to obtain a better understanding of the primary care landscape and relationships that currently exist.

The interview questions were developed around the following themes:
(*For a full list of questions used please see appendix A)*

- **Networks** – *ED Networks; Physician Networks; QIDSS, Health Links and LHIN Relationships;*
- **EDAC Council –** *sharing of information with their regions*
- **Aligning team based primary care** – *What's working now and suggestions going forward*
- **Opportunities and Concerns**
- **Regional Meetings –** *planning suggestions*
- **AFHTO Support** – *how can AFHTO support teams going forward*

Overall Findings: Networks



Networks and EDAC Council

- 70% of EDs stated they had an ED Network in place; over half did not include all FHTs in their regions; only 40% felt they were working as well as they could be.
- There are few formal Physicians Networks – approx. 20%. Engaging physicians was one of the key challenges identified.

- 37% do not have a strong LHIN relationship. Most EDs felt LHINs do not understand Primary Care, or how FHTs function.
- 50% of EDs felt they had somewhat of a good Health Links Relationship. Most EDs felt the concept was good but the implementation has been problematic.
- QIDSS – all EDs value the QIDSS program; capacity may become an issue going forward as there is a stronger focus on measuring performance.
- 75% of EDAC Council members say they share information with their EDs, but it is not with all of the FHTs in their region.

Aligning Team Based Primary Care

- Many teams are sharing resources and aligning services regionally by working with other FHTs and health service providers (CCACs, CHCs, Public Health and Hospitals) to avoid duplication and underutilization of programs.
- Some FHTs felt they were already working at capacity and could not enhance access without additional resources. All EDs were willing to expand access based on appropriate capacity assessments and resources being provided.

Opportunities

- Relationships are key. Closer relationships with the LHIN and other HSPS could provide better coordination across the system.
- Implement a 'systems perspective' -CHC model has a particular focus; NP Clinic has a particular focus; Health Links have a particular focus. Instead of looking at each individual model look at Primary Care as a whole to work together.
- Standardized performance measurement and implementing accountability indicators.

Concerns

- Recruitment, retention and funding # 1 issue.
- Capacity issues and the impact on 'team based care' should services be offered to non-rostered patients.
- LHINs lack of understanding/engagements of FHTs and how they function, relationship to FHOs, budgets, resources etc.
- Data Quality – EMR data is difficult to retrieve but it is also entered inconsistently. Ministry should take EMR funding and reposition it to Data Entry.

Regional Meetings

- All EDs were very supportive of regional meetings if a clear agenda with expected outcomes is developed.

How can AFHTO prepare teams for this evolution?

- A need for AFHTO to be more visible in the field
- Information/education on: D2D and standards for measurement; Data Sharing, Privacy, Liability Issues, What constitutes high performing teams, ED Performance Review Guidance, Board Development
- Introductions to others ie: Public Health, LHINs, CCACs and other HSPs
- Support physician engagement

Overview and Background

It is anticipated the Ontario government will introduce important developments in the evolution of primary care over the coming months. Key phrases from the ministry have included "*Comprehensive regionally governed population-based primary health services for Ontarians, "and" Access to team-based primary care for all Ontarians who would most benefit*." We have been told there will be full consultation to work through the implementation details.

FHT and NPLC Executive Directors play a key role as leaders, facilitators and links within their teams and across their communities, with their peers, staff, physicians, boards, patients and other leaders. EDs, together with clinical leaders, will help shape the direction on key policy questions and on-the-ground implementation, in a way that makes sense for their patients, communities and funders, as well as for the people who are delivering this care.

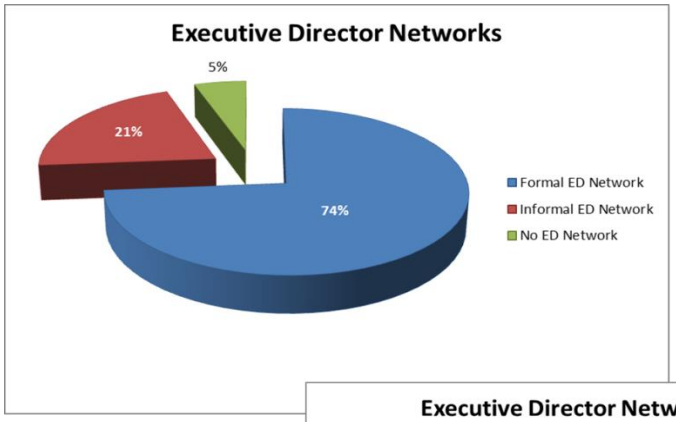
AFHTO scheduled individual calls with each member of the EDAC council to gain insight and feedback in the above areas. Nineteen of twenty three EDAC members participated in the calls. Two EDAC members did not respond to calls or e-mails and two were unable to participate. Members were provided the questions in advance and many reached out to other EDs within their networks for input. All members who participated in the calls were more than willing to provide candid feedback and thoughtful answers to the questions. We thank you for your input and continuing support.

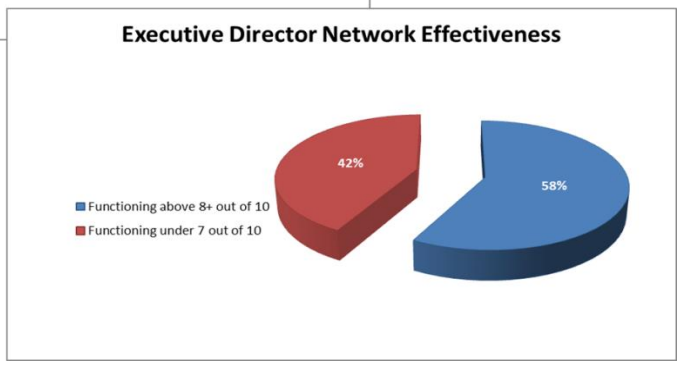
The purpose of this report is to outline the findings from those calls.

Report Details

1. Networks

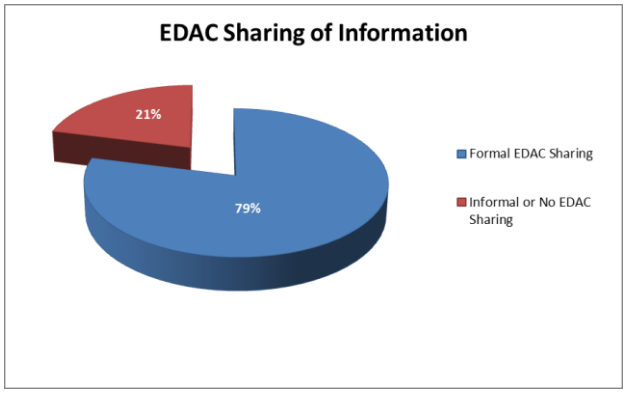
ED Networks





- Based on these calls 70%+ EDAC members stated there was a somewhat formal ED Network in place. However over half of the formal networks that exist did not always include all FHTs in their LHIN regions. Networks tended to be around geographic areas especially in Northern and more rural regions. Just over 40% of EDAC members felt their networks were not working as effectively as they could be. Geography plays a huge impact on how networks come together.
- Those FHTs that felt their networks were functioning at an above average level included both EDAC and QIDSS content on their regular agendas and met at least quarterly.

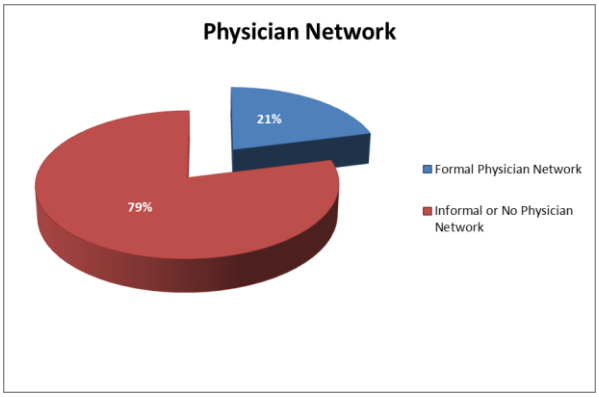
EDAC Council



There are twenty three EDAC members on Council - One from each LHIN region and representatives for Academic, Aboriginal, Francophone, Blended Salary Model FHTs, NPLCs and the AFHTO BOARD. Members share EDAC Meeting information with their smaller networks on a regular basis, but most do not share information with all of the FHTs in their region. Some tailor the information identifying areas to review within the communique but most rely on AFHTO's distribution

of EDAC minutes and thought this information was distributed to all EDs by AFHTO.

- AFHTO will confirm that information from EDAC meetings is shared with ALL EDs.
- A suggestion of sending e-mails to all EDs before EDAC meetings to inform them of the topics for discussion and who to contact should they have suggestions was well received by all EDAC members.

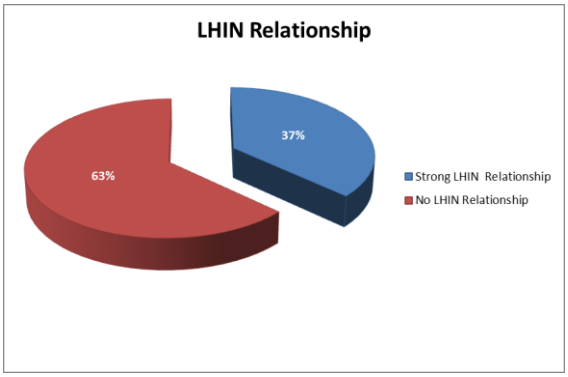


Physician Networks

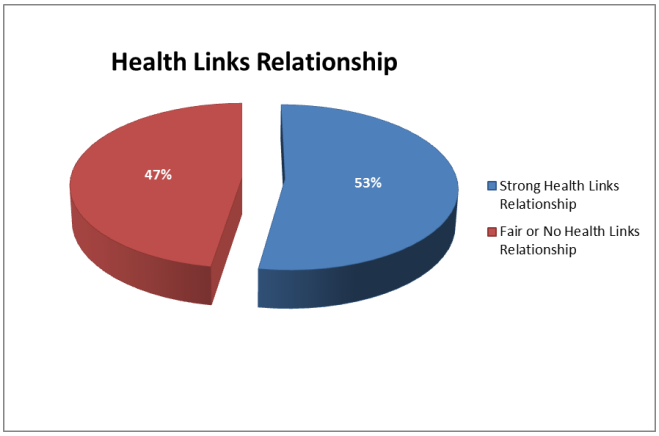
Only 20% of EDAC members FHTs have a somewhat formal physician network. They are generally centred around clinical programs and services being delivered; or connected to academic or teaching sites. Some practices engage physicians as part of their governance model where they are required to be present at meetings. However all respondents stated engaging physicians is a challenge for everyone. In some regions especially Northern and rural areas there is a shortage of physicians. In many areas physicians do everything from working as hospitalists, cover the ER, Home Care, After Hours Clinics, First Nation clinics and working with seniors, while carrying heavy roster loads. Several regions have had physician shortages for several years. Engaging physicians must show value for them to be away from patient care.

LHIN Relationships

37% of EDAC members said there was somewhat of a formal LHIN relationship but these relationships varied widely from no contact at all, to meeting regularly. EDs felt that LHINs do not have a good understanding of Primary Care, how they function, funding models etc. and LHINs have been reluctant to meet with them partially because they don't fund them. In some cases even when FHTs have reached out to be included in discussions, they have been turned down. All feel that building a relationship with the LHIN and educating them about FHTs and Primary Care would be beneficial. AFHTO can help to facilitate this initiative.



Health Links



Just over 50% of EDs indicated there was a fairly strong relationship with their Health Links but this varied drastically across the regions. Those that had very strong relationships were hosts for their Health Links. Most EDs felt the concept is good, but implementation is problematic (*no accountability; funding issues; cannot plan long term without base funding; expectations unrealistic, physician engagement and buy-in remain challenges*) but in some cases Health Links have facilitated a connection between the LHIN and Primary Care.

Many EDs felt that patients could be better served if services that Health Links provided were more formally aligned with Primary Care where resources could be shared. In some regions Physicians who are engaged with Health Links are not necessarily those that others like to work with. Relationships and personalities are also affected in this type of network.

QIDSS:

- All EDs felt QIDSS bring a great deal of value to FHTs but not always universally available to all FHTs who were part of the original proposals. Some FHTs have developed creative ways of working together so all groups are able to utilize the expertise of the QIDSS but others still struggle with how best to use this resource.
- Different skill levels and personalities play a key role in how they are perceived. Some FHTs feel they don't receive the same level of support even though much of the data analysis work that QIDSS can do takes the same amount of time whether you are 30000 patients or 5000. Location of the QIDSS host site, and where the FHT is in their QI journey contribute to some of the frustrations. However several success stories were shared. Here's just one:
    - Success Story: One group of FHTs uses their QIDSS resource jointly. They meet on a regular basis often chaired by a QIDSS. QIDSS items are always on their ED meeting agenda and they are working together to develop the same patient questionnaires, are starting to streamline measurements so they use the same indicators and generally this resource is seen as a catalyst for bringing them all together.

2. Aligning Team Based Primary Care

A variety of examples and suggestions were provided. Many teams are already sharing resources in their communities including opening up the programs to non –rostered patients. Examples such as:

- Aligning services/programs with other FHTs, HSPs (CCACs, CHCs, Public Health, Hospitals etc) to avoid duplication and underutilization – (*ie Diabetes, COPD, Newborn support programs, Congestive and Wound Care Programs and some work with Seniors Homes providing blood pressure clinics with a cup of coffee along with educational & preventative care*.)

- Community Outreach – offering classes to the whole community
- Targeting high users of hospital/ER (*ie. Reach out to their physicians to send patients to FHT services, for example, allowing high users access to home visit programs*)

Concerns:

- Preventative Care: if you open up services and allow a referral based system there are capacity concerns. For example: one FHT manages approx. 400 patients through their INR Point of Care and they've been monitoring them since 2008. They manage those patients so they don't transition to a state of need. This has opened up physician time for more office hours in this region.
- Legal/Liability: a lot of concern around legal and liability issues. However some FHTs have alleviated these concerns by providing clear policy directives. Resources are not allowed to speak about personal medical information at joint sessions. If the patient is in their EMR they are considered "circle of care" which covers liability otherwise they are directed back to their family physician. Lawyers had been consulted in several cases where medical consultations are required. Contacting solo practitioners after sessions remain a challenge for some programs who are concerned patients are left hanging.

Suggestions

- Standardized programs across the province were a suggestion from several EDs. i.e. This is how you run a Diabetes clinic - protocols, measurements, staffing requirements etc. It was identified that FHTs have been open to design and implement programs without direction. If there was a standard way of implementing programs and identifying the number of resources required, measurement of outcomes would be available across the province. This would streamline and reduce implementation costs.

3. Opportunities and Concerns

Opportunities

- Have the conversation around where is the care located and where are the patients located and how do they line up. i.e. look at all of the interdisciplinary teams and there are models that are not attached to Physicians and determine if there is a way to align these different models.
- Look at who are the right people to be caring for the people that are in need and what inter-professional resources are in the region to do this. CHC model has a particular focus. NP Clinic has a particular focus. Health Links have a particular focus. Instead of looking at each individual model look at Primary Care as a whole to work together.
- Some EDs felt that a closer relationship to the LHIN could be a positive change for Primary Care presenting opportunities of access to funding; improving relations with other HSPs; better coordination across the system; greater ability to plan health services regionally with a stronger population based focus; but concerns over the LHINs lack of understanding of the Primary Care world is real.

- Measurement: Need to have consistent agreements like Schedule A. This agreement should have an accountability factor that has teeth. Very standard approach to measurement, like a Scorecard - ie the indicator is one line on the dashboard and references would be – 3-5 pages on that indicator which outlines the why? literature review, definition, recommended threshold. Could be flexibility where for example 12 indicators are provided, 4 are mandatory and 6 are your choice with specific instructions on how to use each EMR to retrieve the data.

Concerns

- Recruitment, retention and funding were by far the # 1 issue identified by all EDs. Staff as well as physicians; and succession planning for physicians. EDs worried physicians who joined FHTs voluntarily would leave if the model is opened up without additional compensation. FHO's do not want to take on the liability.
- EDs felt that opening up FHT resources to others would/ could cause capacity issues. Many are working at capacity now.
- FHTs work hard to make sure that team based care is co-located so they know each other and their patients often for years. They have strong relationships using a Medical Home model. When opened up they find it is difficult to contact solo physicians after visits for follow-ups and patients are left hanging.
- Primary Care Branch has spent years to understand Primary Care. If this is downloaded to the LHIN it's a huge learning curve. One Primary Care voice (Primary Care Lead) cannot be the voice for the whole province.
- Lack of LHIN engagement. For example one group mentioned that they were doing 99% of the Diabetes work in their region and the DEC through the hospital just 5% but the FHT is not represented at the table even though they have asked to be.
- FHTs have a fear of losing resources – i.e. if you are going to have a nurse or physiotherapist then they should be seeing a certain number of patients. NPs should be seeing 150 patients a month. FHTs reluctant to share this information because they may lose resources if they are underutilized.
- Data Quality – EMR data is difficult to retrieve but it is also entered inconsistently. The Ministry should take EMR funding and reposition it to Data Entry or Data Quality.
- Geographical challenges. FHTs in some regions are 4-5 hours apart. Aligning services in regions like this are almost impossible. FHTs fear patients will have to travel long distances to receive the same level of service if alignment of services is done incorrectly.

4. Regional Meetings

- All EDs were very supportive of regional meetings and would assist in setting up the meetings accordingly.
- Northern regions highlighted that travel after early November is not done in their regions due to weather conditions.

- When asked about what the agenda could look like, most EDs provided the following topics:
    - Education on 'AFHTO' and what AFHTO provides, advocates for
    - LHIN education of FHTs
    - FHT education of LHINs
    - Reporting obligations
    - Contract
    - Brain storming

5. How can AFHTO prepare teams for this evolution?

EDs provided a number of areas where AFHTO could support them. These are listed below and will be reviewed going forward to determine priority for each. One of the key areas identified was outlining what AFHTO does. What is their role and/who do they advocate with and for. Most teams do not have a good handle on this.

1. AFHTO to provide more information on what they actually do for FHTs. More specifically around advocacy. What meetings are attended; who does AFHTO collaborate with, align services with. Such as HQO, Primary Care Branch, OMA others?
2. More information on D2D and measurement. Many teams do not understand the value of D2D or measurement and why it is or will be important.
3. AFHTO can facilitate introductions to others such as Public Health, LHINs, CCACs and other HSPs
4. Education and Training. EDs highlighted areas where they felt they could use more training and education or assistance. Data Sharing, Privacy, Liability Issues, more Governance training, Data Sharing Agreements, What constitutes high performing teams, ED Performance Review Guidance, Board Development. Suggestions were made around creating templates for certain types of agreements but doing them together so teams would have a standard to use.
5. AFHTO to make more face to face or teleconference ED meetings. This was mentioned by almost all EDs. Having a face to face presence in these regions would be a good platform for AFHTO.
6. EDAC special member groups: Review how best to service special members group such as BMS FHTs, Academic FHTs, Francophone FHTs or those who service Francophone patients, and Aboriginal FHTs. It was clear these FHTs function very differently from others would like support to engage with others like them.
7. Physician's piece: Physician engagement was one of the main challenges experienced by all FHTs. Getting information to Physicians in a manner that they can understand how it affects them specifically is a challenge. Can AFHTO provide information that is tailored to Physicians? The Member only website causes challenges for physicians as there is a lot of information provided not necessarily relevant to them.

6. Appendix A: Questions

1. The province is moving to comprehensive regionally governed, population-based primary care. What's already working in your area to bring primary care together? *(What networks are currently in place and how are they working? Health Links? LHIN? Physician Leadership? QIDSS? Executive Director Networks? How are you engaging Physicians? Teams working together regionally?)*

2. The province also wants to move toward greater access to team-based primary care for the people who would most benefit. In your area, how would you see this moving forward? *(What could help you and your team to do this? Are you aware of steps teams have taken to expand access to programs and services for those most in need – e.g. group visits, triage, improving internal collaboration and workflow, etc.)*

3. Question 3 and 5 were combined as: What are the opportunities you see ahead for primary care teams and for your community? What are the key hopes and concerns for the group you represent at this time?

4. As an ED on the EDAC Council how do you engage with the others that you represent at the table? *(Do you have a regular conference call? How are topics surfaced for discussion? Is this model working for your region/group? Suggestions for making it better? What other type of leadership, mentorship could be provided?)*

5. What is the best approach for AFHTO to schedule follow-up meetings to support FHT/NPLC leaders in your region? *(Starting in November, AFHTO is looking to schedule follow-up meetings within your areas which include FHT/NPLC leaders, physicians and other stakeholders. What is the best approach for these types of sessions in your regions?)*

6. Having had this conversation, what are your thoughts on how AFHTO can best help prepare teams for this evolution? *(e.g. knowledge-sharing and network opportunities, learning resources to be developed, etc.)*