

# Report from the AFHTO-AOHC quarterly meeting with MOHLTC FHT Unit

June 3, 2013

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## 1 Quality Improvement Decision Support Specialist (QIDSS) implementation:

### **Background:**

- FHT budget proposals are part way through the Ministry's internal approval process. Best guess is that FHTs would receive confirmation of funding at the end of June, or beginning of July.
- Thirty-three positions are being allocated to FHTs through the budget process.
- In addition, proposal for provincial resources (to be housed at AFHTO) is in the approval process. AFHTO has begun recruitment for a [provincial QIDSS project manager](#) to start work on implementation support.
- AFHTO will set up [provincial QIDSS Steering Committee](#) to support and coordinate implementation.

### **Key issue:**

- FHTs would like more information to understand how allocation decisions have been made and what to expect in the implementation.

### **Updates from the meeting:**

- The Ministry's development of the QIDSS position was in direct response to the FHT sector's call for greater support to be able to get better use of data and EMRs to improve patient care.
- In line with [AFHTO's recommendations](#), the Ministry looked for groupings that would spread learning and capacity. They felt they listened to what FHTs proposed, looked at all the proposals as a whole, considered the size of the combined patient populations, and then consulted with FHTs to develop groupings that made the most sense.
- For the first year, funding will include the full year of salaries and benefits. The ministry acknowledges that there may be ancillary costs for on-boarding these positions and suggests that FHTs work with their assigned ministry contact to leverage options for supporting things like travel, equipment/software and training.
- The expectations for the first year are to get the QIDSS onboard, integrate the position into the teams and to make some progress on data standardization and creation of patient registries. The Ministry will be looking to AFHTO's QIDSS Steering Committee for direction on how to evaluate the added value of these positions, going into the future.
- There is some possibility there will be additional positions that could be allocated in the next fiscal year, contingent on year 1 progress and available funding. As well, additional funding to support the QIDSS initiate may be considered following an assessment of the true first year costs. FHTs would be expected to submit this information within their 14/15 budget submissions.

**Next steps:**

- FHT Unit continues to track the Ministry approval process. Funding letters will be issued as soon as they're signed off, hopefully by early July.
- QIDSS implementation to be monitored and evaluated through AFHTO's [QIDSS Steering Committee](#), and recommendations brought forward through AFHTO and the Ministry.

## 2 Physiotherapy in FHTs:

**Background:**

- MOHLTC announced in April that Ontario is improving access to physiotherapy services for eligible Ontarians by changing how and where these services are provided.
- MOHLTC will integrate physiotherapy positions into primary care settings, including Family Health Teams, Nurse Practitioner-Led Clinics, Community Health Centres and Aboriginal Health Access Centres. The total number of positions is not yet known.
- Beginning August 1, 2013, the province will expand availability of community-based physiotherapy, exercise classes and falls prevention services.
- Primary Health Care Branch is coordinating implementation for all of primary care.

**Key issue:**

- FHTs need lead time to respond to call for proposals.

**Updates from the meeting:**

- Aim is to implement the positions in primary care by September. The inclusion of primary care in this announcement was very welcome, but it came relatively late in the process and so the roll-out is being done in a concentrated timeframe.
- The allocation will be done by a call for proposals. Approved positions will be added to base funding. Primary care organizations will be able to apply for more new positions each year thereafter.
- For 2013-14, eligibility is limited to the interprofessional primary care organizations, i.e. FHTs, CHCs, NPLCs and AHACs.
- The number of positions available is not yet known.
- As with all other FHT positions, the FHT funding agreement requires they be hired as employees unless the FHT has applied for exemption.
- The Ministry will be looking for proposals that integrate PT into programs and augment what primary care organizations are doing in chronic disease management and not duplicating services provided elsewhere.

**Next steps:**

- Within the next week, MOHLTC will organize a consultation meeting with the 3 associations representing interprofessional primary care organizations

### 3 Health Links – operational implications for FHTs:

#### **Background:**

- The MOHLTC has clearly expressed that primary care is central to the Health Link (HL) process and is a key driver to the transformation.
- Eleven FHTs are leading HL groups – this is half of the 22 HLs currently in place. Many more FHTs are involved as HL partners.
- For FHTs in a lead role, the burden of moving forward the HL agenda is creating stress on the existing leadership capacity and infrastructure.
- Observations from a number of sources point to primary care as the ideal source of leadership for developing and coordinating HLs. The capacity limitations on FHTs means that many are also dealing with more richly-resourced hospitals and/or CCACs that want to take over the job.
- Funding for project management resources was provided in the HL development grant (\$75K). While HL coordinators await approval of their HL plans and funding, they are continuing their work through their existing FHT leadership and management. Funding approval is required as rapidly as possible to sustain their efforts.
- In addition to the stresses on FHT leadership and infrastructure, there is also pressure for FHTs to take on more complex patients from outside the FHT, and to share IHPs and program resources with partner groups and/or solo physicians. This is seriously stretching existing resources.
- FHTs leading HL have to respond to both the demands and pressures of HL and the on-going management of the FHT operations. MOHLTC and LHINs need to be aligned in their expectations. Alignment between MOHLTC and LHINs is an issue in some areas where there seems to be a lack of coordination.

#### **Key issue:**

- FHTs and primary care need immediate support for infrastructure (project manager) and may require additional staff to support program sharing.

#### **Updates from the meeting:**

- Ministry is aiming to have Health Link budgets approved by the June 17 HL conference.
- FHT Unit staff have been advised to support FHTs, within the FHT accountability agreements, to fulfill what they must do for Health Links to fulfill their objectives.
- Patient and staff pressures will be considered through the usual business planning processes.
- All must recognize the environment of resource constraint. Health Links are about using resources better, not adding more. The challenge for primary care is that it is starting from a very lean position, relative to other health partners.

**Next steps:**

- All will continue to monitor the evolution of Health Links and the impact it has on patients and FHTs, with the view to ensuring FHTs are sufficiently supported to succeed in their roles.

**4 MOHLTC reporting requirements:****Background:**

- The burden of reporting requirements has been discussed at previous AFHTO-AOHC-FHT Unit meetings. All parties have acknowledged some of the data collected is not used at all, and there would be great value in streamlining the reporting requirements.
- MOHLTC has announced that there will be changes to the reporting system for the first quarter reporting.

**Key issue:**

- At this stage, FHTs are seeking clarity as to what is changing, and to ensure adequate training and lead time to implement.
- Going forward, FHTs want input to develop a more meaningful and efficient system of accountability and reporting that ensures funds are invested in a way that provides optimal benefits for patients and communities.

**Updates from the meeting:**

- 1<sup>st</sup> Q reports are to be submitted in the new SRI system by the end of July.
- The SRI system is being rolled out across a number of health sectors, including FHTs.
- The Ministry's SRI program is organizing training and should be in contact with FHT EDs by end of June.
- The content of quarterly reports is not changing substantially – it will just be a different way of submitting the data.
- All agreed once again on the need to re-think accountability and reporting so as to focus on more meaningful measures that enable the Ministry to ensure good value and appropriate oversight for public funds, and less so on low-value data.

**Next steps:**

- Notice of SRI training dates went out to FHTs on June 4. FHT reps to provide feedback to the FHT Unit
- See section 5 of report for next steps on the longer-term question of accountability and reporting.

## 5 Budget Flexibility and Accountability:

### **Background:**

- FHT EDs have identified a number of budget pressures that remain a high priority for many FHTs. (See section 6 of this report for details.)

### **Key issue:**

- Recognizing the environment of constrained resources, FHTs want to ensure patients continue to receive the quality care they need. To do this they want to understand and have input into how budget pressures are prioritized and addressed, and have the flexibility to shift resources to meet needs.

### **Updates from the meeting:**

- A number of funding issues were brought to the table, which led to the key discussion on the need for greater budget flexibility while enabling the Ministry to ensure good value and appropriate oversight for public funds.
- There is some scope for solving some of the funding pressures by giving greater flexibility, since a significant amount of FHT funding is recovered each year and returned to the government.

### **Next steps:**

- To guide decisions for the next fiscal year, the FHT Unit will give the opportunity for FHTs, through their association structures, to give input into priorities for funding.
- FHT Unit will do some background work on accountability and reporting, with the view to convening a joint working group in the fall, with the aim to implement some initial improvements in the accountability reporting process for the start of the 2014-15 fiscal. The process will take draw from the skill and knowledge that will be coming from the new QIDSS resources, AFHTO's work in performance measurement, AOHC's work on evaluation for health promotion programs, and of course, HQO's work in developing a Primary Care Performance Measurement framework.
- This accountability work will set the stage to enable greater flexibility in use of budgets.

## 6 Specific budget issues noted in the meeting

Given that the 2013-14 budget packages are already in the process of being approved, the following points were noted to get a better understanding from the Ministry perspective, with the view to improving the situation for the 2014-15 budget cycle.

**6.1 Funding formulas:**

The FHT Unit noted that, while roster size was a main factor in determining budget allocations in the past, additional factors were considered this year. This included looking at plans to advance priorities in [Ontario's Action Plan for Health Care](#). LHINs were also asked to review plans to assess whether there was duplication. Plans were aggregated and assessed to compare what was being asked.

**6.2 Status of the blended salary model (BSM) review:**

This question was raised since BSM FHTs face staffing pressures related to this mode of funding. Since BSM is about physician payment, it must go through the OMA-MOHLTC process. Ministry staff were unable to get this review into the 2012 negotiations process due to other priorities on the table. They are convening a Ministry group to move the issue onto the agenda for future discussions.

**6.3 Relief funding:**

FHTs do not have access to vacation coverage funding; this results in disruption in service for the patients and for the team. The FHT Unit has not been able to address it to date, since the 2013-14 funding priorities were to implement the QIDSS positions and rolling the Physician Assistant positions into base funding. This could be considered for 2014-15, relative to other priorities. (Note item 5 above.)

**6.4 Unionized staff funding:**

Some FHTs with unionized positions are fully funded to the level required by the Collective Bargaining Agreement (CBA) and others are not. The FHT Unit noted that funding at CBA levels pre-dates the current deficit reduction plan, which allows for no compensation increases.

**6.5 Cyber-risk insurance funding:**

Some FHTs are reporting that the MOHLTC will not fund cyber-risk insurance. While the Ministry has not yet seen the value of this coverage, if FHTs were given budget flexibility, it would be up to FHT to decide if they need it.

**6.6 IT and asset replacement:**

Some FHTs have been told they cannot make a request for either clinical equipment replacement or IT hardware replacement until the equipment fails completely; others have successfully received funding for to replace aged equipment. The FHT Unit advises EDs to speak to their FHT consultant early about these needs and to get process underway. They suggest leasing as a way to even out costs. AOHC is developing an IT sustainability approach that could inform improvements to this process.

## 7 Transfer of rostered patients:

### **Background:**

- MOHLTC policy outlines that rostered patients in a BSM model can belong to the “group”, and the need for an accompanying governance agreement that spells out the disposition of patient rosters when a physician leaves the group. (From Group enrolment and consent principles and procedures”, MOHLTC FACT SHEET dated July 2008.)
- The associations understood group enrolment to mean that, while individual care is assigned to a physician within the group, patients are conceptually rostered to the group. A number of FHTs continue to desire this option.
- Examples exist of FHTs in group enrolment that have experienced challenges in that physicians who have left the group have done so with the patient roster, despite the FHT wanting to continue and maintain delivery of care to that patient roster by another primary care provider working within the group. Recently, a case has arisen where a FHT is seeking permission to transfer the care of patients of a physician who is now deceased to another physician in the group. MOHLTC informed the FHT that they would have to discuss the disposition of this patient roster with the Executor of the deceased physician’s estate and request that the Executor submit written instructions to the Ministry regarding the disposition of the roster.

### **Key issue:**

- FHTs are requesting clarification of policy (or possible policy change) to ensure FHTs can continue to address the needs of patients and make the appropriate transfers.

### **Updates from the meeting:**

- FHT Unit staff reported that enrolment remains a contract between a patient and a physician even in situations where the PEM has group enrolment and consent. Direction for the disposition of a roster must be provided by the enrolling physician. In situations where a physician is deceased and there is a clear governance agreement outlining the disposition of the roster the ministry may consider that adequate direction.
- The broader issue of group enrollment must be clarified with the OMA. The FHT Unit will address this issue internally in an effort to get clarity.
- Following this the associations will advise members on language needed in their internal contracts.
- FHTs who have group enrolment and consent are reminded to ensure they have clear language in their governance and physician services agreements regarding the disposition of a physician’s roster.

## 8 Quick updates:

### ***8.1 Primary care compensation:***

AFHTO, AOHC and NPAO have developed a position paper and are aiming to release this document to members and to Ministry in the next few weeks. The compensation issue is a high priority issues for most FHTs – recruitment and retention issues are greatly impacted by our compensation packages and the discrepancy between the various sectors.

### ***8.2 Nurse Practitioner Activity Reporting (NPAR) roll out:***

Further roll out of the NPAR system is not yet scheduled since other priorities have taken the lead (e.g. Health Links, Physiotherapy and Quality Improvement Plans).

### ***8.3 Poor quality of data on orphan patients:***

The FHT Unit cannot resolve this issue, but it was brought forward for awareness since FHTs are expected to plan for orphan patients and expectations are set by the MOH for increasing rostered numbers of patients. Several FHTs in the North East LHIN feel that they are not receiving reliable and consistent information about orphan patients. The data is cobbled together from a variety of sources, from census data, hospital admissions, MOHLTC remittance advices and other databases. Although this may provide a picture, it does not provide accurate information on a consistent basis.