

Association of Family Health Teams of Ontario

Physician Leadership Council

DRAFT -- Minutes of the meeting of January 21, 2015

Members present: Rob Annis, Sheila Horen, Elyse Savaria, Lalit Krishna, Silvia Orsini, Sean Blaine, Duncan Bull, Monica Debenedetti, Lopita Banerjee, Shane Teper, Kevin Workentin, Tia Pham, Alan Grill, Kaetlen Wilson, Mary Kate Gazendam, Andrew Everett, Caroline Bowman, Alan McLean

Regrets: Chris Cressey, Joe Lee, James Pencharz, Mira Backo-Shannon, Tara Kiran, Christopher Jyu, Tom Richard, Wendy Hamilton, Ann Duggan, Sven “Buzz” Pedersen

Guests present: Sarah Newbery (MD, Marathon FHT and President, OCFP)

Staff present: Angie Heydon (CEO), Bryn Hamilton (Program Lead, Governance & Leadership)

Agenda item	Background material	Key issues & discussion points	Next steps	Done
1. Introductory Business		Meeting was called to order at <u>2:30 PM</u>	n/a	n/a
<ul style="list-style-type: none"> Chair’s welcome & Introductions 	n/a			
<ul style="list-style-type: none"> Approval of Agenda 	1-Agenda	No additions	n/a	n/a
<ul style="list-style-type: none"> Minutes of last meetings 	1.3-PLC minutes-2015-07-30 Link to report from Sept.17 joint EDAC-PLC meeting	The following were received for information. No further questions or comments.	n/a	n/a
2. Responding to Ministry’s Patients First proposal	Patients First-Responding to Ministry’s proposal		n/a	
<ul style="list-style-type: none"> Brief overview of Patients First and input to date web meetings with FHT/NPLC leaders in each of the 14 LHIN regions, and from Ontario Primary Care Council discussions 	2 Patients First-Appendix 1 - Patients First-poll summary; 2 Patients First-Appendix 2 - Patients First-12 topics + member comments	<p>Information, background for discussion in items 2.2 and 2.3</p> <p>To gather initial response and determine priority issues, web meetings were held with the leaders of AFHTO member FHTs + NPLCs in each of the 14 LHIN regions.</p> <p>AFHTO is also working 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.</p> <p>Members briefly reviewed the 12 topics, including the top 3 topics identified by AFHTO leadership during the web meetings:</p> <ul style="list-style-type: none"> - Accountability & Contractual Relationships - Support for Leadership Roles / Smooth Transitions - Primary Care HHR Planning 	n/a	n/a

<ul style="list-style-type: none"> Support for leadership roles / Principles for collaboration between LHINs and primary care leaders 	<p>Please refer to content in APPENDIX 2 as a starting point for this topic</p> <p>Also refer to: 2 Patients First- Appendix 3 - Clinical leadership – Defining and describing the concept</p> <p>Please note, OCFP President (+ Marathon FHT physician) Dr. Sarah Newberry will join this discussion</p>	<p>Sarah Newberry (president, OCFP + chief of staff marathon FHT) led the discussion on clinical leadership, highlighting the need for a clear definition and shared language. Minimal Canadian literature on this topic, most comes from Australia, New Zealand and Britain. OCFP recognizes the tremendous clinical leadership capacity within AFHTO, but to embark on transformative change – we need as many primary care clinical leaders to come to the table – in both formal and informal leadership roles.</p> <p>PLC members reviewed the clinical leadership competencies and roles outlined. Comments included:</p> <ul style="list-style-type: none"> - Should add a category highlighting the need for concrete enablers of leadership. One LHIN has developed a physician leadership table and have looked at what are the key enablers of leadership; one commonality is that all are in FHTs, suggesting there is something in the FHT structure specifically that enables people to step forward as clinical leaders. - In looking at how FHT structures enable clinical leadership, two elements were identified: the triad (“distributed leadership”, which brings together different but essential skills required for leadership) and the availability of support from other team members which allows physicians to take time away from clinical work to take on leadership tasks. - Others noted that distributed leadership extends beyond the triad to include non-formal leadership positions within and beyond FHTs. It also allows for more effective leadership, as leaders have complementary skills. Not every leader needs to have all the competencies described; these are presented as a kind of “ideal” collection of competencies. - Distributed leadership a great concept – could help to overcome physician hesitation to move into leadership roles at the risk of not being perceived as a ‘team player’. Would be helpful to have some shared language on this concept - “Visionary leadership” is another important concept – sharing same vision - The challenge is how to build clinical leadership among family physicians who are not in teams and don’t have that support. - There is a need for additional training/mentoring can be made available to those physicians who want to lead but lack confidence. - We will need to develop leadership at the sub-LHIN level if this is where accountability and governance will be structured <p>Sarah noted that OCFP is first looking at defining the role of a clinical leader and developing a shared language (currently, FHTs, OCFP, and MOHLTC all have different language around this concept). OCFP will also work with the LHINs and their physician leads to identify ways to engage physicians who are not part of the usual conversation tables as well as developing training tools, such as 3-hour workshops (current educational opportunities require significant time commitment), and developing a structured mentoring program to provide peer support for those in less-structured primary care environments.</p> <p>OCFP welcomes suggestions for ways to improve engagement, training, and support for clinical leaders.</p>	<p>Email Sara Newberry (snewberry@mfht.org) any additional comments re. clinical leadership roles & competencies and/or suggestions for training/tool development</p>
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<ul style="list-style-type: none"> Accountability and contractual relations 	<p>Please refer to content in APPENDIX 2 as a starting point for this topic</p>	<p>Patients First document outlines that accountability would be given to LHINs to plan and manage performance in primary care; FHT contracts would stay at the ministry level. Regional web meetings revealed that AFHTO members see this topic as a top priority for response, in order to reduce the potential for misalignment between the two levels (e.g. LHIN performance expectations exceeding capacity of resourcing from ministry) and additional/conflicting reporting requirements.</p> <p>AFHTO has not yet taken a position on LHIN vs Ministry roles in funding and accountability, and comments from a few individual members indicate some divergent opinions. To test this, PLC members completed the following poll:</p> <p><i>If LHINs are to be accountable for primary care planning and performance management, and physician compensation is to be negotiated and administered by Ministry, FHT contracts and FHT funding decisions:</i></p> <ul style="list-style-type: none"> - Should remain with Ministry – 36% - Should move to LHIN – 29% - Either way – 21% - Don't know – 14% <p>Follow-up comments included:</p> <ul style="list-style-type: none"> - If LHIN not given funding authority, they will have no leverage to manage performance - What's more important is physician input into what is being measured and how it is being reported, regardless of where funding comes from - Need to ensure reporting lines and expectations are clear. For primary care providers, does not matter who we report too but the process and expectations will be important: clear and simple as much as possible and access to support if needed - Physician compensation will still flow through Ministry/OMA – it's the FHT funding that's in question - Concern that LHINs do not currently have the knowledge or expertise needed to manage primary care and concern they may set unrealistic expectations when it comes to performance management 	<p>AFHTO to complete further work with membership to identify pros, cons of LHIN vs. Ministry as FHT funders, with the view to developing agreement on what is to be recommended to Ministry.</p>	
<ul style="list-style-type: none"> Primary Care HHR Planning 	<p>Please refer to content in APPENDIX 2 as a starting point for this topic</p>	<p>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. Beyond noting our work on « time spent » indicator, should AFHTO make any other comments on LHIN role in Managed Entry?</p> <ul style="list-style-type: none"> Comments: <ul style="list-style-type: none"> - on the concept of Health Humans resource planning in a team - physicians are also an important resource and AFHTO should absolutely comment on this as well. 	<p>Send additional comments re. Managed Entry to Angie Heydon (angie.heydon)</p>	

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<ul style="list-style-type: none"> Additional comments? 	Please refer to content in APPENDIX 2	<p>Comments made in response to brief roundtable for members to identify their top of mind issues (what's keeping you up at night?):</p> <ul style="list-style-type: none"> Great potential in new proposal; care coordinator makes more sense in primary care – not sure if LHIN can handle this Have faith in the system; no point stressing over what you can't control Huge opportunity to educate LHIN on primary care; resources and funding are biggest challenge – will this align with expectations? <p>Hope LHIN engages all sub-LHIN areas - physicians, EDs and board chairs.</p>	@afhto.ca	
<p>3. Advancing Manageable Meaningful Measurement</p> <ul style="list-style-type: none"> Supporting physician leaders to engage others to review and act on D2D 3.0 results (to be launched on Feb.1), and in the NEXT D2D (ie D2D 4.0) Updates on indicator development 	3 Potential roles for lead physicians in using D2D	<p>PLC members reviewed potential roles for lead physicians in using D2D. D2D has good momentum for measuring care – but the fundamental goal of using measurement to improve appears less common to date. Members noted the responsibility for lead physicians to take a leadership role with respect to QI and the need for more active physician leadership.</p> <p>Other comments included:</p> <ul style="list-style-type: none"> It is challenging to incentivize physicians to take these roles – what are the carrots? Only recourse is if you don't get on board – you might get left behind so better to stay on top than to ignore QI efforts. No clear direction (or consequences) from Ministry on performance management expectations. QI is fundamental to how we do our work – but different approaches for academic FHTs vs community FHTs (different relationships, authority and expectations) which can impact level of physician engagement in QI efforts Need to start somewhere when it comes to physician engagement – start with the champions – start looking at the data...and more importantly what the data is saying and use it to inform decisions. <p>Brief update also provided on the “time spent” indicator, as well as further developments on indicators for ED visits, post-hospital follow-up and potential indicators linked to Choosing Wisely campaign</p>	Members are encouraged to think of ways to engage physicians in QI efforts.	
<p>4. Program planning / Schedule A</p> <ul style="list-style-type: none"> Review penultimate draft of Program Planning Framework for final feedback 	<p>4.0 Program Planning & Schedule A</p> <p>4.1a Program Planning Framework</p>	<p>Joint working group between Ministry and EDs established to i) improve Schedule A as a meaningful tool for program reporting ii) develop a Program Planning & Evaluation Framework. A second area of work alongside the work group is being done by the QIDS to develop a catalogue of indicators linked to program objectives to support FHTs in their indicator selection process.</p>	Provide final feedback on the Program Planning & Evaluation Framework, and any further	

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<ul style="list-style-type: none"> Update on development of indicator catalogue to support program planning, and Ministry expectations re completion of Schedule A 	4.1b Programs Decision Flow Chart 4.1c Programs and Services Tip Sheet	Materials will be finalized and distributed to members at the end of January. A joint webinar between Ministry and the work group is scheduled on Feb 10th and 17th to review the Framework, Indicator Catalogue and Schedule A expectations.	direction on the indicator catalogue and/or next steps to Bryn Hamilton (bryn.hamilton@afhto.ca)	
<ul style="list-style-type: none"> Updates on Governance and Leadership development opportunities 	5.0 G&L Program Updates	Members were provided with a brief update on the Governance & leadership Program, including: ED Mentorship Program – 26 EDs volunteered to be ‘Mentors’; kick off meeting in early February Accountability Reform Initiative (ARI) – 158 FHTs applied; 128 approved or eligible if address targeted issues; 17 FHTs not recommended; 26 FHTs didn’t apply. AFHTO is doing targeted outreach those not recommended and who didn’t apply to offer any training or support that may be required. Privacy Training – AFHTO has partnered with DDO Health Law to offer free privacy webinars for EDs (Jan 27th) and Board Chairs (Feb 4th) Choosing Wisely Canada – patient site is live ECG Courses – available to physicians, NPs, Paramedics or Pas: <ul style="list-style-type: none"> - The basics - Advanced 	n/a	
<ul style="list-style-type: none"> Launch of Mentorship Program & Targeted Outreach (to meet MOHLTC Accountability Reform Initiative requirements) 				
<ul style="list-style-type: none"> Privacy Training 				
<ul style="list-style-type: none"> Training/education opportunity – EKG course in March 	5.3 ECG Basic + Advanced Flyers			
5. Communications				
<ul style="list-style-type: none"> What are the top 3 messages from this meeting to take away and spread? 	n/a	The PLC Chair summarized the top 3 messages he heard in this meeting: 1.The FHT structure has fostered development of strong clinical leadership. Education and support is needed to further develop clinical leadership and extend it more broadly beyond teams. 2.Make change slowly – pay attention to the “critical success factors” to ensure change achieves desired improvement. Keep accountability clear. 3.Quality improvement is fundamental to all we do in primary care, and physician leadership is essential to engage physician colleagues in QI activity.		
6. Conclusion		The meeting concluded at 4:00 pm	Adjourn	n/a