

EDAC/PLC Report to the Membership from meeting on Sept. 17, 2015

## AFHTO members meet with Ministry: What we know and what we're doing about it

Over forty AFHTO members from around the province – the combination of AFHTO's [Physician Leadership Council \(PLC\)](#) and [ED Advisory Council \(EDAC\)](#) – came together on Thursday, September 17, 2015 to [dialogue with the Ministry](#) to gain further clarity on what is known (and not known) as it plans for primary care. One of the messages is that work to develop policy and strategy is underway and that there will be further discussion and consultation as this progresses. Following this dialogue, members concluded the [priorities for action they identified over July/August](#) are on the right track, and then developed [further advice on each topic](#).

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## Meeting summary

So what do we know and where do we go from here? EDAC and PLC members concluded that:

- Members should expect a closer [relationship between LHINs and primary care](#), but we don't know yet what that will look like and whether or not this will include any form of funding and accountability. We need to further develop these relationships right away. AFHTO is facilitating meetings and preparing education materials to help members do this.
- Government's priority on access and equity signals that interprofessional teams must continue (or begin) to look more broadly at their communities to find ways to broaden [access to team-based care](#) to those who need it most.
  - More [equitable funding is needed to attract and retain the staff](#) needed to do all this work. We have no formal commitment from government as of yet; this remains the [top priority for AFHTO's advocacy](#).
  - As demand grows to broaden access to teams, AFHTO members' collective work in defining how we [measure and track health human resource capacity](#) is critical to reduce the risk of compromising patient care and teamwork. The goal is to introduce an initial indicator of this capacity in the next cycle of Data to Decisions – [D2D 3.0](#).
- Government is considering a [common set of publicly reported, primary care performance indicators](#). The collective work of AFHTO members to [advance measurement](#) is absolutely critical to lead the way to ensure these measures are *meaningful* to clinicians and *manageable* for reporting.
- At the strategy and planning level, we remind the Ministry and LHINs of the need for thoughtful ways to include primary care leaders in its development.
- As teams, we also need to look internally at how we can improve the value we deliver to our patients and communities.
- Transparency is critical – at all levels, from the Ministry, from LHINs, from AFHTO, from all of the stakeholders. Information is needed from the Ministry since the voids are being filled by misinformation.

In light of AFHTO's growing impact on the provincial stage, EDAC and PLC members applauded as the AFHTO President announced the board's decision to confer the title of [Chief Executive Officer to Angie Heydon](#), following their recent leadership review.

## Dialogue with Ministry

Phil Graham, Director of Primary Health Care Branch, was invited to the meeting for a one-hour dialogue. While government has not yet concluded its plans for primary care, he was able to discuss some evidence under consideration, general directions and receive comments from this group. The discussion is summarized below. Conclusions and comments from EDAC and PLC members are summarized in the thematic sections that follow.

The context within which government is developing plans was presented as follows:

- The need to continue building on primary care reforms is driven by an emerging body of evidence showing that primary care is a foundational component of high performing health systems and that Ontario's primary care sector is not performing as well as it could on key domains of performance, including ones that are most important to patients such as access.
- The approach to reforming primary care will be shaped by expert advice received through various evaluations and reports, by government commitments (such as the "access guarantee"), and by stakeholders. The Expert Advisory Committee on Strengthening Primary Care in Ontario is one of these but not the only advice under consideration. The report from this Committee is expected to be released shortly.
- Moving forward, the Ministry sees reforms to primary care as an essential component of health system transformation to be implemented in an integrated manner with other transformation priorities, such as Health Links and Home and Community Care Reform.

Government's areas of focus were presented as:

- Access + equity: Initiatives to ensure all Ontarians will have a primary care provider and be able to receive timely access to primary care services.
- Accountability: Local capacity and planning will be enhanced to improve continuity and integration of patient care at the local level.
- Performance Management: Consideration of a common set of primary care performance indicators, including patient experience, will be used to promote consistency and increase quality of care across the province.

Phil Graham added that a key principle for the Ministry is that their role is to define what is to be accomplished, and give providers the room to work out the most appropriate ways to achieve those ends in their local context. He also mentioned that further consultation with key stakeholders is needed to further develop these ideas and approaches.

## EDAC/PLC conclusions by topic:

- [Relationship with LHINs](#)
- [Access to teams](#)
- [Measuring human resource capacity](#)
- [Performance reporting in next MOHLTC-FHT contract](#)
- [Advancing manageable, meaningful, measurement](#)
- [Engaging leaders across AFHTO membership](#)

## Relationship with LHINs

### *What we know:*

- There will be a stronger relationship between LHINs and the primary care sector as we move forward. We don't yet know the extent and exact nature of that relationship, since government has not made final decisions in its review of the Local Health System Integration Act (LHSIA).
- If LHINs are to have any form of funding relationship with primary care, ranging from funding for special projects through to full contract funding and management, LHSIA will need to be revised.
- Sub-LHIN regions have been adopted for Health Links and will likely be an area of focus for broader system reforms. They appear to be at a more appropriate scale for clinical leadership, population health based planning and local innovation.

### *What members said:*

- Teams need to strengthen relationships with LHINs. There is concern that LHINs will want teams to do more – teams will need to provide needed leadership while avoiding burnout, and to negotiate essential resources to do all this.
- Need a thoughtful way to include family physician leaders in strategy development. The current impasse between government and OMA makes physician engagement very difficult.
- Teams may need to become more sophisticated and complex entities. How do we build the management skills and infrastructure to support that?
- There are some challenges in the concept of “sub-LHIN level”. For example, in population-dense places like the GTA, a large proportion of patients come from other sub-LHIN locales. Sub-LHINs in the north are covering huge geographies. Different strategies will be needed.

### *What AFHTO is doing:*

- To foster greater understanding about primary care across LHIN staff, AFHTO, together with the LHIN Collaborative, has initiated development of educational material for LHINs.
- To build profile for FHTs and NPLCs with each LHIN CEO, AFHTO has invited EDAC and PLC reps, at their request, to have AFHTO coordinate a meeting of these reps, AFHTO's CEO and their respective LHIN CEO.
- To support primary care leadership in the LHIN context, AFHTO is organizing “**Regional Leadership Sessions**” - to include FHT/NPLC EDs, Lead Clinicians, Board Chairs, LHIN leadership, AFHTO leadership and other stakeholders deemed appropriate within each LHIN region – to begin after the AFHTO 2015 Conference.

*What you can do:*

- Relationships are fundamental. Start getting to know the other FHTs, NPLCs, CHCs and AHACs in your region, think about how you could strengthen partnerships with the LHIN and other local partners, and how AFHTO might assist.

**Access to Teams***What we know:*

- The Ministry has communicated intent to improve “Access to team-based primary care for all Ontarians who would most benefit”.
- The Minister continues to state that addressing the challenge of recruitment and retention is one of his priorities. We have no formal commitment from government as of yet.

*What members said:*

- Staff turnover continues to be a barrier to access and improving value. *Staff who stay are becoming disengaged and feeling disrespected as they are asked to do more each year, but are still being paid at 2006 compensation levels.* All of this impacts on quality and access.
- Members are also concerned that broadening access will add further pressures on staff, making the problems of disengagement and turnover even worse.
- The concept of “access” needs be seen as “appropriate access”. For example, francophone patients who can only get care from english-only providers do not yet have appropriate access.

*What AFHTO is doing:*

- [AFHTO has advised the Ministry](#), that, to optimize value of and enhance access to team based primary care we must:
  - Above all else, stabilize the work force with sufficient funding for recruitment and retention of skilled professionals, per [AFHTO-AOHC-NPAO recommendations](#).
  - Agree on how to [measure and track capacity](#) such that additional demand can be managed without causing unacceptable increases in waits for appointments and/or decreases in quality of care.
  - Establish minimum requirements for meaningful communication and collaboration for any primary care provider whose patients are receiving services from a team.
- Recruitment and retention remains the [top priority for AFHTO’s advocacy](#). Together with our AOHC and NPAO colleagues, AFHTO has met with the Minister, senior staff in the Ministry and Treasury Board officials. We believe there is no dispute regarding the [required solution](#); we continue to press for the political will to begin implementation.

*What you can do:*

- Continue to keep your MPPs, the Minister and AFHTO informed of your team’s challenges with staff turnover and the impact on your community.

## Measuring human resource capacity

### *What we know:*

- While the Ministry intends to expand access to team-based primary care, there are no commonly-understood definitions or generally-accepted methodologies for measuring the capacity of teams to provide appropriate access and quality of care for a population of patients.

### *What members said:*

- When measuring HR capacity, include ALL clinicians (physicians, NPs, other IHPs) providing care to patients of the team.
- Data collection burden is a major consideration.
- Individual members shared the things they're doing to better understand capacity (e.g. a physician group using a time tracker) and expand it (e.g. use of group visits in social work).
- All agreed that this is not going to be a perfect measure in the first iteration, but we need to start somewhere and learn from the results.

### *What AFHTO is doing:*

- We are accelerating work in developing a measure of human resource capacity, to include it in [D2D 3.0](#).
- The capacity measure is a complement to the measures of quality ([Quality roll-up indicator](#)) and total cost of care already being implemented through D2D. Having data for these three measures makes it easier to answer the question “how much human resources are needed to deliver patient-centered comprehensive primary care at an acceptable level of quality”.

### *What you can do:*

- In depth clinical consultations are underway to define “capacity” measurement. Join the conversation - [Click here to participate](#).

## Performance reporting in next MOHLTC-FHT contract

### *What we know:*

- FHT contracts expire on March 31, 2016. Whether the next FHT contracts are issued by the Ministry or LHIN, the templates will be developed within the Ministry.
- Beginning April 1, 2016:
  - The current Schedule E requirement - Programs and Services Quarterly Report Summary – will be replaced by a report on a standard set of 6-12 meaningful indicators. Ministry will consider AFHTO recommendations.
  - Schedule A will be kept as a document that encourages and gives evidence of program planning, and also enables an inventory of programs across LHINs/Province.

### *What members said:*

- EDAC-PLC members acknowledged the ***Principles for determining accountability measures*** that emerged from the October 2014 AFHTO Leadership session, i.e. the Ministry must provide adequate support to ensure teams have the capacity to collect and report data. These measures must be:
  - Meaningful (evidence-based, clinically important, aligned with priorities, ability to impact the result)
  - Manageable (easy to track and avoid duplication)
  - Sufficiently flexible to allow for variations due to patient complexity and team setting
  - Determined collaboratively, with input from members (including clinicians)
- The biggest concern is when and how teams may be held accountable for achieving performance targets. At this point the only accountability is to report the data.
- Members repeated the call for the Ministry to give greater budget flexibility to allow teams to be responsive and improve care delivery.

### *What AFHTO is doing:*

- D2D is the starting point for Schedule E indicator selection, since these indicators have been selected through extensive membership engagement with a focus on manageable meaningful measurement.
- AFHTO is working with member leaders to identify criteria for selecting indicators to recommend for Schedule E. Broader membership consultation will be conducted over the next few months.
- For Schedule A, AFHTO has established a joint work group with the Ministry to develop a framework for conducting effective program planning and evaluation, and improve the template for reporting program plans. QIDS Specialists are working on a catalogue of standardized indicators linked to program objectives, to help teams in their indicator selection process.

### *What you can do:*

- Watch for further announcements and participate in the contract consultation process.
- Participate in [D2D 3.0](#).
- At the [AFHTO Conference](#), attend the Schedule A workshop, #F-1 in the [concurrent session program](#).

## **Advancing manageable, meaningful, measurement**

### *What we know:*

- [Data to Decisions \(D2D\)](#) is a membership-driven report on performance in primary care, made possible through Ministry funding for QIDS positions at the local level (QIDS Specialists) and the provincial QIDS program at AFHTO.
- Collectively, we have made progress since D2D 1.0! [Decisions from Data: Progress from D2D 1.0 to 2.0 report](#) takes a look at our journey to advance manageable meaningful measurement.
- AFHTO's direction is guided by the [Starfield principles](#): measuring overall quality, human resource capacity and total cost of care.
- The Ministry has given priority to measure and reduce avoidable ED usage and increase 7-day follow-up, AFHTO is consulting with members to make these measures more meaningful.

#### *What members said:*

- Discussion of avoidable ED usage centred on the fact that “low acuity” (CTAS 4 + 5) does not equal “avoidable”, and what could possibly be done to reduce “avoidable” visits.
- A key issue in post-hospital follow-up is the fact there is some disease-specific evidence that follow-up within 48 hours makes the difference (i.e. 7-day threshold is too long), and there are other conditions where it could be longer than a week.
- Members also noted significant limitations when follow-up data is based on physician billings, since follow-up can be appropriately done by phone or email, and by different team members.

#### *What AFHTO is doing:*

- AFHTO is launching [D2D 3.0](#) in January 2016.
- Responding to member feedback, D2D 3.0 is designed to be as much like D2D 2.0 as possible, with the addition of indicators for HR capacity and diabetes care, and improved definitions for indicators on patients served, childhood immunization, EMR data quality, quality roll-up indicator.
- The aim is to have an acceptable measure of avoidable ED and post-hospital follow-up in D2D 4.0.

#### *What can you do:*

- START PREPARING for access to team-level ICES data. Schedule discussions with physicians and Boards as needed to establish the necessary internal permissions to sign up for these reports.
- Add questions for [D2D 3.0 indicators](#) to your patient experience survey so you can collect data on them in the next 3 months.
- HQO is launching team-level access to ICES data via HQO portal for Executive Directors. The [sign up process](#) is now open. Before signing up, EDs must approach the physician team to ensure permission is granted to access the ICES team data. Physicians should encourage their colleagues to grant permission to have teams access this data because it gives them the ability to respond to the data.
- Consider reviewing the [step by step guide](#) for other activities to prepare for D2D 3.0.
- Join the conversation to define the ED and follow-up measures - [Click here to participate.](#)

### **Engaging leaders across AFHTO membership**

- The October 28<sup>th</sup> [Leadership Session](#) immediately before the AFHTO 2015 Conference will provide leaders of member organizations the opportunity to further shape the direction of our collective work within AFHTO and the future of primary care in Ontario.
- [Regional Leadership Sessions](#) will take place in each LHIN area in the months thereafter.