afhto association of family health teams of ontario

Leadership in Healthcare for Ontarians: Learnings from the AFHTO 2013 Conference

Purpose and Summary of this Report

This report summarizes the key messages and insights into primary care leadership gleaned from the AFHTO 2013 Conference. These messages come from speakers and conference participants in the FHT Leadership Session and the opening and closing plenaries.

Primary care is built on long term relationships – with patients, within teams and with others in the community to care for these patients. This unique role fosters distinctive strengths that primary care leaders bring to the health system. As coordinators of care who see the complete range of patient needs and social context impacting these needs, primary care leaders have the skills and drive to develop and lead meaningful partnerships that keep patients at the centre.

This report reminds us all of the distinctive and indispensable role primary care leadership brings to patient care and health system transformation. It will guide development of AFHTO's Governance and Leadership Program to support and strengthen the capacity of current and future primary care leaders.

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1. Introduction

Ontario's *Action Plan for Health Care* clearly places primary care at the center of the health care system: "When patients have faster access to family health care that serves as the hub of our health care system, they stay healthier, get connected to the right care and are less likely to require treatment in hospital". We also know that one of the key characteristics of a high performing health care system is a strong primary care system.

For FHTs and NPLCs to play a central role in ensuring that primary care remains at the centre of the health care system , strong leaders must come forward to initiate the changes required and to develop new ways of working with our partners, including patients. A majority of primary care organizations, FHTs and NPLCs, are leading Health Links initiatives across the province and demonstrating the capacity for primary care to lead changes.

It is important to understand what "leadership" means in primary care and what is unique and distinctive about its contribution.

With the theme of ***" Leadership in Healthcare for Ontarians"*** , the AFHTO 2013 conference highlighted the leadership role that FHTs and NPLCs are currently playing and also created the opportunity for leaders to discuss and identify how best to continue to strengthen and support leadership in primary care.

The leadership theme was woven throughout the conference and specifically brought into focus in each of the following sessions:

1. *Leadership Session*:
   This session specifically for FHT leaders allowed time for reflections on the themes of leadership at the FHT/NPLC level and at the system level.

2. *Opening Plenary* :
   This opening plenary presented a different perspective on" inspiring leadership", recognising the important contribution of each team member.

3. *Awards Dinner:*
   The award dinner celebrated the many leadership successes across the province.

4. *Closing Plenary:*
   The closing plenary offered a humorous debate ending the conference on a strong positive note by highlighting the importance of primary care leadership in system transformation.

2. The Skills and Characteristics of Exceptional Leaders

A number of perspectives on the skills and characteristics of exceptional leaders were presented during the conference such as the insights shared by Drs. Ruth Wilson and Lance Secretan. The participants at the leadership session had the time to discuss their ideas with their team members and colleagues from other teams.

Dr. Ruth Wilson, a respected leader in primary care, remarked on the **common values** that the founding members of AFHTO brought forward to create a new organization leading and supporting change. They emphasized collaboration and team work, respect for all professional involved and a strong belief in comprehensive primary care ("womb to tomb" care for patients).

The group of leaders present at the leadership session discussed and proposed a range of skills and characteristics (please refer to the Appendix for complete list).

The following is the list of the top skills and characteristics identified by the group:

1. Having a **vision and purpose:** she has a clear sense of direction and is able to instill this in staff
2. Good **communicator**: he has strong interpersonal skills including listening, understanding, and empathizing;
3. **Trustworthy and respectful:** she is someone who people can believe and believe in
4. **Lead by example**: he walks the talk
5. **A coach**: she is a guide and mentor, inspiring confidence in others
6. **Firm but fair**: he is consistent, decisive and treats people fairly,
7. **Flexible:** she is not rigid and can adapt to new situations easily
8. **Positive and optimistic:** he has a bright outlook in stressful times without being unrealistic
9. **Fosters learning:** she encourages development, risk taking and learning from mistakes

During the opening plenary, Dr. Lance Secretan introduced the CASTLE principles. Dr. Secretan places these principles at the core of inspired leadership and believes that leaders are most effective when they consciously "live" the CASTLE principles.

The CASTLE principles as described by Dr. Secretan are:

- **Courage:**

"Courage gives us the will to do what is necessary to make change, to rise above the intimidation that our personalities experience from the personalities of others"

- **Authenticity:**

"When we are authentic, we align our minds, our mouths, our hearts and our feet – we think, say, feel and do the same thing with complete congruence."

- **Service:**

"Servant-leadership embodies sharing, cooperation, consideration and consciousness. The servant-leader honors the sacredness in others and in all of life."

- **Truthfulness :**

"There is no logical argument that can support the idea that we can build consensus, community, ethics, teamwork, high performance, organizational and personal transformation, or outstanding customer service and quality without first building the necessary foundation of integrity on which to place them".

- **Love:**

"Violence and love are at opposite ends of a continuum, with selfishness at one end and service at the other. One builds. The other destroys."

- **Effectiveness:**

Living the CASTLE principles is the way to achieve high level of performance and effectiveness.

The similarities between the CASTLE principles and the list of skills and characteristics identified by the FHTs and NPLCs leader group are obvious. The CASTLE principles mirror the ideas brought forward by the group but present the concepts in a different manner and bring into focus the specific individual qualities of leaders.

However, it is clear that leadership in primary care is characterized by a set of values centered on developing trusting relationships with integrity and caring along with the ability to communicate and inspire a clear vision and purpose.

3. The Distinctive Contributions of Primary Care Leadership

From an understanding of the skills and characteristics of leaders, it is worthwhile to reflect on whether or not primary care leaders bring a unique perspective and make a distinctive contribution to leadership in the context of the current health care reforms.

In her reflection, Dr. Ruth Wilson introduced the **three H's** as the areas where primary care leadership could make a distinctive contribution:

- **Health Links**: primary care leaders can make a significant contribution to the manner in which care for patients who are "high users" of the system is improved. Primary care teams are best positioned to understand the needs of complex patients and to propose actions to improve care.
- **Hospitals**: primary care leaders can play a key role in redefining the relationship between hospitals and primary care service providers. This is an important role that will improve the transitions of care and ensure that patients are not left without adequate follow up.
- **Housing**: the concept of "housing" is meant to represent the social determinants of health and the social factors that impact on the health of individuals as well as population health. Primary care providers are often the only members of the circle of care who are aware of patients' social needs and their impact on their health.

During the leadership session, participants identified the following distinctive contributions of primary care leaders:

1. **Builder of system partnerships-** We need to foster collaborations across the system with primary care at the core.
2. **System navigator-** From our unique position we understand the patient's complete needs, provide continuity of care and can identify the care gaps and needs. This enables us to best help our patients navigate the broader health care system.
3. **Hub of patient data-** Primary care should be the hub or centre of the patient's medical care and drive the agenda for better seamless use of EHRs across the patient's journey.
4. **Coordinating entity**- Primary care knows the patient most intimately and must integrate the care of all the community partners.
5. **Patient advocate-** We must act as the advocate by facilitating system navigation and ensuring continuity of patient-centred care including all social determinants of health
6. **Front line tracker of Community Needs**- Primary care is unique because we see the patients most often; are the door to access health care; can effectively advocate for patients and can

influence the health care system by effectively identifying gaps and additional service needs in a community.

7. **Relationship builder for patient care-** We create grassroots solutions through community partnerships that wrap care around the patient by linking the best resources together.
8. **Continuity of care-** Primary care is uniquely positioned to provide access to and continuity of care across the life span of the patient from cradle to grave.

The closing plenary discussion echoed many of the points brought forward by the group of leaders. The key points from the closing plenary are the following:

- Primary care providers have a **long-term relationship with patients**. As a result, primary care is best placed to respond to patients' needs and to coordinate their care.
- Primary care has the capacity to **develop partnerships** with other parts of the system and therefore to improve care transition.
- Primary care understands the **impact of determinants of health** on individual and population health.
- **Patient advocate**, Dr. Glouberman, urged everyone to listen to what patients have to say. The system is currently "misshapen, bloated at the acute care end" and this must be remedied. Primary care leaders can play a key role in changing the shape of our health care system.

4. Leadership Action

During the leadership session, the participants were asked to identify actions they would undertake with their team and partners after the conference. (Please refer to the Appendix for the list of the actions described by all participants.)

The main themes that emerged from the action items outlined are aligned with the distinctive contribution that primary care leaders can make to the health care system. The action items also highlight the focus and capacity of FHTs and NPLCs to create a more patient-centred and integrated system. They can be categorized in the following themes:

1. **Health Links and supporting partnership development in the community**:
   A majority of FHTs and NPLCs mentioned Health Link and the active role they're playing in ensuring that the needs of our most vulnerable patients are met.

2. **Patient advocacy and responding to patient needs**:
   A number of FHTs mentioned they would focus on responding to patients' and community needs as they develop programs for specific patient populations. Some FHTs mentioned the need to address orphan patients. More specifically, a number of providers decided to seek increased patient input in developing programs and services.

3. **Addressing the determinants of health**:
   The importance of addressing the determinants of health in the community was also a central theme. A number of FHTs mentioned they would reach out to their local municipal government and other partners in the community to find innovative and constructive ways of addressing patients' and community needs.

It is also worthwhile to mention that a number of FHTs proposed action items that would enhance their capacity to **access data** and demonstrate improvement and track outcomes of care. A few teams also mentioned involving their board and ensuring that **excellent governance** is in place for primary care to take on a strong leadership role.

5. Defining the Vision for the Governance and Leadership Program

The messages and insight gained at these sessions will inform the development of a vision for the Governance and Leadership Program. This vision will be articulated through a process that will include our members, the AFHTO Board, the Governance and Leadership Advisory Committee and the Executive Director Advisory Committee. The process will also be informed by involving partners and stakeholders.

APPENDIX: Data collected in the FHT Leadership Session

Q. Think of someone you consider to be a good leader. What are the skills, characteristics, values that she or he exhibits?

1. Firm but fare
2. Positive and optimistic, fair (inclusive, unbiased, transparent)
3. Vision and bigger picture
    1. Vision
    2. Distill a sense of purpose
    3. Clear visionary with motivational skills
    4. Visionary
    5. Vision
    6. Clear direction
    7. Visionary
    8. Vision
4. Good listener
5. Inspires confidence in others
6. Foster learning, ability to make mistake (and learn from them), strong beliefs
7. Clear communication and listening - expectations are understandable
    1. Good communicator
    2. Strong communication skills
    3. Expert communicator and collaborator
8. Inspiring others to do something you didn't think you could do
9. Resiliency and persistence
10. Willingness to stand alone
11. Putting the right people in the right position to achieve the vision
12. Good moral compass
13. Team work!!
14. Decisive while embracing change
15. Knowledge and evidence based
16. Confident
17. Humour, spontaneous
18. Integration and synthesize the energies

19.Flexible
20.Connected
21.Engaged
22.Proactive
23.Skills and experience
24.Soft spoken
25.Good facilitator
26.Confident but not arrogant
27.Aware of team members strength
28.Walks the talk, engaged, invested, sincere, inspirational, open minded,
29.Experience
30.Open to new ways of thinking, sees bigger picture, forward thinking
31.Motivating, sales person
32.Creative
33.Coaching and guiding
34.Turn a situation that is difficult into an opportunity
35.Adaptable, agent of change
36.Lead without leading-- knows what the end game is-- being able to find the person who takes an idea and runs with it-plants the seeds in others- to get success- doesn't matter who gets the credit
37.Innovator
38.Doesn't need to be the boss
39.Engages staff at all levels
40.Innovator and new ideas
41.Motivator, good listener, integrity (walks the talk), supportive, big-picture thinker, represents his or her team well, human, recognize their limitations
42.Appreciation and the development of members strengths
43.Passion, think big picture and make complex things simple
44.Acceptance and awareness of people and abilities
45.Engaging and motivating
46.Credibility, humble, inclusive, kind, passionate, informed, political savvy, committed, open, good listener, collaborative
47.Sense of community, role of agency in, collaborative
48.Mentor
49.Organized
50.Not mean and nasty-- "be nice", treats people the way they wish to be treated, thus makes people feel safe
51.Charismatic, ability to make connections with people (networking), ability to balance strong beliefs and goals with human element of people you are leading, credibility, knowledge and skills
52.Connected,
53.Hard working
54.Passion and zeal
55.Great listener (non-judgmental, flexible, open minded
56.Courage
57.Inspirational, leading by example,
58.Communicator
59.Trustworthy
60.Able to communicate, inspire, and respect all
61.Open door
62.Develop others, sees the vision, develops other and allow growth
63.Compromise
64.Coach not control
65.Provides opportunity for the development of ideas
66.Decisive
67.Good coach
68.Respectful
69.Insightful

70. Inspires confidence in others
71. Enable people to learn and enable others to develop leadership skills
72. Inspire but not manage
73. Decisiveness while being inclusive and leading by example
74. Vision, engaged and collaboration
75. A willingness to do things that other people would not do
76. Empower others
77. Mentor: someone who makes others feel motivated, energized, and engaged. . People feel glad that this person is the leader.

Q. What is the distinctive contribution that primary care leadership can make?

1. Table 1:
   1. Working better to improve communication
   2. Extend healthcare into homes (house calls as a FHT)
   3. Understand your community needs and develop a strategic plan to achieve goals
   4. Changing the model of the care from fee for services (i.e. physicians not paid for phone calls) and provide advice for continuing care
   5. Create integrated patient care
   6. Enhance patient care pathways

2. Table 2:
   1. Comprehensive primary care is the path to equity
   2. Opportunity to engage patients to improve the care of the whole health care system, governance system important
   3. By using data to drive the quality
   4. Initiate system process mapping
   5. Ensuring that every patient has a primary care physician
   6. Ensuring that patient has trust relationship with members of the primary care team, provides a circle of care, primary care can provide team based care to patient
   7. Social determinants of health can be addressed by primary care leadership
   8. Physician leadership to lead health link primary care inclusiveness

3. Table 3:
   1. Breaking down barriers and getting rid of turf wars between the different primary care associations/organizations
   2. Coordinate the role CCAC within primary care
   3. Best situated to do the needs assessment to determine what our particular community needs
   4. Advocacy - for each individual patient in the system (micro) and amongst the sector to the decision makers (macro)
   5. Coordinate the health care and social determinants aspect of care (cradle to grave)
   6. Prevention - primary care sees things before individual in crisis (identify in advance)
   7. None of the other aspects see the whole person - primary care does
   8. Patient engagement and involvement in their health and forming programs and services
   9. We are the primary stop in health care (hub) for care - play a role in where the patient gets care (educating the patient where to get their health care)
   10. Who needs access to interprofessional care? Are the right people getting the care?

4. Table 4:
   1. First ones that see the patients "we're the access point"
   2. We can drive innovation in the community
   3. We have an intimate connection in the community
   4. We're in the driver's seat- at the helm

5.We're able to link our patients to other services- to help navigate through primary care
6.We function as a hub0 we have a n overview of the whole patient supposed to other parts
7.Mind body and spirit
8.We're the best to assess the gaps because we know the patient populations best
9.We know the demographics of our patients
10.We knew the supports that we all have; we know about ccac and palliative care services
11.We know it a t the patient level
12.We able to do the needs assessment
13.We have the opportunity to identify patients' needs and we have the opportunity to service the missing things
14.We can look at new and innovative things because specialists are constrained
15.We don't have the constraints because we can see the patient; needs and we have more sources - nor perhaps should have more
16.We're agile
17.We're have the benefit to see the cause and effect- we have the ability to track patients and follow through
18.The patients are discharged- not necessarily seen within 7 days
19.As a primary care, we should be able to make it important to contact the patient- through IT needs
20.We are the best ability to find the patient needs and the consequences if things don't happen- "continuity "
21.We're have the opportunity to improve transitions in care- especially with Health Links
22.We can see where the patient is following off- nurse coordinator- to book back with the patients
23.Recall is not happening- anecodte0 our Health links- patient navigator from the primary care end
24.Navigator- trying not different ideas- inequity to provide staff- some FHT's- can get pilot projects

5.Table 5:
1.Community involvement/knowledge
2.Knowing your population via data mining from the EMR
3.Advocating for patients through health care system - patient navigation
4.Education and engaging patients as to the methods behind our processes
5.Keep it more patient centred
6.Do better at promoting that medical homes are the heart of the healthcare systems- patients ideally should be attached to a medical home who acts a steward to their healthcare need
7.A unique perspective as the key group connected to the patient
8.- Should therefore be involved in healthcare systems discussions
9.Communicate to the general population about their health - health promotion and prevention
10.Continuity of care overtime, and context that that care is happening within
11.Holistic view of patient - including whole body, social situation, history
12.Unique trust and relationship
13.If they come to us, helps patient and the system
14.Addressing social determinants of health, knowing social services in the community
15.BUT we require an acknowledgement of primary care's role -- so we get discharge summaries, ER notes, appropriately informing primary care in order to be able to do the job we are the best at doing

6.Table 6:
1.Coordination of services, extensive knowledge of patient information
2.Looking at the whole person
3.Improving the health of the community
4.Historical relationship of patients
5.Proactive care
6.Knowledge of the community itself
7.Primary health promotion
8.Changing your community thoughts and focus
9.Coordinating education efforts
10.Knowledge of other resources "hub" -- developing partnerships
11.Addressing community health problems

12. Taking the leadership role to a seamless transition
13. Connecting patience for resources and advocating
14. Influence patients making good changes (train of thought)
15. Influence community leaders to change systems -- health, exercise for a healthier community
16. Involving patients --- patient centred care

7. Table 7:
   1. Community knowledge/involvement
   2. Inclusive
   3. Utilize comprehensive nature of primary care to ensure effective utilization of health resources
   4. Link with social services and other community agencies to improve health outcomes
   5. Utilizing emr data to improve patient care with a focus on prevention
   6. Multidisciplinary care that is available
   7. Using the emr and social determinants of health to predict and proactively mitigate population health

8. Table 8:
   1. - holistic view on community's health
   2. Patient navigation through all community providers (e.g., social, housing, mental health)
   3. Continuous care
   4. High standard of health care provision
   5. Follow through post hospital care
   6. Hub of the wheel of healthcare in the community
   7. Coordination of communication of patients health information (e.g., common EMR)
   8. Overseeing all social determinants of health and addressing needs in all areas
   9. Advocate for focus on prevention of chronic disease
   10. THE patient's advocate

9. Table 9:
   1. Coordinator for services
   2. Available community services
   3. Access to healthcare
   4. Identify gaps and needs
   5. Patient advocate

10. Table 10:
    1. Clinical leadership vs. political leadership
    2. Primary care sees the whole picture vs. specialists point of view
    3. Show the MOH where funding should be spent
    4. Primary care brings the patient point of view
    5. Patient centred, wrapping care around the patient
    6. Engage all agencies and addressing all patients needs
    7. Providing solutions based upon content specific i.e. location, population specific
    8. Through the creation of Health Link to address local issues
    9. Grass roots solutions
    10. Our task is to make the system to adapt to the needs of the patient
    11. Primary care might contribute to decreasing of silos
    12. Using local knowledge for local solutions
    13. Importance of regional knowledge and communication to the larger political venue
    14. Sharing regional knowledge among providers and primary care leaders

11. Table 11:
    1. In primary care we get to know the patient very well, and there is cost savings in tests being ordered that are truly needed
    2. Start with self- management of health disease and ownership of our own health
    3. Relationship and trust between patient and provider has great benefits and makes primary care more special than hospital care

4. Driven by costs and MOH funding available - time factor
5. Link between patient and other resources in our community - linking to those services when needed before they are in crisis
6. In primary care we are the centre of the hub to be able to communicate and link the patient to the proper - we have that responsibility to navigate the patient
7. 7 day revisit to provider after hospital discharge - patients feel cared for in this process
8. Attention being given to 5% high end user patients
9. Need to advocate on our patient's behalf for programs, services that are needed (i.e. Addictions)
10. Relationship

12. Table 12:
    1. Primary care is the quarter back
    2. Patient is central focus
    3. Cradle to grave - nurture lifelong relationships
    4. Cradle to grave nurturing of continuum of relationship
    5. Health advocacy and informed advisors
    6. Supporting transitions
    7. Decrease duplication of resources
    8. Increase interprofessional conversations
    9. Culture of care
    10. Build health literacy and partnering in their care at the level they are capable of being involved

13. Table 13:
    1. Health wellness and primary prevention
    2. Continuity of care
    3. The medical home
    4. Make primary care an open door

14. Table 14:
    1. Emphasize prevention over treatment
    2. Emphasize chronic disease prevention
    3. Prevention and health promotion
    4. Holistic view of health and good health
    5. They know their patients - identify local trends and solutions
    6. Increased access to hospital data by generalist physicians to improve quality of care
    7. Education among physicians of the importance of sharing patient data

15. Table 15:
    1. Access
    2. Proactive not reactive
    3. Implementation of innovation
    4. Facilitating change
    5. Better understanding of needs
    6. Management of transitions

16. Table 16:
    1. Patient centred rather than patient driven- i.e. the correct clinic decision making does not always make the patient happy but it might be better for them.
    2. Prompt the idea that the medical home is the centre of health care system-- that ideally a patient is attached to a medical home who in turn acts as the steward of their healthcare journey
    3. Doing better at explaining to patients the methods to our processes and engage them as to how this can be better
    4. Primary care needs to drive the health care system more-- become less hospital centric
    5. Primary care needs to do better at advocating for improving social supports such as living wage and low income housing.
    6. Improving and advocating for better hospice care and in-home care. Better support for looking after

dying patients at home.
7.****better utilizations of electronic health information-- seamless regional access to electronic health information. Promote and advocate for improved use of electronic health records

17. Table 17:
    1. Promoting Self-management
    2. Provide holistic perspective to the patients' health - Boots on the ground!
    3. Coordination of Care/ Assist patient with navigation of health services
    4. Provide good customer care, flexible care
    5. Most effective in influencing patient behaviour because primary care has the most contact with the patient
    6. Timely and effective primary care decreases the need for outside usage of the health care system and specialist's appointments
    7. Primary care provides leadership within the health care system because of the diversity of care we provide to a population from birth to death
    8. Primary Care is the gatekeeper of the health care system.

18. Table 18:
    1. Awareness of controlled and uncontrolled health
    2. Hub of wellness and life
    3. Primary care giver
    4. Role of patient advocate
    5. Societal connection and link to community
    6. Hub of care across the lifespan

19. Table 19:
    1. Only sector that covers entire spectrum of healthcare. Need to bring all the family physicians involved and engaged.
    2. Relationship with patients allows opportunity to empower patients
    3. Communicate and educate patients
    4. Evidence based education is required
    5. Accurate data extraction

20. Table 20: What is the distinctive contribution that primary care leadership can make?
    1. Personalized knowledge through relationship
    2. Accessibility to different resources
    3. Resource co-ordination
    4. Advocate for adjustment of resources according to the needs

Q. When we get back to our community, what will we do to lead the action needed to improve care and outcomes for patients, communities, regions, and the province?

1. Algonquin FHT will take a leadership role in the evolution of the Muskoka Heathlinks
2. Alliston will coordinate a care plan for high user groups
3. Arnprior FHT - Will work with the municipality for financial contributions to physician recruitment to provide primary care for orphan patients
4. Athens FHT : We need to meet within the coming week to discuss and determine with our team the community priorities for our patients! Focus on top 10 high user patients to determine what needs are.
5. Aurora Newmarket FHT
    a. will establish links with groups beyond the local healthcare community, especially local

politicians and community business leaders
    b. Aurora/Newmarket FHT will grow our patient population to meet increasing demand from our demographic
6. Barrie: a) develop a patient advisory council for Barrie HL, b) develop Barrie Community Care Coordination plans for Atrial Fibrillation, COPD and CHF c) develop IT supported patient communication portal
7. Brighton Quinte West: we will advocate for better housing and social supports for patients in our community
8. Burke Falls: We will commit to participating in local our Health Link development, to advocate for our rural patients living in isolated communities with little transportation to health care
9. Burlington FHT: We will meet with Halton CCAC to improve home palliative care
10. Cambridge FHT: We will drink more coffee to be more awake to provide better access (24/h Twitter access)
11. Champlain LHIN FHTs: We will harmonize our clinical data management to drive quality within our individual FHTs and across the region.
12. Chapleau: We will work to launch the Seniors Wellness Program.
13. Chatham Kent FHT/Tilbury FHT - Will advocate for better primary care representation in the development of our community healthlink initiative.
14. Cobourg - Will advocate for primary care representation with community healthlink/integration projects.
15. Cochrane FHT will invite CCAC to participate in our existing memory clinic to improve efficiency and coordination of care
16. Delhi FHT: To improve the quality of our data
17. Dorval FHT continue to develop a metric output system for primary care health
18. Dufferin FHT: We will continue to lead the Dufferin Healthlink and specifically roll out the comprehensive care health plan working with our community partners
19. East Elgin will continue to develop integrate psychiatry in the FHT
    a. East Elgin will continue to influence community leaders to enhance social determinants of health
    b. East Elgin will continue to recruit physicians successfully
    c. East Toronto: We will increase access to interprofessional team care for complex patients of traditionally solo working family physicians
20. East Wellington: we will endeavour to engage our local municipal government to better understand their role in the social healthcare needs of the community.
21. Elliott Lake: We will develop the role of patient navigation in Elliott Lake through the FHT.
22. Espanola and West Nipissing FHT's: We will continue to encourage the physician groups to work together and increase accountability to the FHT.
    a. Espanola FHT: Encourage better communication among all team members
23. Etobicoke will continue to develop Health Links to connect with partners who aren't necessarily known as partners
24. Fort Francis FHT we will mandate for future funding to be able to expand on our services
25. Four Counties FHT: we will meet with the hospital CEO and community health centre to redefine overall primary care reform within our own community.
26. Ft William will continue to co-lead the local Health Link
    a. FW will continue to develop partnerships with CCAC
27. Grandview Medical Centre FHT will engage with Cambridge Memorial Hospital emergency room leadership to determine how we can decrease the inappropriate usage of the emergency room by Grandview patients.
28. Greenstone FHT will increase community partnerships
29. Halton Hills FHT: We will establish a Healthlinks in Halton Hills
30. Halton LHIN to create a model where the primary care, therapeutic relationship is an active part through all transitions of care
31. Hamilton FHT: We will make engaging in the Health Link a priority.
32. Harrow will provide leadership for the local Health Link to change funding dynamic
33. Huntsville: We will continue to link with community services that we have not yet utilized to collaborate and remove care gaps within our community

34. Huron Shores: We will be the custodians of process for data sharing
35. ICFHT will continue to work on strong relationships with community providers (mental health, homeless, etc.) to ensure that those set up to provide coordination of care (case managers, housing workers, shelters, drop-ins) are connected with primary care and aware of needed client care activities and service needs.
36. Inner City FHT: We will act as leaders in providing care for marginalized patients and supporting other primary care providers in doing the same.
37. KDFHT,TFHT,HFHT,GNFHT,EDFHT: We will continue to work as a group of Primary Care Providers within our district. We will put patient care first and work collaboratively to deliver patient centered care across the district. We will continue to develop new programs within our district to meet the unique needs of our rural areas. We will also work towards establishing new partnerships and enhancing existing partnership towards complete comprehensive care for our patients.
38. Kingston FHT: We will continue to surface key programs areas i.e. depression initiative and take it across all family health teams through Healthlinks
39. Lakelands: We will continue to provide a leadership role in the development of the Kingston Rural Healthlink
40. Listowel will develop governance
41. London FHT: We will develop programs of shared care with our community partners i.e. post hospital discharge working with CCAC
42. London FHT: We will reduce smoking rates in our FHT & create Health Links in our region
43. Maitland valley FHT : we will aim to provide care for all in our catchment area
44. Manitowaning: We will advocate consolidate small hospital restructuring
45. Markham FHT: Advocate on behalf of Primary Care
    a. Markham will identify larger scale barriers to healthcare and work towards removing them
46. Midwest Toronto Health Link: further FHT ED's engagement to achieve outcomes
47. Mindemoya: We will continue to address the social determinants of health and continue to advocate for the development of physical infrastructure to further develop primary care partnerships
48. Minto/Mapleton & Upper Grand: we are going to implement our community outreach team
49. Mississauga: We will proactively pursue phase II of our COPD project by creating and fostering relationships with specialists, THP, CCAC, OLA, Oxygen suppliers, primary care branch of Miss. Mount Forest FHT: we will continue to lead the development of the rural wellington health link.
50. New Vision FHT: we will continue to build partnerships and work with our local hospitals to ensure patient discharges are communicated in a timely manner.
51. Niagara Medical Group FHT - We will establish a data base for community resources that will be accessible to all providers and patients and co-ordinate care between Chronic Disease Managers and Social Workers
52. Nord-Aski FHT: We will improve communication between the physicians and the community and develop a common vision
53. North York FHT we will mandate for better IT funding to provide support
    a. North York FHT: We will investigate the opportunities to access a Patient System Navigator for our team
    b. North York: we will be more inclusive of independent practitioners within our community to improve primary care
54. OMA: We will work with the Ministry to develop primary care models that help physicians provide comprehensive primary to our patients
55. Orillia: We will listen to the patient and create a patient advisory council to incorporate patient input into their healthcare
56. Parry Sound: We will build physical infrastructure to further develop primary care partnerships
57. Peterborough: we will attempt to standardize our data to ensure we have accurate measures to improve patient outcomes
58. Powasson: We will continue to build community partnerships to further the development of primary care within our catchment area
59. Prescott FHT: Will have regular meetings with allied health care providers i.e. ccac, healthcare connect to help our patients better navigate the health care system
60. Prime Care FHT: We will work with our LHIN to establish Healthlinks in our area

61. Prince Edward FHT: proposal for system navigator to prevent patients falling through the crack
62. QFHT Belleville: we will actively participate in HealthLinks, keep them on track to its original vision (to improve services to patients in the entire HealthLinks catchment area)
63. QFHT Kingston: A) we will empower our team members to provide patient-centred care one patient at a time B) we will continue to raise the profile of the importance of primary care within the wider healthcare system by being part of more external committees, partnering with more outside healthcare silos and working towards improved healthcare integration.
64. Queens Square FHT: further develop Health Links
65. Rapids FHT (Sarnia): we will continue to grow our partnership base in the community
66. Rideau Ottawa - Develop board perspective on community need and development
67. Sauble FHT will partner with the regional diabetes centre to enable the diabetes educator to provide services within the FHT
68. St. Michael's Academic Family Health Teams: we will hire a health promoter for low income individuals
    a. St. Michael's FHT: continue to integrate and coordinate precious resources by optimizing access while decreasing duplication
69. STAR (Stratford) FHT: We will provide our local Health Links leader with concrete cases where this initiative could help. We will undertake a PDSA of case management for one of our high user patients and we will encourage our other health link partners to do the same.
    a. Stratford FHT will continue to work with community and regional partnerships
70. Table 4- All: We will lead health care integration din our community through partnering with our allied health care provider organizations: CCAC< the LHIN, the local hospital
71. Timmins/South Porcupine: We will identify gaps in services and improved care pathways for our patients through the Health Links initiative.
72. Toronto Western: We will work with local ER and hospital admissions departments to obtain information to facilitate continuity of care
73. Trent Hills FHT: To improve the co-ordination of the different services in the community.
74. West Durham Family Health team - develop closer link with hospitals specifically diabetes education centre
75. Wise Elephant: We will improve electronic connections from hospital and pharmacies, ministries and specialists to serve patients in a timely and efficient manner.