afhto association of family health teams of ontario

Primary Care: The road ahead

REGIONAL GOVERNANCE WORKSHOP: ESC

NOVEMBER 7TH 2016

Objectives

I. Setting the Context

II. A Glimpse Across the LHINs: What we Know and What we Don't Know

III. What Does this All Mean: Where can FHT/NPLC Boards Focus Now?

- ✓ *Enhancing Boards Skill, Role & Knowledge*
- ✓ *Building a Culture of Quality & Patient Safety*
- ✓ *Strengthening Relationships*
- ✓ *Meaningful Measurement*
- ✓ *Taking a Population Based Approach*
- ✓ *Expanding Access to Team Based Care*

I. Setting the Context

"I'm forming a committee to create a task force to choose a team leader to assemble a board to hire the best people to determine the fastest way to deal with the problem."

Increased Focus on Governance & Quality

- **Ontario's Action Plan for Health Care** (2012): Strong focus on primary care
  - **Patients First** (2015): the next phase of Ontario's plan for changing and improving the health system
- **Quality Improvement Plan**: Required for primary care 2013/14
- **Governance & Compliance Attestation** (2014): Supporting strengthened governance practices

- Increasing *need for data and performance measurement* to support quality in primary care
- Increasing need to implement strengthened governance practices
- Increasing *role of the board in supporting quality*

Thus, Governance training for <u>quality</u> in primary care.

Development of FHT-MOHLTC Contract Templates

- New FHT-MOHLTC contract templates to come into effect April 1st 2017.
- We anticipate the consultation between Ministry the AFHTO membership will take place …..late Fall???
- AFHTO has already recommended indicators for inclusion in the contract (at the MOHLTC invitation)
- Key issues and advice identified through AFHTO's Leadership Session will be brought forward to the Ministry
- The consultation and implementation processes will be supported by close to $110,000 members voluntarily contributed to the Legal and Consulting Fund.

AFHTO's Leadership Session: Summary of what we heard

Team Accountability

- While all acknowledge that physicians are key contributors to team performance:
  - 29% of participants indicated that FHT governors should be accountable for team performance that includes physicians; whereas
  - the majority (60%) believe FHT governors should **NOT** be accountable for team performance that includes physicians

Relationships between Physicians + FHTs

- Two-thirds indicated some form of agreement between FHT and physicians should be mandatory, in the form of either:
  - A contract (36%) – be it between FHT and
    - FHT + each physician (14%)
    - FHT + FHO (9%)
    - FHT + FHO plus FHT + each physician (13%)
  - Or an MOU (31%)

AFHTO's Leadership Session: Summary of what we heard

Governance

- Three-quarters agree with adopting a **single contract template** for all FHTs, with schedules to deal with unique situations (e.g. blended salary model physicians, academic mandate, etc).

The most consistent themes identified by many tables in their discussions were:

- The need for board and ED **training** in governance, role of board, and handling conflict – especially for struggling boards
- The need for **skills-based mixed board**s
- Need to be very clear in defining **conflict of interest** and put in place processes to manage it (including many further comments about need to move to mixed boards)

AFHTO's Leadership Session: Summary of what we heard

Population Accountability

- When it comes to defining the population for which FHT governors should be accountable:
- 30% said FHTs should be accountable for the sub-LHIN population
- 61% felt FHTs should participate in subLHIN planning but accountability should remain for rostered patients.

II. A Glimpse Across the LHINs: What we Know and What we Don’t Know

What is happening across the LHINs?

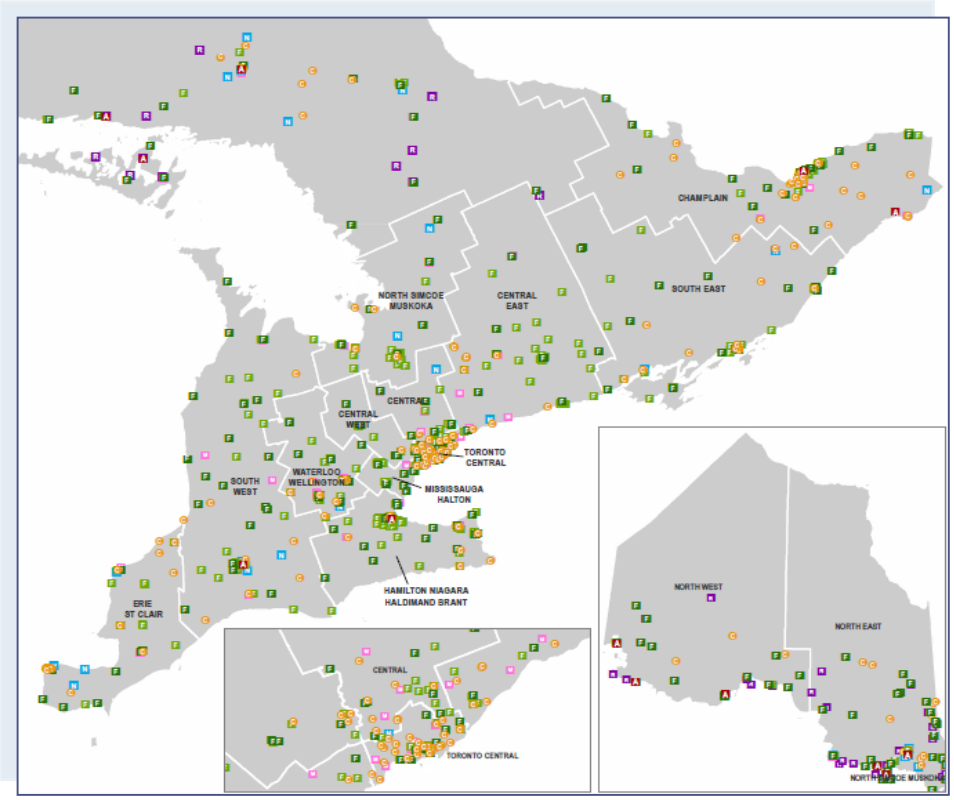
LHINs + Primary Care = the **start of a collaborative, continuous process**

- Expect LHINs to get going right away to establish subLHINs and build relationship with primary care. They don't need legislative change to move ahead with this.
- There are varying approaches to Patients First across the LHINs and varying relationships between LHINs & primary are
- FHTs / NPLCs can – and are – further developing their relationships with their LHINs, primary care colleagues and other providers to identify and respond to population health needs in the community.
- D2D 4.0 will for the first time report primary care performance at LHIN level – when sub-LHIN boundaries are known, this could be incorporated into subsequent iterations

LHIN	# of D2D 4.0 entries	# of teams in LHIN	%	# of rostered patient reported by team
Did not report	1		N/A	106,956
1-Erie St. Clair	8	11	73%	187,219
2-South West	15	20	75%	358,807
3-Waterloo Wellington	8	9	89%	163,960
4-HNHB	10	15	67%	365,365
5-Central West	0	6	0%	
6-Mississauga Halton	5	7	71%	102,495
7-Toronto Central	9	13	69%	130,993
8-Central	7	12	58%	184,552
9-Central East	8	10	80%	88,366
10.South East	11	15	73%	135,151
11-Champlain	8	19	42%	90,856
12-Nth Sim. Muskoka	3	6	50%	128,722
13-North East	19	27	70%	117,326
14-North West	3	15	20%	13,929
Grand Total	**115**	**185**	**62%**	**2,174,697**

The LHIN Challenge:

Primary care is a diverse sector with over 4,000 entities delivering primary healthcare to Ontarians.



- **738** group practice models (FHO, FHN, FHG, RNPGA, etc); **7,562** physicians
- Approx **3,000** solo practice physicians in fee for services or enhanced fee for service
- **186** family health teams
- **79** midwifery practice groups
- **73** community health centres
- **26** nurse practitioner led clinics
- **10** aboriginal health access centres
- Several specialized models.

The most advantaged?

	Waterloo Wellington	North Simcoe Muskoka	South East	North East	South West
Demographics:					
Total pop'n in LHIN	778,676	453,710 (2009)	442,800	565,000	962,539
% MDs in team-based PEMs (ICES data, hi to lo)	66%	65%	61%	57%	56%
# FHTs / NPLCs	10 / 1	6 / 3	15 / 2	27 / 6	19 / 2
# CHCs / AHACs	4 / 0	2/ 0	6 / 0	6 /3	5 / 1
# subLHINs	4	5	7	5 "hubs" / 24 PCGs	8

In the middle?

	Hamilton Niag-H-B	Erie St. Clair	North West	Champlain
Demographics:				
Total pop'n in LHIN	1,400,000+	640,000	235,046	1,230,655
% MDs in team-based PEMs (ICES data, hi to lo)	48%	44%	44%	41%
# FHTs / NPLCs	15 / 0	9 / 3	15 /2	21 / 1
# CHCs / AHACs	7 / 1	5 / 2	2 / 3	9 / 2
# subLHINs	5	8	5	8

The GTA Challenge?

	Toronto Central	Central East	Mississauga Halton	Central	Central West
Demographics:					
Total pop'n in LHIN	1,150,000	1,400,000	1,200,000	1,800,000	840,000
% MDs in team-based PEMs (ICES data, hi to lo)	37%	37%	31%	24%	21%
# FHTs / NPLCs	13 / 1	10 / 3	7 / 0	11 / 1	6 / 0
# CHCs / AHACs	17 / 0	7 / 0	1 / 0	4 / 0	2 / 0
# subLHINs	9	7	6	4	5

What Does this All Mean: Where can FHT/NPLC Leadership Focus Now?

cpsi icsp
Canadian Patient Safety Institute
Institut canadien pour la sécurité des patients

CHSRF FCRSS
CANADIAN HEALTH SERVICES RESEARCH FOUNDATION
FONDATION CANADIENNE DE LA RECHERCHE SUR LES SERVICES DE SANTÉ

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Overview of Work Shop

- Presentation
- Questions/Discussion
- Board Reflection & Assessment
  - ➢ Action Plan

What's Top of Mind for YOU?

- Given your role on the board and the evolving primary are landscape, what are your key questions, concerns or priority areas of focus?

- What do you hope to achieve from this learning session?

WHY QUALITY IS IMPORTANT FOR BOARDS

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Institute of Medicine Report 2000

44,000–89,000 patients die yearly from adverse events

Equivalent to 1 jumbo jet going down every 2 days

25–50% are preventable

Canadian Adverse Event Study 2004

Findings:

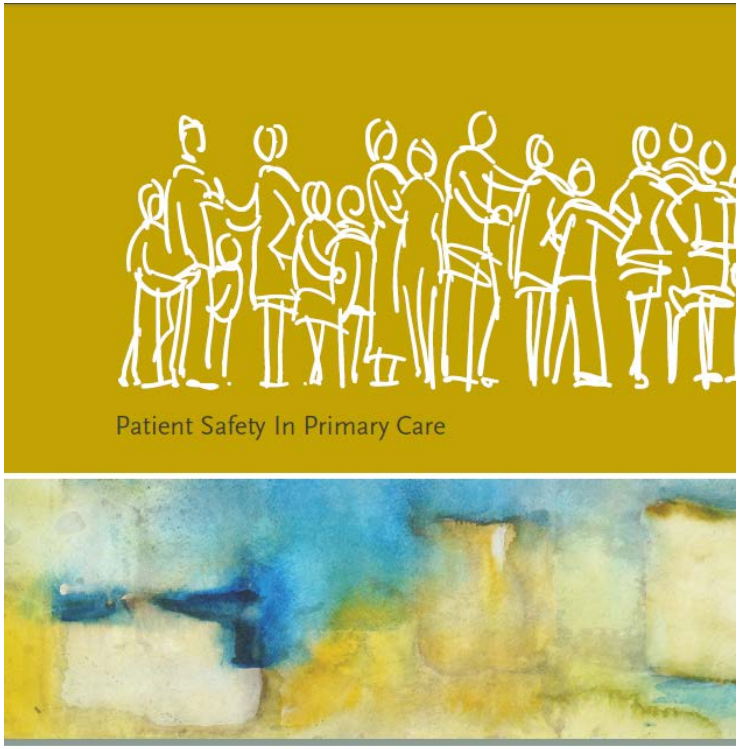
- 3,745 charts reviewed
- ~7.5% of hospital admissions involve adverse event; 37% of adverse events considered preventable

Extrapolation:

- Of ~ 2.5 million hospital admissions in Canada in 2000
  - 185,000 experienced 1 or more adverse events
  - 70,000 of the 185,000 were determined to be preventable
  - between 9,000 and 24,000 deaths due to adverse events could have been prevented

Baker, G. Ross, et al. "The Canadian Adverse Events Study: the incidence of adverse events among hospital patients in Canada." Canadian Medical Association Journal 170, no. 11 (2004): 1678-86.

Primary Care Research



- Major Themes
  - Missed – Delayed Diagnosis
  - Medication Management
- Sub-Themes
  - Communication
  - Administrative Processes
  - Knowledge & Skills of Provider

Primary Care Research

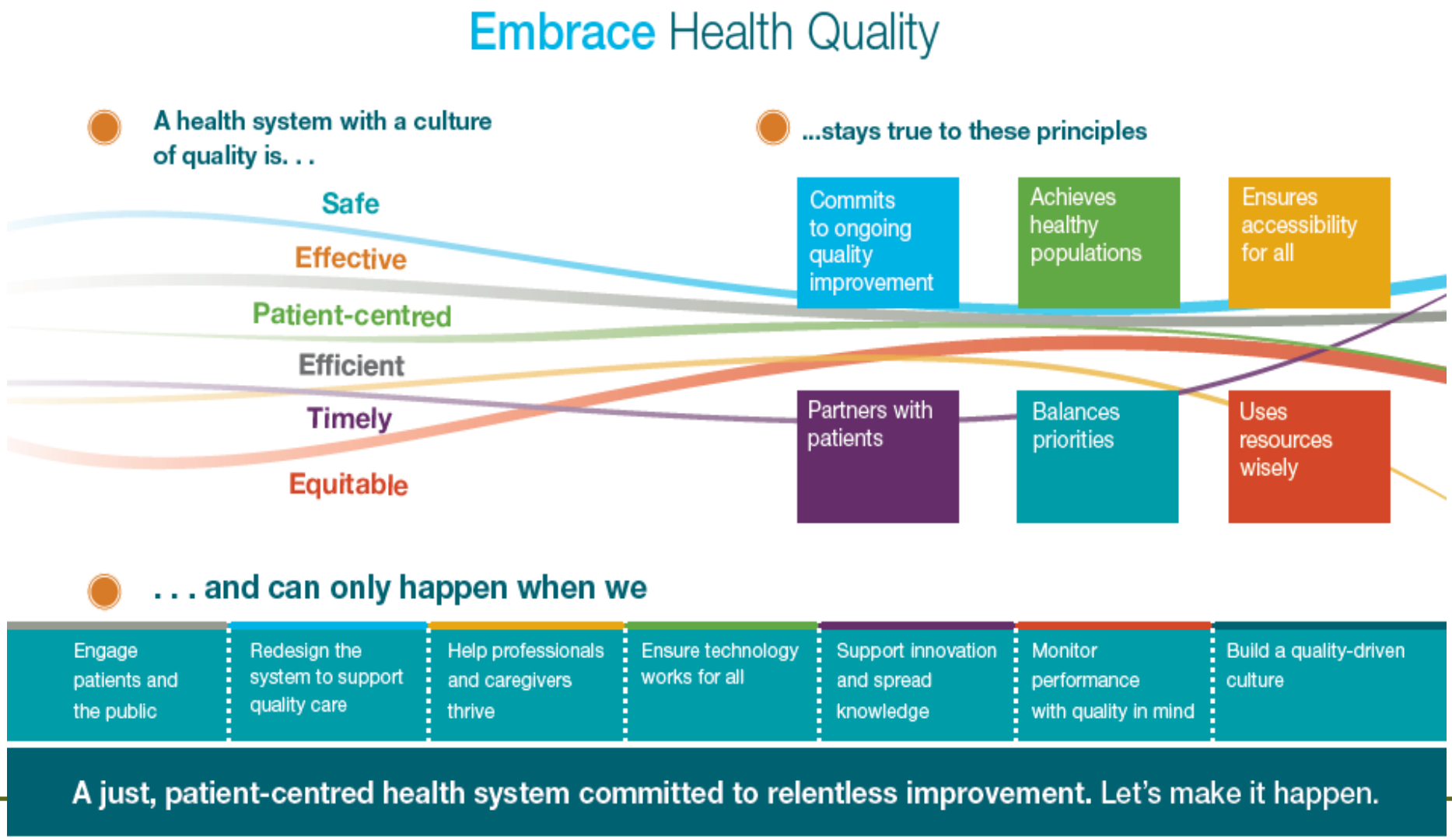
Open Access Research

BMJ open
accessible medical research

A systematic review of evidence on the links between patient experience and clinical safety and effectiveness

Cathal Doyle,[1] Laura Lennox,[1,2] Derek Bell[1,2]

Dimensions of Quality



Read our vision for achieving a quality health system
Quality Matters: Realizing Excellent Care For All

www.hqontario.ca

Ontario
Health Quality Ontario

Impediments to Board Involvement in Quality

- Large boards
- Lack of board skills, expertise & obligations
- Lingering culture of autonomy
- Lack of data
- Lack of conversation in quality
- Deference to clinical leadership
- Poor information
- Healthcare silos
- Founder syndrome (age and stage of the clinic)

The Drivers of Effective Governance for Quality and Patient Safety