Erie St Clair LHIN

Primary Care Implementation Framework Template

September 30, 2015

1.0 Executive Summary -- ERIE ST CLAIR LHIN

- *Provide an overarching summary of the LHIN`s planned implementation framework to advance primary care access and performance.*

As an ongoing focus, the Erie St. Clair Local Health Integration Network (ESC LHIN) is seeking to transition the local health care system to perform and create improved patient care results through an integrated responsive system of health care providers (HSPs). As the agency accountable for the local system, the ESC LHIN strives to create the improved health care outcomes by utilizing the following guiding specifications or performance characteristics.

- Health care related actions and planned activities based on improving individuals clinical outcomes, functional outcomes, health care cost outcomes, and the patient/family experience and satisfaction outcomes
- A single coordinated and integrated care experience for the client (one integrated care plan designed to create the above outcomes)
- Equity and guaranteed access for all residents
- The use of evidence based protocols, standing orders, checklists, unobtrusive measures and crisis plans for clients with incidences of high morbidity
- Guaranteed and timely access to appropriate diagnostics and therapeutics
- Low reliance on emergency department and acute care (days/1000 pop) in order to achieve individual desired health outcomes
- Decision-making based on evidence
- Patient-centred process vs. provider-centred decision making
- Engineered and reengineered processes aimed at efficiency, effectiveness, and economy
- A system that creates timely check-ins with its most vulnerable populations
- Efficient, safe, and effective technology use
- 24-hour access/reassurance mechanisms (telehealth/on-call systems)
- Timely access based on best practices
- A desire to move information and services to the patient and not inconveniently move the patient where possible
- Critical mass
- A heavy reliance on an academic acumen/lean and six sigma acumen
- The ongoing growth of competency (knowledge, skills, ability and attitude)
- Treating patients at the right place and optimally on the service continuum

In order to fully take advantage of this transformation opportunity, this LHIN will build on our existing knowledge and experience context as it relates to:

- A sub region/county improvement and emphasis focus
- The information gained as per the MOHLTC/LHIN ‘Stocktake’ experience
- The experience gained from understanding the patient transportation context
- Our growing understanding of the impact of social determinants of health and social deprivation index mapping
- Continual acute days/1000 population drill down analysis
- A 7-day, 21-day, and beyond readmission improvement focus
- A mental health and addictions focus
- Convalescent/long-term care (LTC) avoidance strategies learnings
- Understanding the opportunities that are available in utilizing emergency medical services (EMS)/paramedic services and competencies

- Growing our activities based largely on the work and experience that has been gained with Chatham-Kent Health Link

Framework Planning:

On an overarching strategic outlook, the ESC LHIN will focus its attention within the primary care transformation context on a county-by-county basis with an enhanced focus on the performance of sub regions and Health Links within each county. As the characteristics of the patient population and the health needs of patients differ within the geographic boundaries of the counties, the ESC LHIN will carefully analyze the localized data and rely on exiting work that has begun in Chatham-Kent with the concept of managing population based morbidity in four steps. Grounded in local tactics that identify the clientele and continually measure the results, the overarching steps are as follows (four step process):

Step 1: Manage the top 50 frequent users within a sub region over a period of 3 to 6 months

Step 2: Manage a critical mass for a systemic effect over a period of 9 to 15 months

Step 3: Manage chronic disease needs in major consumers over a period of 15 to 24 months

Step 4: Continue disease-based management

In terms of key standardized activities on a county-by-county basis:

- Identify the sub region within each county, examining and identifying the implications of the data together with data analysts, public health expertise and the EMS
- Develop an HSP providers table, providers who are stakeholders in the results of the data
- Develop data presentation and take it to HSP providers table to examine results and plan activities
- Introduce technology to crystalize the focus on vulnerable high intensity clients
- Create Stocktake-like processes to ensure momentum and hold gains
- Identify one primary care lead per sub area to champion the activities amongst local stakeholders
- Examine the health service provider footprint of each sub area and drill down to understand causal relationships and performance gaps
- Review possible governance frameworks that would formalize and ultimately operationalize the improvement
- Continue progressing along the Managing Population Based Morbidity Pyramid

Key Next Actions:

Focus on three to four key sub county regions as a start. This being the Sarnia Central Sub Link area, the Essex County South Shore sub link area, the Windsor West Sub Link area and an expansion of the work to date of the Chatham-Kent Walpole and Northern Chatham-Kent geographic region.

Develop an administrative liaison in each area as well as a physician liaison.

2.0 Recent or Ongoing Primary Care Engagement and Performance Improvement Activities

- *Provide a brief summary of recent or ongoing primary care engagement, primary care performance improvement, or other primary care initiatives that will be leveraged to advance implementation of this strategy.*

General Level Primary Care Activities:

- Primary care site visits by Physician Lead to explain/advance work
- Primary Care Council established to serve as a network to primary care organizations
- Health Links engagement and processes
- Primary care "education road show" with the LHIN, CCAC, Transform (targeted CHC, FHTs, Physicians, Other Interested Allied Health Parties)
- Completed a Primary Care Strategic Plan (three year time frame)
- Communications via ESC LHIN and Primary Care Lead and Primary Care Council
- Several topic specific education sessions and evening seminars held

Specific Local Example (Primary Care Performance Improvement):

- Chatham-Kent Health Link
- Focus on 'high users' of the health care system (metrics - ED utilization, hospital admissions/length of stay (LOS), use of community services/number of agencies involved with patient)
- Increased access to primary care for high users of the health care system using MedGPS (information sharing and patient care management system)
- Improved system accountability through care plan uptake, clearly defined 'case manager role', appropriate and timely patient flow/hand-offs
- Results included decreased inpatient bed days for high users of the health care system, better more timely access to primary care and more appropriate use of other community providers, improved overall system collaboration, better tracking and reporting on results, and increased patient satisfaction

3.0 Implementation "Snap Shot"

- *Based on the commentary in the above two sections please provide a **brief** "Snap Shot" that describes in one or two paragraphs how the LHIN will approach the implementation of this strategy.*

Based on the above sections and the innovative work completed to date, the ESC LHIN approach will begin to tackle the transformation initiative by utilizing the focused improvement techniques demonstrated through the Chatham-Kent Health Link. Through the identified four step process (described in Section 1 of this submission) for managing population-based morbidity, it is assumed that an inclusive evidence-based methodology will heighten accountability, integration and improve patient outcomes within specified geographic districts of concentration.

Specifically, the proposed scalability strategy below builds on the unique approach of the Chatham-Kent Health Links project, whereby the following steps are identified for scaling the integrated model of care for the high user population across the ESC LHIN.

1. Identify three new communities to scale the Integrated Model of Care for the High User Population. Lead agencies have been proposed as follows:
   - Essex County South Shore (Leamington area):
     - Leamington District and Memorial Hospital in close partnership with the Leamington Family Health Team
   - Sarnia Central (Petrolia area):
     - The Central Lambton Family Health Team in close partnership with Charlotte Eleanor Englehart Hospital of Bluewater Health
   - Windsor West:
     - The Hotel Dieu Grace Healthcare and Windsor/Essex CMHA (mental health teams)

   Note: It is also anticipated that the current Chatham Kent Health Link will expand in the Walpole Island region as well as scale above the current activity levels

2. Identify Key Clinical Leaders in each site, including the following:
   a) Clinician team in emergency departments
   b) Key leaders in primary care, specialist leaders (mental health) where applicable (Hotel-Dieu Grace Healthcare)

3. Share findings of the MedGPS analysis with stakeholders, building collaboration across leaders to identify care processes, transitions across agencies, communication patterns, gaps, and overlapping care approaches.

4. Secure and install MedGPS software for each of the three sites, tailor software to local clinical needs and train staff in the use of the technology to create a "portrait" analysis of the high user population in each community. Below is a brief description of the proposed MedGPS tool:

   MediaMed has developed a suite of tools such as a Global Performance Solution system (MedGPS) that incorporates sophisticated algorithms and intensive care management interventions focused on an identified "frequent user" population. These technologies are designed to mitigate economic and clinical risk of the strata of the population that has the most complex needs, and that is poorly served by current "one size fits all" primary and specialty care delivery models. In Ontario, the MedGPS system uses:
   - *A data repository built on core clinical-administrative information systems*
   - *A dynamic portrait of the clinical and financial activities of a health institution or region;*
   - *A software product that can measure and improve performance, based on Lean/Six-sigma principles; and,*
   - *A clinical perspective throughout the continuum of care.*

5. Use MedGPS data to map the current care processes across the continuum of care for the identified high user population in each community. Identify gaps and overlap in care for the first 50 high user cohort as a notional pilot study to create and refine the high user caregiving strategy. Engage consultation support to educate the primary care physician stakeholders in the project.

6. Complete process mapping of the clinical processes and design new integrated processes with MedGPS data output as a guide. With this data, engage the primary care lead in each community to design primary care leadership action teams for the high user population based on where the patient is attached to a primary care physician.

7. Construct a communication strategy and accountability framework that ensures all team members and care providers are informed, outcomes are communicated for each patient, and the model of care is personalized to the needs of each patient.

8. Construct 24/7 surveillance care for each community, engaging a technique similar to the Chatham-Kent Medavie EMS home visiting program for appropriate high need patients. Use the principles of implementation science such as proven quality practices and therapies, accountability, and access to care to lead change and create dynamic and responsive learning networks.

9. Build leadership capacity through engagement of key leaders in each community in the Executive Program in Health System Innovation to develop capacity to lead the integrated model of care innovation.

10. Develop data collection strategies in each community to build an ESC LHIN framework of outcomes measurement to reflect the regional impact of the innovation for patients and their families that captures health utilization patterns and health outcomes overtime.

11. Design and implement a regional "dashboard" for the ESC LHIN that captures key information metrics that informs decision-makers on resource allocation across the region, identifies health outcomes across the test communities and emerging trends across the high user population in Erie St. Clair.

4.0 Anticipated Sub-LHIN Regions

Clearly defining your sub-LHIN boundaries is an essential foundational step to advance this reform strategy. These boundaries will become the focal point for data provision, performance improvement activities, progress tracking and reporting in addition to broader health service integration activities.

- *Describe the boundaries of the proposed sub-LHIN regions and the approach that was taken to define these boundaries.*
- *If these boundaries are different than those defined for Health Links, provide an explanation.*
- *Provide postal codes of these boundaries to support data extraction in addition to existing maps, where available, to be included in an appendix.*

The overall population of the ESC LHIN region is 636,000 (2015) of these 63% reside in Windsor/Essex, 20% in Sarnia/Lambton and the remaining 17% in Chatham-Kent.

The sub-LHIN boundaries (at a general level) will be the same as the approved ESC LHIN Health Links Areas (N=4):

One in Sarnia-Lambton Health Link ~pop 126,000

One in Chatham-Kent Health Link ~pop 106,000

Two in Windsor-Essex (one in Essex County ~pop 193,000 and one in Greater Windsor ~pop 211,000).

The Health Links general areas were further divided by postal code into local sub regions for future planning purposes (see attached ESC LHIN Approved and Planned Health Link Areas Map). These areas will be used to delineate the "Integrated Primary Care Delivery Teams" using a population parameter of 50,000 residents or more for each designated team. More discussion will be needed at the local level to assess readiness and opportunity for launching this initiative in specific local sub regions:

- Sarnia-Lambton Health Link sub areas: Sarnia City Centre, Sarnia Central, and Lambton County Lake Huron
- Chatham-Kent Health Link sub areas: Chatham-Kent City Central, Chatham-East, Southern Chatham, Walpole and Northern Chatham Kent
- Windsor-Essex Health Link sub areas: Essex County South Shore, Tecumseh Lakeshore, Amhurstburg Lasalle, Windsor West, and Windsor East

5.0 Performance Improvement

Performance improvement is a centrepiece to this strategy. The strategy relies on a common set of performance measures, the sharing and tracking of data against these measures, and community-based performance improvement activities. The common set of performance measures being used initially are as follows:

- *Access:*
  - *Attachment to a primary care provider (key focus area)*
  - *Same day and next day access to primary care appointments*
  - Access to primary care in the evening or on a weekend
- *Integration*
  - *Primary care appointments within 7 days post-hospital discharge*
  - *Readmission to hospital with 30 days for select medical conditions*
  - Avoidable emergency department visits
- *Effectiveness*
  - *Preventative care compliance rates, including cancer screening and immunizations*
- *Patient-Centredness*
  - *Patient experience measures*

Although it is acknowledged that detailed implementation plans to improve performance will depend on data that LHINs have yet to receive and the engagement of local providers, please provide general commentary on how the LHIN will approach improvement across priority performance areas against each of the identified indicators (see Appendix B for Operational Definitions)

(i) <u>Access</u>

In addressing primary care access needs in the ESC LHIN, our vision/focus will be on the provision/development of a 24 hour/7 day per week primary care access service. To achieve this we will work toward establishing a patient-focussed on-demand primary care service (similar to the 'Uber' car service model) that would allow patients to request access to physicians (anytime) through applications for iPhone and Android devices and regular telephone. The service will utilize access software to locate an available primary care physician (pooled resource) for all requests for access anytime of the day/night. Once connected the patient will receive immediate notification/confirmation of the appointment time, method (telephone consultation or on-sight visit) physician name and location. The following steps to request the "primary care access service" could be as follows:

1) Visit the ESC LHIN Primary Care Access Service Web Page (note physicians would not work directly for the access service but would pay a percentage to get listed)
2) Click the Sign Up link. You will be asked to create an account. The primary care access service will need your name, mobile number, email, language, etc.
3) Read the terms and conditions. Make sure that you are 'OK' with the primary care access service terms and privacy policy before continuing on with the service
4) Click the Sign Up button. Your account will be created and you will be sent an email confirming the creation of the account. You're ready to start using the primary care access service.
5) Getting access to a physician - download the app. The primary care access service app is available for free. Install the app to your device and then open it
6) Sign in. Once you've downloaded the app, you will need to sign in the first time that you run it. Log in with the username and password that you signed up with.
7) To book an appointment – sign in and indicate your primary care concerns (reason for an access request), preferred location (choose from listing), time of consultation, consultation type (e.g. in person – by telephone), physician name if known
8) Once your request has been submitted/received you will obtain an immediate response/notification of your primary care appointment (when and how to access care)
9) If you don't have access to the app, you can request access by texting your request to the service and/or by directly telephoning the Primary Care Access Service Operator to set up an appointment

(ii) Integration

An important element enabling/promoting system integration will be the proposed 'bottom up' governance model/structure in the ESC LHIN consisting of a "Primary Care Governance Network" directly accountable to the LHIN Board for achieving agreed upon outcome improvements and the four "Regional Integrated Primary Care Delivery Teams" established to determine 'how' to proceed on an operational level (refer to section 12 of this submission). These structures will advance integration opportunities through the provision of:

- A strong vision for primary care and leadership
- Innovation in service delivery at the local level
- Potentially the sharing of health care resources
- Collective responsibility for identifying and planning to meet the primary care needs of patients in their community
- Multi-tiered accountabilities and responsibilities defined for the various stakeholders (e.g. local, regional, provincial)
- Clear service delivery expectations, goals and performance targets at all levels established through a bottom up process
- A defined reporting process and mechanism (primary care scorecard)
- On-going meaningful public and community input into the primary care decision-making process
- Actively engaged, knowledgeable and responsible decision-makers within the governance structure

(iii) Effectiveness

Generally, to improve effectiveness we support the focus on increasing best practice screening to meet compliance rates as outlined in Appendix B for (Breast Cancer screening, Cervical Cancer, Colorectal Cancer and for the uptake on influenza vaccination rates).

More specifically, initially our effectiveness work through strengthening primary care reform will focus on lowering 30-day readmission rates to hospital for specific populations and conditions (e.g. Aboriginal, high users and for certain medical conditions – COPD, CHF patients). To ensure consistency across the ESC LHIN sub regions, scorecards will be developed to track effectiveness in a formalized – standard manner across the Erie St. Clair region. Improvement targets will be established locally through the Regional Integrated Primary Care Delivery Teams. Knowledge transfer from this approach will spread LHIN-wide over a three-year period.

Why focus on 30-day readmissions? Evidence strongly indicates that one of the best ways for communities to reduce healthcare costs quickly and improve patient care is to implement initiatives to reduce hospital readmissions. Research studies and quality-reporting initiatives have shown that 15 to 25% of people who are discharged from the hospital will be readmitted to the hospital within 30 days or less, and that many of these readmissions are preventable. These patients certainly would not mind having fewer hospitalizations, and billions of dollars in spending on hospital stays could be saved if these hospitalizations could be avoided. In other words, reducing readmissions is a win-win for both cost and quality, without a hint of rationing. Moreover, savings can be achieved rapidly, since the principal focus is on a short-term outcome: reduced readmissions within 30 days.

(iv) *Patient-Centredness*

It is anticipated that patient-centeredness care will be a central element of the ESC LHIN primary care reform performance charter and accountability framework. This approach will replace our current physician-centered system with one that revolves around the patient. This will require that physicians practicing patient-centered care improve their patients' clinical outcomes and satisfaction rates by improving the quality of the doctor-patient relationship, while at the same time decreasing the utilization of diagnostic testing, prescriptions, hospitalizations, and referrals.

Patient-centered practitioners will be expected to focus on improving different aspects of the patient-physician interaction by employing measurable skills and behaviors. This type of care can be employed by physicians in any specialty, and it is effective across all disease types. Going forward, strategies for

promoting an active role for patients will pay attention to health literacy, shared decision-making and self-management. These interventions may include, but are not limited to:

- Written information that supplements clinical consultations
- Web sites and other electronic information sources
- Personalized computer-based information and virtual support
- Training for health care professionals in communication skills
- Coaching and question prompts for patients
- Decision aids for patients
- Self-management education programs.

6.0 Data Needs

- *Please identify any additional data needs beyond those noted in Appendix A.*

Population Information:
- Further breakdown of population to ESC LHIN sub regions
- Further information on Aboriginal and Immigrant distributions

Provider Information:
- Information on public health utilization targets (for their clinics)
- Information on walk-in clinic and solo care practitioner utilization
- Roster information by physician/delivery model
- FTE definition (e.g. number of hours per week)
- Age distribution of physicians by postal code across the Erie St. Clair region
- An assessment of cross ESC LHIN primary care utilization patterns
- Percentage of enrolled patients in primary care models (including fee for service)
- Assessment of expected outcomes by model of care

Access:
- Assessment of weekend and seven-day access (by model type)

Integration:
- Information on information flow from ED to primary care office (turn-around times)

Patient Centeredness:
- None

Effectiveness:
- None

Cost:
- Assessment of the cost effectiveness of Ontario's Primary Care Models (e.g. for blended models, inter-professional models, specialized models, and for teletriage programs).

7.0 Leadership

- *Clinical and other local leaders will be critical in the implementation of primary care reform. These leaders will drive provider engagement and collaboration at the sub-LHIN level and will be the central organizing element of each local network. Describe your approach to and criteria for identifying and engaging these leaders, as well as the expected role of these leaders.*
- *Where possible, identify likely lead individuals or organizations.*

As noted throughout this document, introducing change into the health care system can be challenging. In some cases people can be hesitant to accept change and will argue to retain the status quo. A good leader can help to make change possible even in adverse situations. Effective leaders must demonstrate many qualities depending on the task at hand. For our purposes we will consider the following criteria/attributes in our leadership selection processes, with the overall goal of facilitating change transition(s) as smooth as possible in the primary care sector:

- Inspirational

  An effective leader should motivate and enthuse followers into action. In order to inspire followers, a leader must have a vision, belief, or cause that they champion. A leader must also be able to motivate and encourage others to adopt this cause as their own. To bring others to action, a leader must first garner trust from his or her followers. The leader's followers must trust that the leader is leading them on a true and just path for change that the followers themselves want to occur. As part of building this trust, the leader's ability to communicate his or her ideas and vision effectively and clearly is crucial.

- Courageous

  Leaders must be courageous, they must be able and willing to defend their visions against both outside and internal attacks. Leaders must also have the courage to change and adapt their vision to respond to supportive ideas from others that benefit the vision or to shifts in the economic, political, or social landscape.

- Persuasive

  It helps that an effective leader be persuasive to help facilitate change. A good leader can take the information given, put it into a format that makes the change look acceptable and then convince the stakeholder population that the upcoming change is good for the system.

- Thorough

  For change to benefit the system, all of the possible outcomes must be explored. A good leader takes the time to ask as many questions as possible, and run the change ideas through every potential case scenario. By exploring all possible outcomes the work will become more results-based.

- Confident

  With change comes questions. Stakeholders may question the abilities of the leader, and there may be questions about how the change will affect the future of the community. A good leader can soothe many of those problems by remaining confident throughout the change process. When the leader stands by the change idea and offers nothing but positive words about it, that confidence helps to rally people around the change as well.

- Unwavering

  To go along with confidence, a good leader needs to stick to the guidelines of change and see it through as planned. Some change may require directions that some stakeholders do not like. But if the leader has the confidence that the changes are for the good for the system, then they must remain unwavering in their execution of those changes

- Effective Communicator

  Change can cause many stakeholders to become concerned. A leader who is a good communicator before, during, and after the change process is critical to making sure that change causes as little disruption as possible.

- Empathetic

  Finally, we believe that leaders must be empathetic; they must feel compassionate towards those who they are leading and must be able to understand their concerns. Empathetic leaders can understand the root cause behind what is driving stakeholder actions, and empathetic leaders make people feel confident and capable, inspiring them to do more than they would on their own.

We will formally engage the primary care and wider community sector(s) to select 'Lead' change management organizations. These may include but are not limited to the following: 1) primary care – FHTs, CHC's, physician champions, FHOs, and FHG's. In the 2) wider community sector – CCAC, Public Health, LTC, community agencies, EMS, hospitals, politicians, other Interested parties/individuals.

8.0 Work Plan

- *Provide a project plan which articulates your implementation approach and includes the following components:*
  - *Identification of relevant work streams and deliverables.*
  - *Planned start dates for these activities.*

The information contained in this section on our implementation approach draws heavily on the Hamilton Niagara Haldimand Brant LHIN's proposed implementation framework work plan (for standardization purposes) and our local Chatham-Kent Health Links high-end user process improvement currently underway. We are in support of a phased approach that begins with background planning, then a current and future state assessment, small tests of change/rapid improvement cycles, spread and scalability, and ongoing evaluation.

Note that the implementation strategy outlined below for the ESC LHIN could be initiated within the next month (building on current successes) and would take three years to fully implement across our Erie St. Clair region. Using a targeted approach, starting in specific areas of documented need, we could realize results in as little as four to six months of project initiation.

<u>Phase 1</u> – Planning:

- Establish Proposed Primary Care Governance Network (Terms of Reference)
- Advance a Project Charter
- Prepare a Communications Plan
- Outline a Community Engagement Strategy
- Consider Risks and Mitigation Strategy for key actions/changes
- Develop a Change Management Plan
- Primary Care Renewal Kick Off Event(s)

Phase 2 – Current State Assessment:

- Conduct a needs assessment and gap analysis
- Conduct SWOT analysis (strengths, weaknesses, opportunities, treats)
- Produce a primary care service and human resources inventory
- Map the current care processes for high end users (using technology
- Prepare a current sector utilization and capacity assessment report

Phase 3 – Future System Design:

- Build on current successes (Chatham Kent Health Link)
- Establish and engage Regional Integrated Primary Care Delivery Teams
- Advance an accountability framework for the teams to follow
- Advance new system design models for specific 'priority' primary care renewal areas
- Set new performance targets and specific measures for primary care reform in these areas
- Launch a community engagement strategy/process to get input on new design and directions
- Launch communications plan

Phase 4 – Staged Implementation and Rapid Cycle Improvements:

- Identify/confirm ESC LHIN sub regions (using the Chatham-Kent Health Link experience as a starting point)
- Assess local readiness for change
- Identify local champions (individuals/organizations) to lead local change process
- Outline expected actions, results and outcomes
- Prepare and implement accountability agreements (including identified roles and responsibilities for all involved parties)
- Implement change actions, assess results, build on success
- Continue to engage the community throughout the change process
- Initiate a bottom-up approach to resolve conflict and ambiguities and celebrate wins

Phase 5 – Spread and Scalability:

- Building on the successes of the Chatham Kent Health Link model/process continue to identify new communities for scalability/expansion
- Identify key clinical leaders in these communities to support/champion change
- Share findings, results, successes from previous projects/change sub regions (using a standard score card and reporting metrics)
- Expand software solutions to each of the new communities
- Confirm data collection and reporting expectations and methods within new communities
- Building on expansion efforts and successes, design and implement a regional primary care renewal performance dashboard for the ESC LHIN (this would support primary care decision-making allocation across the entire region)

Phase 6 - Evaluation:

- Evaluation will be built in up front in this process
- It will be on going
- Primary Care performance will be incorporated into the existing ESC LHIN accountability performance monitoring and reporting processes/framework
- Evaluation will consider outcomes as well as process measure improvements

9.0 Key Stakeholders

- *List the stakeholders that you will work with to implement primary care reform, identifying both who they are and what their role will be.*

We would undertake a broad interaction with advisors and consultants in developing our 'performance improvement charter, accountability framework' and our primary care reform implementation strategy.

At the formal/advisory level we would engage the:

- ESC LHIN Primary Care Governance Network
- ESC LHIN Primary Care Leadership Council
- ESC LHIN Quality Improvement Council
- and externally other quality committees within primary care community organizations

At the Stakeholder Engagement Level:

- Patients and families
- Primary care advisors and consultants
- Local medical societies
- College of Family Physicians
- Interested community leaders

At an Operational Level:

- Physician and clinical leaders from primary care organizations
- Management/leadership from primary care organizations (CCAC, LTC, Public Health)
- Other allied health care professionals
- Quality improvement advisors/experts
- Primary Care Decision Support Professionals (MOHLTC, Locally)

10.0 Strategic Linkages

- *Describe how the proposed approach will align with and connect to other activities within your LHIN, including:*
    - *Public health.*
    - *Home and community care.*
    - *Aboriginal service delivery.*
    - *Other*

Ideally, the new vision places primary care at the hub of the health care system, with clear expectations for all other health care programs and activities to align with this direction (e.g. acute care, community health, homecare, public health, aboriginal health care, EMS, etc.). This new approach/direction will recognize 'care coordination' as an essential element, involving deliberately organized patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care.

The main goal of care coordination is to meet patients' needs and preferences in the delivery of high-quality, high-value health care. This means that the patient's needs and preferences are known and communicated at the right time to the right people, and that this information is used to guide the delivery of safe, appropriate, and effective care.

There are two ways the ESC LHIN will achieve coordinated care under the new primary care model: 1) using broad approaches to improve health care delivery and 2) using specific care coordination activities.

Broad approaches may involve:

- Teamwork.
- Care management
- Medication management
- Health information technology
- Patient-centered home care

Specific care coordination activities may include:

- Establishing accountability and agreeing on responsibilities
- Communicating/sharing knowledge
- Helping with transitions of care
- Assessing patient needs and goals
- Creating a proactive care plan
- Monitoring and follow-up, including responding to changes in patients' needs
- Supporting patients' self-management goals
- Linking to community resources
- Working to align resources with patient and population needs

11.0 Key Risks

- *Identify the key risks associated with the proposed approach and mitigation strategies.*

There are a number of risks and challenges associated with primary care reform which provide some difficulties for implementing new models. Although the term 'health care system' is often used, in Ontario we really don't have a system. Primary care is still viewed as a program on its own. It is not connected to other parts of the health care system such as mental health services, long term care facilities, or home care programs.

Under current legislative agreements, neither funding models nor the provincial health professional regulatory framework are structurally supportive of primary care reform. Currently, funding is tied to providers rather than patients. On the regulatory side, health professions legislation is based on distinct professions with their own education requirements, practice standards and regulatory colleges. There is no common approach even in areas of overlapping scope of practice. Until a system approach is taken that integrates the constitute elements of health care, primary care reform change will likely be slow.

Key Risks and Mitigation Plans:

- <u>Lack of financial investments</u>

  The change that is being proposed in the primary care system will require some initial up-front financial investments to be successful (e.g. IT investments, project management, dedicated physician leadership, administrative and decision support, etc.). This will be crucial to getting the project underway in a timely manner and establishing quick wins and building on these successes to expand the vision.

- Resistance to change from professional associations/individuals

  Resistance to change is a common risk factor. Associations/individuals are usually set in their ways and are reluctant to accept new program changes/care models. In addition, they may remember previous failed/or limited change initiatives. One way to overcome this resistance is to scale down ambitions, meaning not try to implement everything at once. A successful strategy may involve achieving incremental, demonstrable success with small-scale, targeted change projects. This will help to build credibility in the primary care sector and facilitate the implementation of future projects.

- Being overly prescriptive in the change management approach

  Instead of trying to force change, government and community leaders/champions should create a need for it at every level of the primary care system, reinforcing the message internally and externally. All involved parties should understand why the change is necessary, because without their buy-in, the change process may not succeed. Using a bottom up approach, champions are needed at every level. These leaders, who support the change initiative and understand the operational/technical details, will help to drive the local process forward with their peers.

- Change disruption

  Operational disruptions are another risk factor of primary care system change and/or organizational change. In order to minimize this it is important to determine the right implementation pace, which will vary depending on the scope and the complexity of the project. Effective change management involves working with health care system stakeholder groups to help them understand what the change means for them, helping them make and sustain the transition and working to overcome any challenges involved.

12.0 Governance and Organization

a) *Describe your proposed governance structure for delivering on this proposal, Identify any relevant committees, advisors, and working groups, and describe the accountability structure of the project.*

b) *Describe the changes & resources required within your organization to support this work.*

c) *Describe your approach to tracking and reporting on progress in delivering on this proposal.*

a) The ESC LHIN proposed governance structure could consist of a regional “Primary Care Governance Network” that would be directly accountable to the LHIN Board for achieving agreed upon outcome improvements (e.g. focus on determining ‘what’ needs to be done – consistent with the LHIN strategic plan).

Directly under the Primary Care Network there would be four “Regional Integrated Primary Care Delivery Teams” (segment by the LHIN geography/Health Link boundaries) that would be accountable to the Primary Care Network to determine ‘how’ to proceed on an operational level to get things done that would result in the agreed upon outcome improvements. These groups would be resourced by ESC LHIN staff.

Essentially, the Primary Care Governance Network would follow a bottom-up decision making leadership process/model. This approach has been successfully implemented locally through the Chatham-Kent Health Links process.

A bottom-up leadership model has been showed to increase participation resulting in collective decision-making, leading to enhanced project ownership and successful implementation. Key objectives of this approach are to:

- Actively involve the local community to express their needs, expectations and/or planning ideas.
- Draw out ideas and generate initiatives, calling for a degree of open-mindedness and acceptance of the risks associated with innovation. This would foster dialogue between people, convergence between sectors and the exchange of knowledge.
- Build consensus, participatory decision-making can help to ensure broad and fair representation of all interest groups, thereby providing an opportunity to build consensus, manage conflict and foster new links between sectors and groups.
- Delegate decision-making powers, adopting the bottom-up approach means delegating decision-making powers from other levels of governance to the local level hence improving the spread of new ideas and implementation.

To succeed the group needs to support the following values: to respect ideas and people, to recognize the existence of diverse needs, and to introduce transparency in the distribution of tasks and in decision-making processes.

The following results can be produced from a bottom-up leadership approach:

- More clearly identified local problems and needs
- Better organization of all involved parties
- Better understanding of local decisions by the community
- Greater acceptance of local decisions by the higher authorities
- Stimulation of new ideas and projects
- Better success with implementation

b) The ESC LHIN would need some organizational changes and resources to support this work including:

- Dedicated Project Management support
- An “Administrative Lead” to oversee the work of the Primary Care Governance Network
- Dedicated staff to resource the “Regional Integrated Primary Care Delivery Teams” (e.g. a .2 FTE LHIN staff coordinator for each Delivery Team)
- Increased decision support capacity specific to this project (coding and tracking results)
- A dedicated primary care lead (either an individual or organization) one day per week
- IT support e.g. MedGPS incremental costs for each of the new sub region work

c) The ESC LHIN would track and report on progress using a score card with common measures and outcomes for each of the identified sub-LHIN regions. Improvement targets would be negotiated through the bottom-up process described in this section. The delivery teams would report to the Primary Care Governance Network on a quarterly basis.

Endorsed by	
Name	**Gary Switzer**
Position	**Erie St Clair LHIN CEO**
Signature	
Date	**October 9, 2015**