South West Primary Care Alliance

Sub-region Primary Care Approach

Background and Context

In the South West Local Health Integration network (LHIN), services are planned in partnership with other parts of the health care system and across sectors including long-term care, home and community care, mental health and addictions, acute care and primary care. A sector is a sub-set of the health care system inclusive of a group of organizations or providers that deliver similar/like care and services to shared populations.

A strong primary care sector is a cornerstone of a high performing, efficient and robust health care system. As the initial entry point to the health system for many patients and families, an integrated, sustainable and comprehensive primary care system also acts as the mechanism to ensure continuity of care throughout the system. The ability to effectively fulfill this role is dependent on primary care being integrated as a sector within itself and with other sectors and partners in the broader health care system.

Historically, primary care has been a fairly unstructured sector with few formal relationships between independent primary care providers. As a result, primary care has faced challenges in functioning as a cohesive sector working collaboratively to address common issues, challenges and barriers within sub-regions.

Input from primary care providers gathered at 5 engagement sessions held in fall 2015, 9 primary care provider forums held in fall 2016 (attended by 64 primary care providers) and 100 primary care provider surveys as part of the Primary Health Care Capacity planning work done by the South West LHIN has identified that primary care needs to be supported to coordinate itself to:

- Work together as a cohesive sector;
- Advocate for adequate resourcing of primary care as a foundation to the health care system;
- Facilitate a healthy work force; and
- Integrate better with other parts of the local health care system including acute care, primary home and community care, public health and mental health and addictions to improve patient outcomes.

By working as a cohesive sector, primary care will be able to provide advice and recommendations to the LHIN through the Sub-Region Integration Tables (SRITs) and Health System Renewal Advisory Committee being established to support Patients First. By functioning as collective, rather than independent providers, primary care will also be better positioned to identify and act on sector-specific and cross-sector issues, challenges and opportunities including, but not limited to:

- Ensuring equitable access for patients with highest need;
- Advocating for a well resourced primary care system
- Improving access to specialists both inside and outside of acute care settings; and
- Leveraging quality improvement resources to implement Evidence based care resulting in high patient care and system outcomes
- Optimize electronic medical record systems
- Provide system leadership with primary care expertise.

The sub-region primary care approach described below has been developed as an internal tool to be leveraged to more effectively enable the South West LHIN to support primary care as a foundational part of the health care system by operating as a cohesive sector. This approach was developed and supported by the South West LHIN` and was based on the input and advice of the South West LHIN Physician Leads.

Why do we need to do something different?

Primary care providers have a responsibility to the population to advocate for and impact practice and system change at local and regional levels. In order to do so, primary care must coordinate itself to function as a cohesive sector. To do this, Primary care must be resourced and enabled by the Ministry of Health. Formation of the Primary care Alliance demonstrates that commitment. Such changes are necessary in order to improve patient outcomes, support primary care providers to provide good care and to fully participate in the important health system transformation described in Patients First.

How?

It is proposed that the community of primary care providers within each sub-region come together with the guidance and support of the South West LHIN Sub-region Clinical Lead to create a core representative group of primary care providers to be known as the "Sub-region" Primary Care Alliance (PCA) (e.g. Grey Bruce Primary Care Alliance).

Each sub-region PCA will be comprised of members who represent the boarder primary care sector in the sub-region. For this reason, the number and mix of representatives may differ in each sub-region based on the unique primary care landscape in the region. The membership would include a representative of primary care provider associated with each LHIN-accountable primary care group (Nurse Practitioner Led Clinics, Aboriginal Health Access Centres, Community Health Centres and Family Health Teams (FHT) and non-LHIN funded primary care organization (Fee for Service (FFS), Family Health Organizations (FHO), Family Health Groups (FHG) and Family Health Networks (FHN).

It is an expectation that leadership from these models of primary care delivery attend however the attendance is not limited to leadership.

PCAs would be enabled to invite ad hoc members as required to support a particular topic or piece of work. For example: Civic leadership regarding housing, police, public health, EMS or library integration.

Two co-chairs will support each Sub-Region PCA:

1) The South West LHIN Sub-region Clinical Lead
2) A representative elected from the sub-region PCA by the members

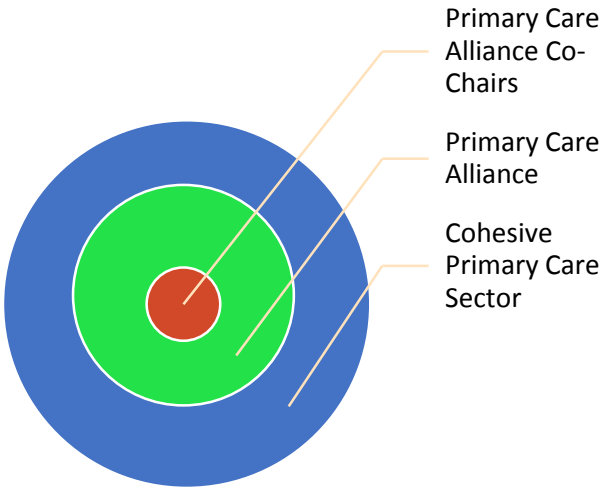
The elected co-chair will be accountable to the local primary care sector to represent their identified needs, interests and opinions. For example: The elected co-chair will be able to observe at the SRIT. Local primary care will need to determine the length of term of the co-chair and the process to elect or identify that individual.

The sub-region Clinical Lead is accountable to the LHIN to support and influence the design and implementation of the sub-region primary care strategy, to provide primary care leadership within the sub-region and to act as the liaison between the LHIN and primary care sector within the sub-region. The sub-region Clinical Lead is also responsible for:

- Information flow to and from the LHIN administration and Clinical Leadership; and
- Ensuring availability of local and LHIN-wide tools and resources to support work of the group
- Advocating for primary care within the SW LHIN Sub Region and provincially as required.

The LHIN is accountable to the primary care sector to provide a response to the issues/information elevated to them by the sub-region Clinical Lead through the Sub-region Integration Table on behalf of the sector. This accountability includes ensuring connections are made to the appropriate resources, elevating issues/information to the necessary groups and clearly communicating back to the sector why the LHIN does not intend to take action in response to certain issues/information in instances where this is the case.

Members are responsible for following-through on decisions and participating in quality improvement plans that are identified and agreed upon by the PCA.



This image is a visual representation of the relationship between the primary care sector and its PCA including the co-chairs. The co-chairs would be responsible for representing primary care at other system tables (see description below). It is intended that communication would flow freely and transparently from the whole primary care sector to the members of the PCA and vice versa. Any member of the primary care sector would be free and encouraged to bring any information, issue, concern or question to the PCA regardless of their past level of involvement or interaction with the group.

How will the Alliance interact with the Sub-region Integration Table?

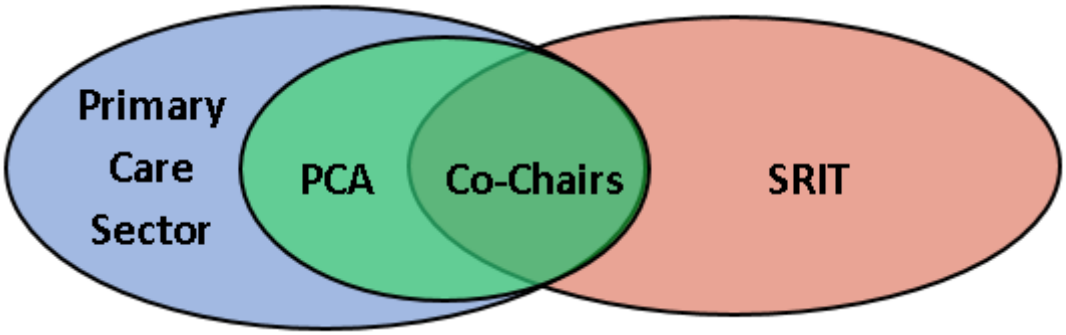
The SRIT will enable, enhance and champion collaboration between patients, providers and other system stakeholders.

This group will report to the Health System Renewal Advisory Committee (HSRAC). Terms of reference for this can be found on the SW LHIN website with this link.
www.southwestlhin.on.ca/.../sw/.../PF_TOR_HealthSystemRenewalAdvisoryCommitte...

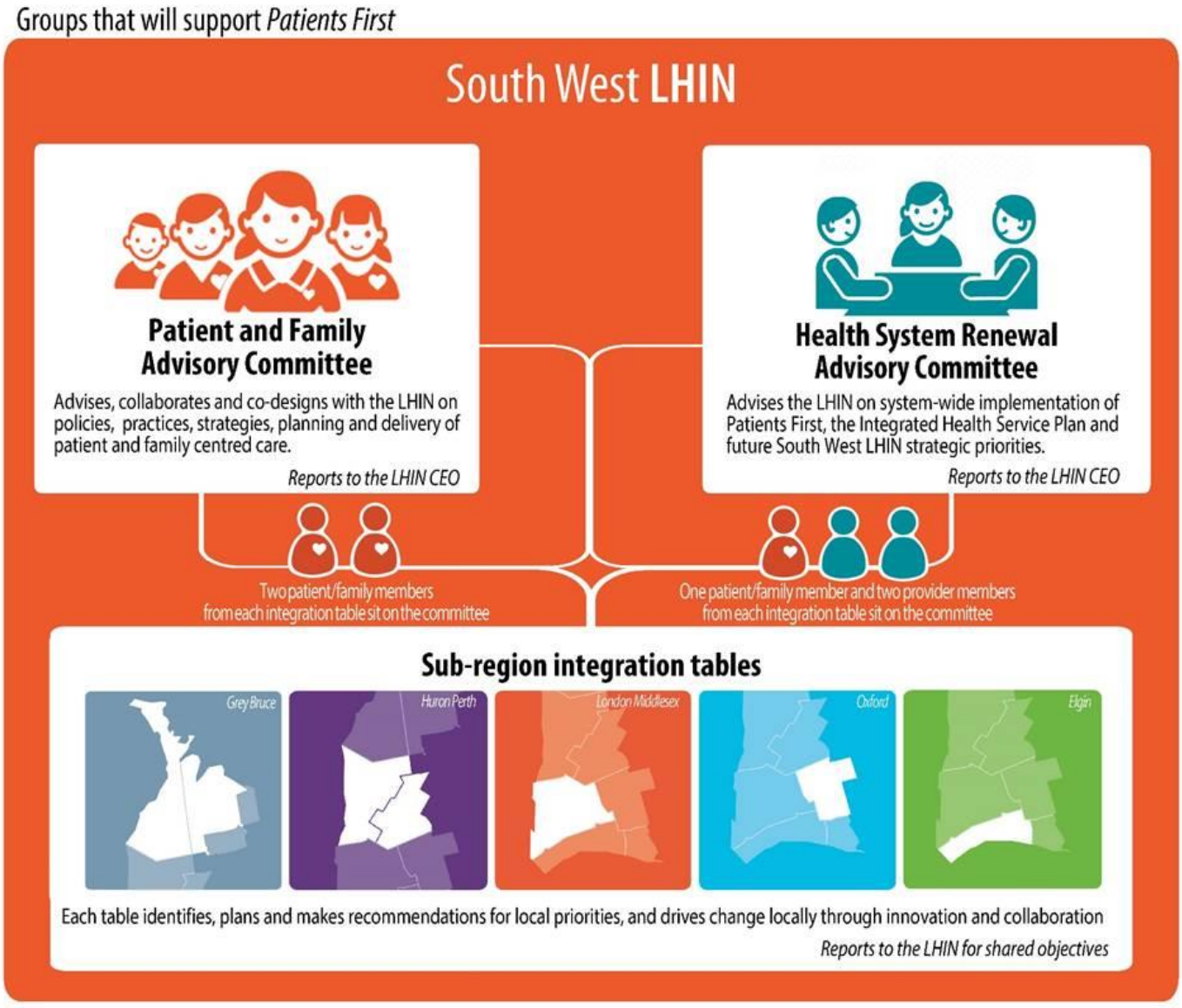
Within a specific sub region, the primary care sector will be represented with voting membership on the sub-region integration table (SRIT) by the Sub Region Clinical Lead. The elected Co-chair will also be invited to attend, as an observer. The Sub Region Lead and Sub-Region clinical lead will provide system leadership to the SRIT table and ensure that the issues/concerns of the primary care sector are brought forward to the SRIT. A strong triad will be formed with the Home and Community Care leader as they work closely together, also supported by a Health System Planner.

The role of the PCA co-chairs as primary care representatives on the SRIT is to:

- Actively contribute to achieving the overall aim of the SRIT
- Inform of and bring a primary care perspective and business case to system issues
- Work with the SRIT members to collectively improve the health care system
- Ensure the flow of information between the SRIT, the PCA and the broader primary care sector



The graphic below visually describes the relationship between the Sub-region Integration Tables, the two other tables that are being developed to support Patients First implementation and the South West LHIN.



How will the Alliance do its work? (Function and Role)

The Primary Care Alliance will be responsible to:

- Advance a culture where primary care functions as a cohesive sector
- Empower and encourage any member of the primary care sector to identify and raise issues, challenges and opportunities from within the sector to any member of the PCA including the co-chairs

- Be accountable to ensure that issues, challenges and opportunities, they are made aware of, are discussed and a best course of action is identified. For example: connecting providers in the primary care sector to a common project or issue such as opioid prescribing or palliative care delivery, escalating a cross sector issue to the SRIT such as Emergency room wait times, connecting with a neighboring PCA on a shared issues such as mental health and addictions, and leveraging the sub-region Clinical lead to raise an issue directly to the Chief Clinical Lead.
- Always have a equity and quality lens on the work done integrating the social determinants of health
- Be mindful of the need for a business case lens

- Be action oriented. Creation of an ACTION list with transparency of progress will be beneficial.
- Be accountable to follow through or indicate that they will not action something.
- Be nimble
- Act as the communication/feedback conduit for issues requiring primary care input with the use of LHIN communication resources such as the Communication team, Website, newsletters etc.
- Foster an environment of shared responsibility
- Work together to reduce duplication and increase integration of services
- Influence, inform and guide practice change

What will the Alliance do? (Actions and Deliverables)

The Primary Care Alliance will:

- Build trust and engagement among primary care providers in the community
- Be the "go to table" about primary care for all local primary care providers and other sectors or structures within the local health system
- Respond appropriately to each issue and opportunity brought forward by the sector (i.e. providing education, make connections or linkages, or action)
- Identify/confirm and address gaps in care, process and/or resources in the sub-region related to primary care
- Identify and address primary care improvement opportunities such as creating shared capacity, integrating programs and services, implementing Quality Improvement Plans, coordinating care and standardizing approaches to care
- Ensure there is follow through on issues elevated by the group to the LHIN through the Sub-Region Integration Tables
- Ensure patients within and beyond sub-regions receive coordinated care
- Define and create communication and reporting structures to share information with the primary care and other sectors
- Leverage its knowledge of the sub-region primary care landscape to provide advice and recommendations to:
    - the SRIT on primary care priorities
    - the LHIN on resource allocation, health human resource planning and local implementation of primary care related strategies
- Identify emerging/best practices for spread and scale sub-regionally and/or regionally
- Develop a shared commitment statement to indicate agreement to work towards an overall aim and priorities (future state)

How will the Alliance move to shared responsibility? (Accountability)

The mechanism to support increasing shared responsibility and clear accountability will be to:

- Initially focus on building relationships and processes
- Evolve from communication and cooperation to being jointly responsible for integrating care
- Reflect the shared commitment statement in individual Service Accountability Agreements of LHIN funded primary care organizations

- Consistently reflect the shared commitment statement in all organizations in each sub-region
- Sign a shared commitment statement to indicate agreement to work towards the overall aim and improvement plan priorities
- Mature over time to a formal accountability agreement or MOU (future state)

Individual members of the Alliance remain accountable to their own respective Boards (where applicable), and organizations, and Health Service Providers funded by the LHIN would be accountable to the LHIN, for both their own performance (sector specific) and their contributions to the shared improvement plan.

What does the Alliance need to be successful? (Enablers)

Several key enablers have been identified as important to ensure the success and sustainability of the Alliance:

Operational:

- Clear and succinct Terms of Reference including transparent procedure for electing the co-chair and replacing the co-chair in the case where the group does not feel they are adequately representing the group
- Funding for the Elected Co-chair role
- Customizing and making resources/supports equitable to all providers and patients (e.g. Quality improvement, data/decision support and admin support)
- LHIN support for:
    - the development of communications tools to support sub-region Clinical Leads to recruit co-chairs, members of the core group and inform the work of the group;
    - meeting and group administration and facilitation;
    - remuneration of co-chairs for their leadership;
    - follow through on information, issues and suggestions raised through the Sub-region Integration Tables; and
    - leadership from the Chief Clinical Lead, Sub-region Clinical Lead and Administrative Leads

Culture:

- Going at a measured pace and checking for support along the way
- Accepting that it is okay for each geography to move at its own pace – some geographies might be able to start from further along the path
- An approach that allows for sub-region variation/customization with common core elements and a common purpose (e.g. varied membership reflective of local primary care landscape)
- Owning that “change is coming” and “a culture of change is needed”

Leadership:

- Supporting leader development through leadership training and opportunities
- Transparency to the entire primary care sector to ensure priorities and actions remain primary care-led

Vision:

- Mapping out 2-3 key steps for long-term vision (see maturity model below)
- Support of the principals of a population based approach to primary care delivery
- Support of a common vision for the pillars of primary care

Accountability:

- Based on gaps, developing a local work plan and report on it to SRIT
- Mechanism for the group to hold:
    1. Elected co-chair accountable to represent the opinions of the group

2. Co chairs accountable to report on the work of the PCA to the SRIT
3. Sub region Lead accountable to advocate as needed the work to the Chief Clinical Lead and LHIN

How will primary care know that it is becoming a cohesive sector? (Sub-region primary care sector evolution)

The model below provides a structured description of the evolution of the sub-region primary care sector over time. It is intended as an internal tool for sub-region clinical and administrative leads and PCA co-chairs to use to as a reference tool to help support the development of this approach.

These are early days for a more formalized sub-region approach within primary care and as such the sector will need to evolve to fill its full function. To this end, the framework below, grounded in a maturity model, lays out the expected path the primary care sector in each sub-region will take to move from a collection of independent practitioners to a cohesive sector. The “end”, “future” or “ideal state” components translate into a high-level of maturity. Progressive steps are necessary to achieve the mature state. The descriptions of levels under the domains describe transitions from start-up state to becoming a more cohesive sector in areas such as culture/integration, quality and accountability.

At start-up, the primary care providers within a sub-region may start with a review of the model and assess themselves against the maturity scale. This understanding of current state will be important to demonstrating success and monitoring progress. As the providers begin evolving to work as a more cohesive group, they will pass through different stages of maturity in each of the 4 domains: culture/integration, quality improvement, accountability and population health. The primary care sector in each sub-region may move through the levels within each domain at different paces. Each sub-region to set goals, plan its development and track and report on progress can use the framework.

Maturity Level	Domains			
	Culture/Integration *Evolution of trust and respect initially between table members and ultimately shared responsibility across sector*	**Quality Improvement** *Evolution of quality improvement activities to move from individual quality improvement activities to shared focus and sector capacity*	**Accountability** *Evolution to shared responsibility and clear accountability to the health care system including shared accountability for performance and results*	**Population Health** *Evolution to a clear understanding and collective actions to reduce health inequities across the sub-region*
Level 5 Adaptive Responsive Integration	Integration • PC is able to work collaboratively with other sectors • Strong, defined active connection to SRIT through Sub-region PCA • A culture of regionalized planning • Respected by other sectors and recognized as a unified sector by primary care providers • Shared responsibility for outcomes is normal and embraced • Sharing of resources/capacity between providers (e.g. IHP) is occurring fluidly to improve patient care • *'Performing'*	• Best practices are implemented at scale • Minimal variation in access to primary care across sub-region • Capacity for quality improvement including patient co design is fully established • Quality or practice improvement is embedded in organizations/practices	• Shared accountability for performance and results • Shared commitment statement to indicate agreement to work towards the overall aim and priorities (QIP) • Shared responsibility for monitoring and acting on outcome measures • Sector plays a coordinated role in stewardship for the health care system	• Efficient, equitable, high quality, integrated care • Impacting health care at scale (e.g. access or attachment) • Primary care needs of the population are fully supported • One primary care group that is accountable for the care the population • Sector plays a key role in being the integrator of care across sectors based on patient needs
Level 4 Continuous learning Adoptive Collaboration	Collaboration • Functioning as a unified table: collaboration between PCPs is formalized and strong • Any PCP is comfortable bringing issues forward and knows where to connect • Confidence to bring a unified voice on issues and priorities • Ability to action cross-sector opportunities for change	• Shared (QIP) improvement plan for the sector within the sub-region in place and being implemented	• Using understanding of PC metrics to drive priorities and develop work plans • Monitor and act on shared outcome/performance measures • Providers are able to continue to oversee the care of their patients across sub-region and LHIN boundaries	• Leverage resources and leadership for population issues affecting the sub region based on sub region need. Example: Safe injection sites
Level 3 Consistent Defined Coordination	Coordination • Primary care providers are engaged and highly participative • Primary care providers feel safe to raise issues and trust that they will be followed through	• Being able to proactively identify shared QI opportunities • Effectively resourced to drive Quality improvement • Aligned with Regional Quality Table priorities and acting on them – Cross sector QIP metrics are influenced	• Follow through on decisions made • A documented work plan • Routinely monitor relevant PC system metrics • Report on progress of sector work plan to SRIT and the LHIN	• Sector is able to leverage their own data to drive improvements in the health of the patients in their sub-region • Data sharing between providers within the Sub Region to advance care delivery
Level 2 Developing Exploring Evolving Cooperation	Cooperation • Clinical leads have contact info for all PCPs in their geography and have had contact with each one at least once • Establish communication processes between Alliance and broader sector • Build shared understanding of how table will evolve	• Able to work together to design and act on a QI opportunity • Effectively leverage QI resources across models of care and within the LHIN to act on QI opportunities and to foster EMR maturity	• Established decision making process • Making decisions together • Understanding PC system measures and how to impact them • Identifying meaningful measures for Primary Care from those identified priorities within HQO and the LHIN and agreeing on which indicators to prioritize • General agreement that access is an issue	• Individual providers are able to leverage their EMR for roster specific metrics
Level 1 Baseline Startup Contact/ Communication	Contact/communication • A small core group (coalition of the willing) joins sub-region clinical lead on a shared issue • Focus on building relationships between members – new relationships needed for success are being forged • Shared understanding of how Sub-region Alliance will evolve • '*Forming*'	• Knowledge/information sharing around current Quality Improvement Plans, local quality improvement initiatives and provider capacity (Awareness) • Awareness and understanding of available QI resources	• Just showing up • Learning about the SW LHIN structure and operations • Learning about the HOW and WHERE of decisions in the system • Focus on building relationships and processes • Communication and cooperation • Awareness of PC system measures	• Providers are familiar with existing information/data related to regional population health (i.e. Primary Health Care Capacity, Partnering for Quality, Health Links, Public Health data etc.) • Data priorities are provided to the sector from the SW LHIN