North Simcoe Muskoka LHIN Primary Care Provider Consultation re: *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*

1.0 Engagement Strategy

1.1 Engagement Sessions

Primary care providers were engaged via sub-LHIN specific engagement sessions held over the period of January 19th to February 17th, 2016. Invited participants included primary care physicians, nurse practitioners, and primary care front-line staff including Integrated Health Professionals, as well as representation from the CCAC, Public Health, Health Force Ontario, Ontario College of Family Physicians, and administration of local FHTs, FHOs, and CHCs.

Six sessions were held over the 4-week period, including a webinar for interdisciplinary health providers and other front-line staff who were unable to attend the evening geographic sessions. The engagements were conducted as open, generative discussions using the questions included in the *Patients First Discussion Paper* as a guide and facilitated by positive inquiry. Participants were also provided with notepaper and were encouraged to record their comments in the event that they were uncomfortable articulating their views to the group. All sessions were facilitated by the NSM LHIN's Physician Lead for Clinical Planning and System Integration.

A total of 133 participants were in attendance across the 6 sessions.

1.2 Online Survey

In addition to feedback provided at the in-person sessions and the webinar, primary care providers had the opportunity to provide input through an online survey targeted towards health service providers. Input collected via the survey has been used to supplement the information collected through the engagement sessions, as applicable.

2.0 Results – Key Themes

The engagement questions provided by the Ministry were used as a basis for the discussion, however participants were free to comment on other areas relevant to system reform. Given that many of those in attendance had strong views on the subject, the discussion did stray from the 21 prescribed questions. The following 10 themes reflect the most salient issues and concerns brought forward by those who participated in the consultation. When appropriate, excerpts from participants' written feedback and/or survey submissions are included to further illustrate their perspectives.

2.1 Data and performance metrics

Comments from primary care providers indicate that data is a key area of concern, as it relates to collection, applicability, accountability, and information sharing.

Several participants identified the need for greater rigor, in terms of both indicator development and data collection. Along with the need for improved data quality, participants' comments suggest that there is a need for dedicated resources to support data entry and extraction.

> *"Need to collect data in a more rigorous / scientific way."*
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> *"Public performance publishing – need +++ confidence in accuracy of the metric."*
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> *"Data needs to be robust if it is going to be reported at a provider level. Public reputation is a concern for physicians."*
>
> *"Measurements for MOHLTC/HQO daily stats should be electronically extrapolated, easily and by IT staff. In an NPLC model, the NP or admin staff (with very little IT knowledge) have to do this work."*

The importance of clinically relevant indicators was noted by a number of participants, as was the need to identify measures that are within providers' control. Specific concerns were noted regarding existing access metrics, which were considered to be subjective and poorly defined. Participants identified the need for clinician input into the development of quality indicators and several specific suggestions were made. It was also noted that quality indicators should be provincially defined, rather than being left to the discretion of individual LHINs or sub-LHIN areas.

> *"What are essential clinically relevant QI measures of [family physician] quality?"*
>
> *"We fear being 'accountable' (i.e., financially on the hook) for measures and outcomes beyond our control."*
>
> *"The access data is too vague and subjective and poor in quality to be useful."*

> *"Ideally I would see public reporting showing access rates (access to the team of which the physician is a part of not just to the doctor), patient reported outcome measures and preventative care screening rates."*

> *"Find clinically relevant sentinel quality indicators that are incidence based – but these should be provincial, not left to each sub-LHIN to define."*

The following commentary related to performance and accountability has been provided by the NSM LHIN's Physician Lead for Clinical Planning and System Integration:

> *It was heard throughout the LHIN that providers want to be held accountable for their performance, and that they recognize that their performance and practices impact the system as a whole. There was concern from providers regarding being held accountable for system performance. As leaders within the Health care system, we will need to determine how best to reflect back to providers their impact upon the system without holding them individually accountable for the performance of a system, particularly while that system is in development.*

Concerns regarding privacy and data sharing were also cited by a number of participants. It was noted that a centralized privacy framework and common interpretation of the legislation would be required to increase provider comfort and support sharing between providers and across sectors.

> *"Opportunity for LHINs to mandate and provide regional privacy and IT resources…"*

> *"Sharing of info is a political issue. LHIN can take an active role in data sharing agreements."*

> *"LHINs should identify the gaps and then communicate that throughout. Where fixing the gaps requires data sharing among organizations, the LHINs or MOH should facilitate that."*

> *"LHIN should play a role in creating a data sharing protocol between [primary care] and public health."*

2.2 Access – Meaningful attachment, provider workload, current definition of patient access

Access was a key theme reflected across the engagement sessions, as it relates to meaningful patient attachment, provider workload, and the current definition of patient access. There were also comments pertaining to access that cut across several themes, specifically concerns regarding data quality, unintended consequences of the focus on in-office access, and patient accountability. These have been noted separately in sections 2.1, 2.3, and 2.4 respectively.

Several participants identified concerns related to meaningful attachment for patients who have primary care providers outside the region and their ability to affect access for these patients.

> *"I am concerned many patients in my area have MD in Toronto. I can't affect their access."*

> *"…[data] suggests that a large number of 'attached' patients are attached to doctors outside the LHIN. We need to break down access numbers by distance from their doctor."*

Participants' comments reflect concerns about primary care provider workload as it relates to the expectation to improve access. It was also noted that current practices by certain specialty groups have increased the workload in primary care.

> *"How do family MDs working 50 hours per week on 6 call schedules…how do we improve access?"*

> *"Downloading from surgeons to GP for the post-op items (i.e., suture removal)."*

As noted in 2.1, there were specific concerns about the quality of existing data. Comments suggest there is a need for new provincial standards to define access and that these definitions should be informed by clinical input. There were specific suggestions to broaden the definition of patient access to capture visits with nursing and/or interdisciplinary health providers, as well as including novel forms of access such as phone calls or electronic communication.

> *"Provincial standards to define access - defined by clinical need."*

> *"Ideally I would see public reporting showing access rates (access to the team of which the physician is a part of not just to the doctor)…"*

> *"LHIN or MOH needs to 'count' all forms of access, including phone calls, email, fax."*

2.3 Unintended Consequences – Focus on in-office access, misaligned incentives

Some participants cited unintended consequences related to the increased focus on in-office access. Concerns were identified in relation to how after-hours service requirements will impact FP capacity to provide comprehensive services such as palliative care, low risk obstetrics, and house calls, as well as ED coverage and inpatient hospital care. There were also comments reflecting the tension between improving access and the provision of high quality care.

> *"Will GPs who do inpatient care be supported? Will there be incentives to continue this work? (i.e., less after-hours requirements since we are already on call at [the] hospital."*

> *"Need to be careful about what metrics we are chasing. Will we lose "good" care? Will we lose comprehensive care?"*

Participants also expressed concerns related to the ED Pay-for-Results program having the unintended effect of increasing ED utilization for less urgent and non-urgent conditions (CTAS IV and V) that could be seen in primary care settings.

"Need to re-educate patients about ER as we have created a 'fast food' expectation [and] increased demand."

2.4 Patient accountability and education

There were a number of comments regarding patient accountability, in particular in relation to patient expectations about same day/ next day and after-hours access. It was noted that there is a need for patient education on the most appropriate point of access and prudent use of health care system resources.

"Where is the patient accountability? Will the government / LHIN provide greater education on better use of health resources?"

"Patients need to know what their accountability is in the equation."

"Patients are driving access habits and expectations."

"[I] echo sentiments about need to educate public re: 'need' vs 'want' access."

Comments regarding patient expectations for timely access also intersect with concerns about the definition and quality of the access data.

"Any differentiation in access data between patients who needed quick access and those who did not?"

2.5 Governance – Clinical representation, consistency, consolidation

Input regarding system governance was limited, however a several participants noted the importance of clinical representation on LHIN and/or sub-LHIN Boards of Directors. There were also concerns raised about ensuring consistency in the quality of governance across LHINs and sub-LHINs and the need for consolidation in governance structures.

"Physician leadership is needed on skills based boards of sub-LHINs."

"How to ensure consistency of quality of Boards of LHINs and sub-LHINs?"

"[There is a need for] training and consolidation - we have too many boards which is diluting the effective governors in our region."

The NSM LHIN's Physician Lead for Clinical Planning and System Integration has provided the following reflection on system governance:

Through primary care engagements very few comments were directed at system governance. This may reflect the fact that governance is a very particular skill set which we should mindfully develop across our LHIN. Additionally, it may reflect that providers who were in

attendance at the engagement sessions had underlying assumptions regarding the proposed structure and governance that were outlined in the Price Report and in the NSM LHIN Primary Care Implementation Framework.

2.6 Accountability – Accountability without authority, physician self-regulation

There were a number of comments noting the incongruity between proposed LHIN accountability for primary care planning and performance management and the Ministry of Health and Long Term Care's continuing management of primary care contracts. Specifically, participants identified concerns regarding the LHIN's ability to enforce accountability among primary care physicians without the appropriate levers.

"How can the LHIN make all the providers accountable when the FHT does not answer to the LHIN?"

"Will LHINs have authority to enforce accountability?"

"LHINs need to have financial decision making power - governance/accountability without effective control of finances is of little value."

"If LHINs are being given the responsibility to plan and monitor the performance of all health services, then FHT funding needs to come under the LHINs and the LHINs need tripartite involvement in the PEM contracts. While physician payment may be retained and negotiated with the MOH, the LHINs cannot remain ignorant to the content of the contracts."

Related to this were comments around self-regulation and the role it plays in physician accountability. Physician comments reflected concerns about what is driving the need to improve accountability in primary care, whether this indicates a failure of professional self-regulation, and if there is a need to strengthen self-regulation to maintain autonomy.

"I agree with increased provider accountability but need to remain independent practitioners."

The NSM LHIN's Physician Lead for Clinical Planning and System Integration has provided the following commentary related to physician self-regulation:

There was feedback received throughout the LHIN in engagement sessions regarding physician self-regulation. Physicians are trained within the culture, and credentialed in a college, that reinforces the importance of self-regulation. Therefore, physicians respond well to and are motivated to improve performance based upon the feedback of other physicians as opposed to feeling managed by feedback and reflections that are provided by other professionals. This reinforces the need for clinical leadership that is outlined within the discussion paper. Those leaders will need to have training in quality improvement skills in addition to other leadership skill sets.

2.7 OMA Ministry relations

There were a number of comments from physicians that reflected concerns regarding primary care reform in the absence of a Physician Services Agreement. Attendance at LHIN-led engagement sessions was variable across the region and there was some suggestion that participation may reflect the sentiments of some physicians in this regard.

> *"Must have a physician services agreement in place to engage the MDs."*
>
> *"I would like to echo [other] comments that until an OMA agreement is in place that primary care reform is futile. I think the lack of attendance at consultation meetings reflects this sentiment. Many feel that the rush for consultation by the Ministry is a tactic to get the process moving yet giving them the option to say 'well we did talk to the docs'. It just feels like they are pushing through with their agenda regardless of our opinion. That is the feedback that I would like to give to the Ministry."*

2.8 Integration – Communication and electronic information sharing

Comments reflected the importance of greater integration, as it relates to communication and more specifically, electronic information sharing. Participants identified the need for either a single EMR or interoperability between EMRs and it was noted that provincial leadership would be required to resource and scale such a project.

> *"I want to communicate more easily with all providers – need common EMR."*
>
> *"[Need] EMRs that talk to each other."*
>
> *"Cross platform communication among EMRs will need to be resourced and managed. A large change project ideally performed at the provincial or at least LHIN level."*
>
> *"Continue with increasing IT funding and integrations – seamless integration between all partnering groups."*
>
> *"We need provincial leadership to integrate health records."*

There was reference to the need for greater integration between primary care and a number of specific sectors, including the CCAC, Public Health, and local Emergency Departments and Urgent Care Centres.

> *"Family MDs certainly need more integration (communication) with CCAC, public health and the ER."*
>
> *"Public Health – it would help if there was some automatic way to share immunization data."*

"There needs to be better communication between services and primary care providers (e.g., I don't often know what CCAC has been offered for a patient, or why services have been refused or discontinued."

2.9 Navigation, case coordination, case management

Participant comments reflected the importance of optimizing system navigation, case coordination and case management functions for primary care. Some participants suggested embedding such services directly into primary care offices. Others identified a need for more general navigation tools, such as an online searchable database of existing local services.

"Integrating home care into primary care - case management should include a component of system navigation so that physicians can reach out to that person for help in finding services."

"As the complexity of the patient increases, the size of the team of system navigators will need to increase - no single clinician can have complete understanding of other sectors - resources, [personnel], etc."

"Providing a clear "road map" from a SINGLE source on a website for easy access that can be updated or current with resources available & contact information to refer to service."

"[Need] good, reliable information. There are so many programs and forms for primary care that it is impossible to stay on top. A searchable database may be helpful."

Participants referenced pay equity between CCAC and primary care staff as a barrier or risk of integrating case coordination into primary care. It was suggested that these issues be resolved before attempting to integrate these functions into primary care practices.

"Case coordination should be housed within primary care and the only fair way to do that is to ensure pay equity is dealt with."

2.10 Inequity

There were a number of comments that reflect perceptions of inequities in the current system. A sub-set of these comments pertained to resourcing within NSM's 5 sub-LHIN geographies and the need to ensure equitable distribution and sharing of resources. Others were in reference to the current alignment of Interprofessional teams with only certain primary care models and the challenges this poses in ensuring access to these services for all local patients.

"What about 'over resourced' sub-LHINs – will the 'sharing' of resources extend beyond these boundaries?"

"How will all Ontarians be able to access Interprofessional services given that many models of care presently don't offer this?"

"[Need for] allied health sharing?"

"What is essential primary care team for equity of access to IHPs [interprofessional health providers]?"

It was also noted that the social determinants of health significantly impact patient access to and utilization of services; this was cited as a challenge in relation to both housing and transportation.

"Equity – bringing care to the patient. We lack a transportation system. Patient can't always come to us."

"Transportation and housing have huge impact on access to care and utilization of services."

There were also a number of comments related to the current LHIN boundaries and their impact on patient care. Some participants indicated that changes in boundaries were not necessary, but stressed that geographic boundaries should not translate into clinical issues that are evident at the patient level. Other comments suggest that cross-LHIN efforts may be required in the Collingwood area and that boundaries in Barrie and Muskoka may need to change to better reflect current service utilization.

"No - not necessary, but boundaries should not impact care delivery nor integration."

"Review LHIN boundaries (e.g., Alliston usually sends to RVH)."

"*Northern boundary [in Muskoka] needs adjustment*."

The NSM LHIN's Physician Lead for Clinical Planning and System Integration has provided the following commentary regarding patient equity, as it relates to LHIN boundaries:

It was clearly heard in three of our sub-LHIN regions that LHIN boundaries create barriers to care. In Collingwood, the sentiment was that LHIN borders should not change but work should be done across boundaries with all agencies to ensure that those boundaries are not barriers to care. In Barrie and in Muskoka there was a perception that boundaries are not aligned with patient referral or access patterns. In both those regions there was a request to use population data to create more informed and representative boundaries.

3.0 Conclusion

Through primary care consultation in North Simcoe Muskoka we have identified 10 key themes that reflect the issues and concerns most relevant to the physicians and other primary care providers who attended engagement sessions. Although the consultation questions provided by the MOHLTC were used to guide the discussion at each of the sessions, participants' comments did depart quite significantly from the prescribed questions. Data from an online health care provider survey has been used to supplement the findings of the consultations, as applicable. This report has been submitted to the Ministry of Health and Long-Term Care along with the raw (unanalyzed) survey data as part of the NSM LHIN's overall response.