Building Integrated Health Networks of Care Communities:

Strengthening Access, Performance and Accountability of Primary Health Care within the Central West LHIN

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Introduction

Background

Primary care is the entry point to the health care system for most Ontarians. Primary care providers carry out assessment and treatment as well as referral to secondary and tertiary care and community supports. How primary care performs can often have a cascading impact on other parts of the health care system. In fact, evidence shows that jurisdictions that have a strong foundation of primary care also have better health equity and overall better health system performance.

Although reform efforts within Ontario's primary care sector over the past decade have yielded several benefits, there is a clear body of emerging evidence showing that Ontario`s performance in this sector lags behind our international comparators. In particular, Ontario ranks lower than others in areas of performance that matter most to patients, including timely access. This is being seen despite advances in the supply of providers, the introduction of new payment models, the expansion of interprofessional teams, and increases in per capita investments. Given the importance of the primary care sector to patients and to our overall health system transformation objectives, there is a clear imperative for reform.

Patients First: A Strategy to Improve Access, Performance and Accountability in Ontario`s Primary Care Sector

Ontario`s *Patients First Action Plan for Health Care (2015)* commits to bring forward a plan "to ensure that primary care providers [including both physicians and other primary care providers] are organized around the needs of our population, such as those in northern, rural and fast-growing communities, focusing on greater accountability and access for individuals and families." Fulfilling this commitment will be a key priority for the ministry and health sector moving forward, in conjunction with other priorities such as home and community care reform and integrated care.

This priority will be addressed through a multi-year collaborative reform strategy to be implemented by the ministry and Local Health Integration Networks (LHINs) with the goal of improving access, accountability and performance. Most importantly, this strategy will work to achieve the government's goal of ensuring a primary care provider for every Ontarian that wants one. The strategy has many features, but its core is to provide LHINs with the mandate and tools to improve how Ontario's primary care sector performs for patients and how it functions as part of the broader health care system.

Beyond this core element, the other components of the strategy include: (i) developing and implementing a common set of performance measures that are tracked and reported on regularly; (ii) identifying sub-LHIN regions to be the focal point for planning, performance improvement and integration activities; (iii) assigning 'primary care leads' to support LHINs in their performance improvement, planning and integration activities, and; (iv) reforming current contracts and provincial access programs, such as Telehealth Ontario and Health Care Connect (HCC).

Following discussions with LHINs and health care providers, the approach to implementation will balance the need for provincial standardization and local flexibility. The ministry, in collaboration with LHINs, will identify 'what' we are trying to achieve, while the LHINs and local providers will determine the 'how'.

The standardized elements of the approach include a common primary care performance measurement framework and an approach to performance improvement that focuses on sub-LHIN regions supported through a primary care lead. Local flexibility can be applied in several areas, including the implementation of specific initiatives that will improve performance against a common set of indicators, how sub-LHIN regions are identified, and approaches to defining primary care lead roles. These are discussed in greater detail below.

Key Components of the Strategy

(i) Common Performance Indicators

Health Quality Ontario (HQO) has led a multi-year exercise with key stakeholders to develop a set of indicators for measuring and reporting on primary care performance. Based on this work, the ministry has identified a subset of indicators that will be used initially to guide performance improvement activities in the priority areas of Access, Integration, Effectiveness, and Patient-Centredness. These priority performance indicators are as follows (see Appendix B for operational definitions):

- Access:
  - Attachment to a primary care provider
  - 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

LHINs will be aided in this work through the provision of baseline data at the LHIN-level, sub-LHIN level and provider-level, as feasible (see Appendix A for a summary of the data that will be provided).

(ii) Sub-LHIN Regions

Based on research into care and referral patterns, we know that populations tend to be treated within specific geographic regions. These regions are smaller than a LHIN, with there being typically 5-10 per LHIN. As such, the strategy aims to build on the Health Link model by focusing on integrating care within regions at the sub-LHIN level. Sub-LHIN regions,

identified by LHINs, will be the focal point for all data provided and for performance improvement initiatives and tracking. While the initial focus of these sub-LHIN regions will be primary care performance improvement, they will also serve as a platform for further health service integration activities, including home and community care.

(iii) Primary Care Leads

The ability to improve performance and advance integration activities requires effective clinical engagement. Clinical engagement in the primary care reform strategy will take form through a 'Primary Care Lead'. The role of a Primary Care Lead will be to support LHINs by working with primary care and other providers within the sub-LHIN region to advance performance improvement initiatives. The Primary Care Lead should be a clinician or clinical organization with sufficient peer recognition and respect that can help to advance the improvement activities that are required. LHINs will have flexibility to identify the Lead that best supports this work based on the performance improvements that are required, the composition of primary care in the sub-LHIN area, and the existing peer networks and relationships that exist.

Examples of Primary Care Leads could include an individual clinician such as a Primary Care Physician LHIN Lead, a primary care organization such as a Family Health Team or Community Health Centre, or a local hospital.

(iv) Contract, Funding and Program Reform

Although strengthening the role of LHINs vis-a-vis the primary care sector is the main component of this reform strategy, the ministry currently retains responsibility for the administration of many contracts, funding, and primary care programs. The reform strategy also includes a commitment to work with key partners to modernize these contracts and programs and to align them with the performance improvement activities led by LHINs. Contract modernization will include amendments to provider agreements to enable quality improvement, while program modernization will enhance Telehealth Ontario and Health Care Connect by leveraging new technologies (e.g. mobile) to give patients greater flexibility in using these services.

About the Implementation Framework Template

At this preliminary stage of implementation, LHINs are being asked to detail your approach to implement this commitment through the attached template. The template is based on discussions among LHIN and ministry leadership and is adapted from preliminary work undertaken by the Hamilton Niagara Haldimand Brant (HNHB) LHIN. It asks LHINs to provide a range of details that will support further joint implementation planning. This includes:

(i) The identification of sub-LHIN regions that will be the focal point for primary care planning and performance improvement;

(ii) Description of planned approaches to improve performance against key performance measures, including attachment and timely access to primary care;

(iii) Approaches to clinical leadership to facilitate performance improvement, including the type of lead, their roles and how the LHIN would work with them to advance the goals of the strategy.

An essential feature of implementing the primary care strategy will be the ability to receive, evaluate and deploy evidence. To this end, the template also identifies the data LHINs can expect from the ministry (related to the LHIN's population, composition of primary care, and primary care performance) once sub-LHIN regions have been identified. The template also provides LHINs with the opportunity to identify further data needs.

The efforts of LHINs to populate this template will be instrumental to inform further implementation planning and eventually advance initiatives to improve Ontario's primary care sector and put patients first.

Support for LHINs

LHINs have already demonstrated leadership in primary health care planning and have developed much of the necessary expertise to lead primary care performance improvement efforts. However, it is recognized that LHINs will need data to support their work and that other forms of assistance may also be required as early implementation activities get underway.

The Primary Health Care Branch of the ministry currently manages approximately 1,700 contracts with primary care providers and through this role has acquired a significant body of knowledge on primary care performance, funding and accountability. This includes an intimate understanding and knowledge of various primary care contracts and provincial access programs such as Family Health Teams, Nurse Practitioner Led Clinics, Aboriginal Health Access Centres, Telehealth Ontario, Health Care Connect, Midwifery, specialized northern programs, and various physician payment models. Because of this, the Primary Health Care Branch of the ministry is well-positioned to provide assistance to LHINs as they carry out activities to implement the primary care strategy.

Each LHIN will have an identified contact within the Primary Health Care Branch whose role will be to answer any questions and share information about primary care with you and your staff. This individual will liaise with other parts of the branch and the ministry to provide you with the information you need and serve as a resource to assist in the development of this proposal. Your LHIN's contact person is:

Barbara Ouzunoff
Senior Program Consultant
Email: barbara.ouzunoff@ontario.ca
Phone: 416-326-7033

Once completed, please submit your proposal to Phil.Graham@ontario.ca, no later than Friday October 9, 2015.

1.0 Executive Summary

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

The Central West LHIN framework to advance primary care renewal and performance proposes a strategy that that is built on and informed by consecutive waves of evolutionary change in this sector, while being flexible to strategically align with other transformative change initiatives such as home and community care renewal. Within and across Health Link geographies, this framework for renewal will be informed by readiness assessments and ongoing engagement within existing primary care structures and also include other service providers to facilitate collaborative partnerships within other models of primary care delivery.

Ultimately this framework, aligned to ongoing development of Health Links, will lay the foundation for the development of Integrated Health Networks of Care Communities within the Central West LHIN.

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.*

The Central West LHIN has a strong history of primary care collaboration and initiatives linked to improving performance in primary care. By accessing and partnering with a strong network of primary care leaders throughout the LHIN the following offers a few highlights of recent achievements:

- Central West LHIN Primary Care Network: Chaired by the Physician Primary Care LHIN Lead the Network has a strong membership that represent various practice profiles and geographies across the LHIN. The focus of the Network is to align primary care physician activities and objectives with the LHIN's Integrated Health Services Plan and various change initiatives.
- Primary care and Health Links: the Central West LHIN has developed all Health Links with a primary care co-lead as a purposeful partnership intended to increase the capacity of primary care to coordinate care needs for the most complex patients. This coordination includes home and community care, social services, mental health and addictions services as well as acute care providers to ensure Health Link patients have the necessary access to a coordinated delivery of services.
- Telehomecare: Utilizing technology as a tool to support patients and their respective primary care provider the Central West LHIN adopted a collaborative partnership between the acute care hospitals and physicians to implement telehomecare. The results of this program dramatically reduced both emergency department and inpatient utilization rates for patients with COPD and/or CHF.
- Electronic Medical Records Integration: The Central West LHIN has supported Headwaters Health Care Centre in a unique collaboration with the Dufferin Area FHT that will support the migration of electronic medical records to the hospitals IT infrastructure and the creation of a single instance of the health record. This will support the physicians by providing access to patient medical records including the embedded Coordinated Care Plan for Health Links. This access can be accommodated within inpatient units as well as the emergency department to ensure continuing of care. The hospital will also support the use of the medical record as an

information tool that will support evidence based decision making and quality improvement initiatives

- Central West LHIN Advanced Health Leadership Program: For the past three years the Central West LHIN has supported 45 participants to attend a unique program in partnership with the Rotman School of Management. At least half of the participants in any given year are family physicians/consultants and the program is a recognized continued medical education program through the Canadian College of Family Physicians (accredited Mainpro-C).
- Surge capacity planning: Ensuring that community providers are able to care for patients during peak holiday periods as well as partnering for anticipated and unanticipated periods of surge within the acute care environment has been a consistent focus. This partnership brings together primary care, the CCAC, Long-Term Care and the acute care.
- Transitions in care initiatives: this initiative bridges care from acute care to primary care, aimed at establishing a foundation for Quality Based Procedure planning in areas such as COPD by developing care pathways between hospital, home care and primary care.

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.*

The model for each Health Link developed in Central West LHIN has been based on developing and supporting a Lead and co-Lead partnership between a hospital or CCAC, that have strong capacity to support this work, and a Family Health Team or Community Health Centre that are directly connected to primary care providers. The Central West LHIN established a Secretariat that continues to provide ongoing project management and implementation support across all five Health Links.

Capitalizing on investments and supports already in place the Secretariat will assume an enhanced role as an important enabler to the implementation management of the Integrated Health Networks of Community Care beginning with primary care renewal. The Secretariat will ensure the consistent implementation of a shared provincial and LHIN blueprint for primary care renewal. The Secretariat will also act as a resource for the collection and distribution of metrics and associated reporting, enabling data to inform ongoing planning and support evidence informed decision making and continuous quality improvement.

Based on an assessment of readiness and engagement activities facilitated through the Central West Primary Care Network a Primary Care Lead Organization and Local Physician Lead will be identified in each Health Link geography. The analysis of readiness will be supported by an environmental scan of current system level performance and outcomes that will inform base accountability agreements with Primary Care Lead Organizations.

The following table represents the anticipated waves for developing Integrated Networks of Care within the Central West LHIN. Waves can either occur independently or concurrently depending on readiness and/or opportunity. In addition to the organizations associated with each wave, the LHIN is also prepared to engage with individual leaders within these organizations and communities. These Local Integrated Network of Care Physician Lead are likely to be identified as current members of the Central West Primary Care Network and validated through the readiness assessment and engagement process. The waves are anticipated to occur as follows:

Wave	Health Link	Lead Organization
1	Dufferin & Area	Dufferin Area FHT
2	Brampton & Area	Development of a cluster of FHT partnerships with shared services and after hours Wise Elephant, North Peel, Queens Square and Central Brampton FHTs as well as discussions with William Osler Health System regarding collaborative partnership opportunities
3	NEMWW	Development of a cluster of partnerships around Woodbine (CANES) FHT and Rexdale CHC to develop a strong lead organization
4	Bramalea & Area	BramEast FHO as well as discussions with William Osler Health System and Bramalea CHC to determine collaborative partnership opportunities
5	Bolton-Caledon	Bolton FHO

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.*

Health Links formulate the geographical framework through Integrated Networks of Care will be developed. These Networks will include, but not be limited to, primary care as well as home and community care renewal strategies. Within the Central West LHIN primary care will be aligned to the Health Link geographies as follows:

- Dufferin Health Link encompasses all areas of Dufferin County, North Caledon south to Olde Base Road/Airport Road/Old Church Road
- Brampton Health Link encompasses all areas from Olde Base Road south to Hwy 407, Winston Churchill east to Hwy 410/Hurontario north of Mayfield Road
    - Through the readiness assessment process there may be an opportunity to create 2 integrated health networks for primary care, a North Brampton and a South Brampton
- Bramalea Health Link encompasses all areas from Olde Base Road south to Hwy 407, Hwy 410/Hurontario east to Gore Road/Mayfield Road/Hwy 50
    - Through the readiness assessment process there may be an opportunity to create 2 integrated health networks for primary care, a North Bramalea and a South Bramalea
- Bolton Health Link encompasses all areas from Hwy 9 to Mayfield Road, Gore Road to Caledon King Townline/Albion Vaughan Road
- North Etobicoke encompasses the LHIN planning areas of Malton, Rexdale, and Woodbridge

The following map indicates these boundaries:

Map of Central West Health Links Sub-LHIN structures

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 AND on weekends
- *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)

Health Links has provided the opportunity to change the health system planning narrative from organization based conversations and planning to a health equity and population based approach. It will be important that primary care renewal strategies reinforce a population based approach with a focus on:

- Individualized and customized approach to care that enhances the patient experience
- Care that is provided closer to home
- Coordinated care that is reflective of a quality service, efficient and cost effective
- Resources and services that are aligned and responsive to population needs
- Comprehensiveness and continuity in the delivery of primary care.

Based on these principles Primary Care Lead Organizations and local Physician Leads will be engaged in the creation of a performance and outcome framework with associated accountability and services agreements that reflect common dimensions. A baseline assessment of performance aligned with the following common provincial performance measures will be part of each adoption wave:

- Access
- Integration
- Effectiveness
- Patient-Centredness
- Efficient use of resources.

Based on current performance standards accountability and service agreements between the LHIN and the Primary Care Organization will be developed in collaboration with the Ministry and member based organizations such as the Ontario College of Family Physicians. In these early stages, change management and rapid cycle evaluation frameworks will ensure that the approach to enhancing accountabilities supports opportunities to apply early learnings and the identification of risks, barriers and mitigation strategies that balance the input from multiple stakeholders.

Plainly stated, data will support physicians in seizing this opportunity.

6.0 Data Needs
• *Please identify any additional data needs beyond those noted in Appendix A.*

Beyond the measures and data listed in Appendix A and based on the previous section related to enhancing accountabilities and performance, the Central West LHIN is requesting access to the following:
• Existing Quality Improvement Plans and any associated reporting for all 6 FHTs
• Any existing FHT agreements with the Ministry as well as any performance related expectations and reporting
• Assessment of Integrated Healthcare Provider (IHP) resource complement and utilization by Central West FHTs benchmarked against provincial averages
• Proportion of residents accessing specialists services within and outside of Health Link geographical area and outside LHIN
• Proportion of LHIN residents with frequent rostering changes (for example more than 3 physicians in three years)
• Practice level data on patient utilization of primary care services outside of those provided by the primary care provider they are attached to
• Practice level data that reflects current access to primary care:
  • Involvement in call groups
  • Hours of operation
  • After hours – weekends, evenings, after hours clinics
• Practice level data on proportion of patients seeing their Primary Care provider in LHIN within 7 days of hospital discharge
• Practice level data on ER visits for conditions that could be providing in the primary care setting (ACSCs and CTAS IV and V visits)
• Health Care Connect attachment rates for complex and chronic patients by primary care setting
• Number of physicians providing comprehensive care compared to Walk-in-Clinic/Urgent Care delivery

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.*
Local physician leadership within the sub-LHIN area will be critical to ongoing change management and support of colleague physicians as well as identifying key opportunities and risks. The Central West LHIN is proposing to recruit five part-time local Primary Care Physician Leads within each of the sub-LHIN areas that formulate the Integrated Networks of Care. A short list of candidate based on previous participation in the Central West Advanced Health Leadership Program and the Central West Primary Care Network will support the identification of key physician leadership. In addition partnerships and support from existing LHIN structures and leaders will be critical to supporting local implementation.

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.*

Proposed Implementation Timelines

2015/15			2016/2017				2017/18			
Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Strategic communications and Engagement activities: Consistent, transparent and frequent supported by physician to physician discussions										
Environmental Scan										
	Readiness Assessment and Assignment of 5 Implementation Waves									
		Wave 1 / 2 Project Charter and Accountability Agreement Development and Sign-off								
			Wave 1 / 2 Implementation							
			Implementation and outcomes dashboard - performance monitoring							
				Waves 3, 4 and 5 Project Charter and Accountability Agreement Development and Sign-off						
					Wave 3 / 4 Implementation					
						Wave 5 Implementation				
									Central West LHIN Primary Care Summit – report preparation highlighting successes to date	

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.*

One of the key elements of successful implementation within the Central West is size, given the small number of service providers the Central West LHIN has a strong record of fast paced and nimble strategic implementation. As a result, many of the key stakeholders of primary care renewal are also key leaders. In addition to those key champions listed in the previous sections the Central West LHIN will include:

- Ontario College of Family Physicians – assuming that the College will be an important enabler of the primary care renewal strategy and associated blueprint it will be critical to ensure that local physician leadership and the Secretariat have a collaborative relationship that can provide consist and locally aligned messaging, supportive educational opportunities.
- Core Action Groups – the role of the LHIN's Core Action Groups will assist in a local population based planning that can be aligned to primary care and evidence informed decision making in the determination of development of integrated networks of care.
- Health Link Leads – ensuring that primary care is at the core of care coordination for complex patients has been a consistent principle of Health Links in the Central West LHIN. Primary care renewal is considered to be a key enabler to the success of Health Links as well as a supportive strategy for primary care delivery. The LHIN, through the Secretariat, will ensure that planning and associated activities of Health Link Leads are aligned and collaborative with regards to the renewal strategy.
- Health Links Steering Committee – with representatives from the acute, community and homecare sectors as well as primary care this Committee provides overall strategic governance for the ongoing implementation and support of Health Links. There may be opportunity for this committee to support primary care renewal and the establishment of Integrated Networks of Care.
- FHT and CHC Boards and Executive Directors – important change management leaders and providers of consistent messaging to their associated physicians, staff and patient populations.
- FHO and FHG Physician Leads – ensuring that the physician leads of these primary care organizations are involved in initial planning activities will ensure collaborative relationships are developed and maintained to support the long-term vision of the renewal strategy, through principles of consistency and transparency.

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*

The Central West LHINs IHSP 4 positions the building of Integrated Health Networks as a strategic planning priority. By coordinating Health Links, home and community care, mental health and addictions services, palliative and end-of-life care and long-term care redevelopment these Networks will provide improved access to the right care, at the right time, and at the right place. This means better integrating existing resources, working with existing networks of care and investing in those areas requiring additional capacity to meet the needs of the growing population of the Central West LHIN.

The Central West LHINs approach to system planning is aligned to the vision and priorities of Patients First: Action Plan for Health Care as outlined by the following key objectives:

- Access: Improve access – providing faster access to the right care
- Connect: Connect services – delivering better coordinated and integrated care in the community, closer to home
- Inform: Support people and patients – providing the education, information and the transparency they need to make the right decisions about their health
- Protect: Protect our universal public health care system – making decisions based on value and quality, to sustain the system for generations to come.

These priorities provide a context for the Central West LHIN to continue to focus on partnerships among patients, caregivers, Health Service Provider's, cross-sector partners and the community at large. Working together, the LHIN and its partners will continue to deliver high-quality care that meets the needs of the community, including Francophone and aboriginal communities, and other diverse communities within the LHIN.

To ensure success, the Central West LHIN will be flexible and adjust to the changing needs of the environment. The LHIN will continue to engage communities, providers and HSPs to understand and respond to the needs of the patient.

The Central West LHIN has been a provincial leader in driving significant healthy change initiatives. The gains that have been achieved and those it hopes to achieve in the future are the result of hard work on the part of local health service providers and the LHIN over the past decade.

Continuing to build strong and effective partnerships with both traditional health providers and non-traditional partners will continue to be a strong focus for enabling change. Connecting services together with primary care providers will be eased by the strong relationships and partnerships the Central West LHIN has developed.

Health Links has provided the appropriate framework for meaningful strategic linkages and collaborations. Clinical and programmatic linkages for complex patients are critical to the success of meaningful primary care renewal, the Central West LHIN will continue to facilitate linkages between and among primary care and the following representatives programs and partners:

- Centre for Complex Diabetes Care
- Telehomecare and Telemedicine Network
- Palliative Care Network
- Health Link Care Rounds
- Core Action Groups
- Regional and Local Health Units including the Region of Peel Public Health, Toronto Public Health and Waterloo Wellington Dufferin Public Health
- Home and community care.

11.0 Key Risks

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

The following provides an overview of some key risks and associated impacts and mitigation strategies. While this list is not exhaustive it does highlight initial implementation risks and barriers for consideration as renewal begins:

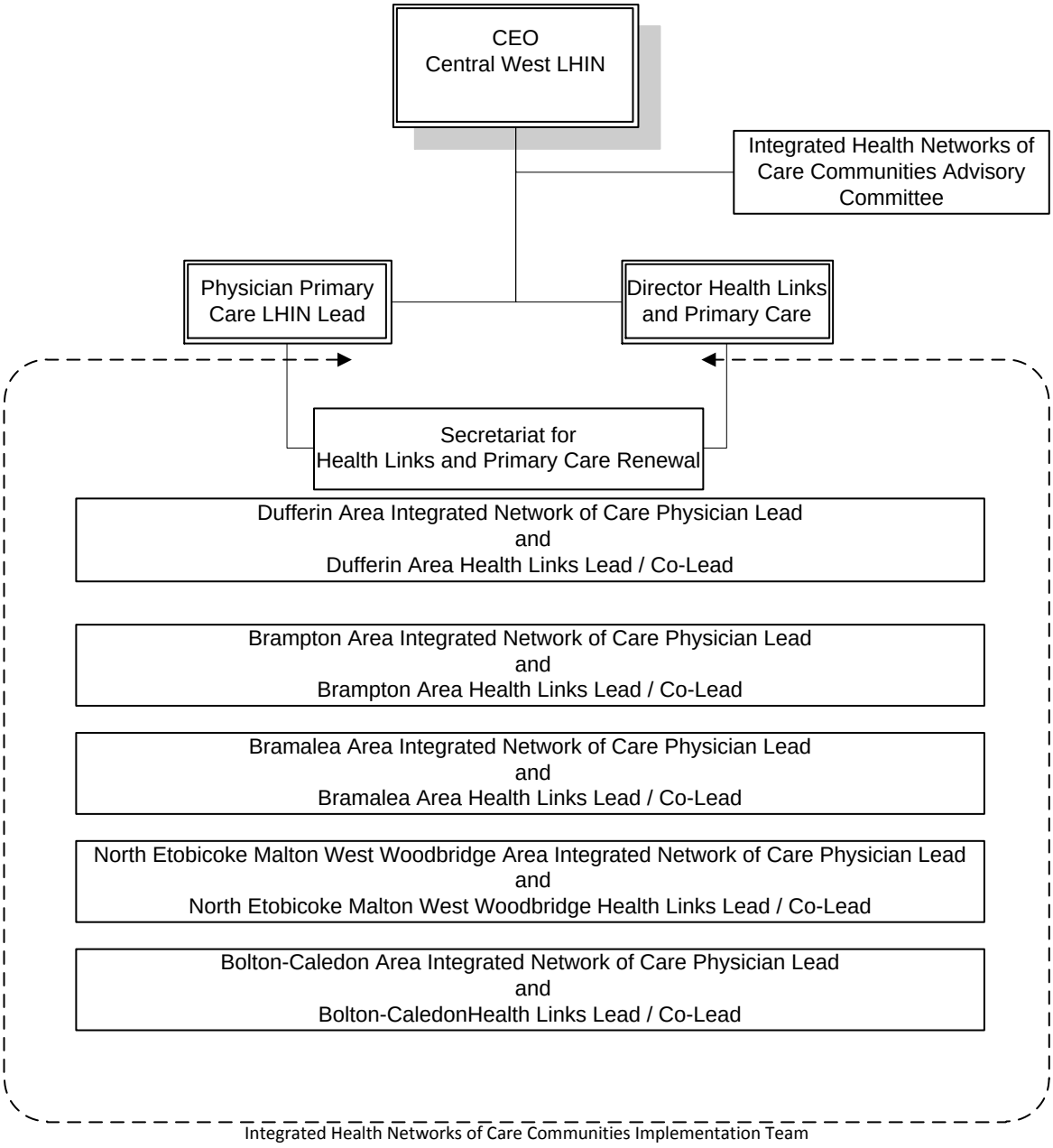
Risk	Impact	Mitigating Strategy
Engagement without physicians services agreement	• Unwillingness to participate in meaningful dialogue or planning	• Begin dialogue with physicians and organizations that have strong ties to the Central West Primary Care Network, as much as possible facilitate physician to physician conversations and planning • Align to Health Links tables and planning initiatives
Lack of existing policy	• Limited ability to develop meaningful and effective accountability agreements	• Work within existing SAA methodologies to pilot agreements that may inform provincial policy while using the process to enable change management
Lack of supportive implementation funding	• Lack of consistency across the Central West LHIN • Inability to support the planning and/or implementation framework • LHIN's limited resources to manage transformation	• Build on existing Health Links infrastructure to create economies of scale and reduce silo's of planning • Specifically access the Health Links Secretariat and Steering Committee to support this work and planning • Determine what in year surpluses are available as well as future community funding can be accessed to support renewal activities • Better utilize FHT/CHC resources while planning to address the structural deficit of integrated health provider resources in the Central West LHIN

Pace of implementation	• Tensions between wanting to move fast and approaching this major transformational agenda is a strategic and planned manner	• Facilitate local primary care providers having a place at provincial planning tables to ensure transparency and active participation in creating reform/change • Provide constant and transparent communication to the primary care sector • Create implementation plans a that are flexible and afford opportunity to support multiple objectives
Lack of provincial consistency and standardization	• Lack of consistency in approach to primary care renewal will jeopardize the viability of the strategy	• Ensure that the secretariat function maintains consistency throughout the Central West LHIN • Ensure that Central West LHIN leadership has effective working relationships with the ministry as well as other member organizations such as the Ontario College of Family Physicians to ensure renewal blueprints are implemented and aligned locally and provincially

12.0 Governance and Organization

- *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.*
- *Describe the changes required within your organization to support this work.*
- *Describe your approach to tracking and reporting on progress in delivering on this proposal.*

To support implementation and renewal the governance and organizational structure to support renewal activities will need to be aligned to existing Health Links Steering Committee and Secretariat functionality. The following organization chart demonstrates how this structure relates to the Central West LHIN:



The following points highlight some of the key organizational changes and supports that will be required to support this work and the achievement of the needed outcomes and accountabilities:

- The existing Health Links Steering Committee provides a structure that can provide strategic implementation oversight as well as monitoring of metrics related to outcomes and performance.
- The Physician Primary Care Lead position will be enhanced to provide a more focused approach to renewal and change management initiatives, with a specific emphasis on supporting physician-to-physician relationships and communications.
- A part-time Local Physician Lead will be assigned to provide capacity support within existing local structures. In addition to local capacity for collaboration and in partnership with the Primary Care Lead, these Local Physician Lead will set the context for improved access, integration and the effectiveness of care delivery and improved patient experience. Supporting physician with data that will further support local quality initiatives and continued renewal.
- The existing Health Links Secretariat can be enhanced to provide overall project management support for this renewal strategy and ensure the appropriate alignment of primary care within the context of Health Links. In addition the secretariat will be accountable for reporting on dashboards and metrics related to the renewal strategy.
- The Central West Health Links have developed dedicated leads within each Health Links to support focussed and timely implementation that are supported by the Secretariat, together with the local physician leads this will create a local team that can support and develop collaborative approach to primary care renewal within Integrated Health Networks.

Endorsed by	
Name	**Scott McLeod**
Position	**CEO, Central West LHIN**
Signature	
Date	**October 17, 2015**

APPENDIX A
LHIN DATA PACKAGE

To support LHINs in their design and implementation efforts, the ministry will provide a data package to each LHIN that provides information on the LHIN's population, the composition of primary care within the LHIN, and baseline performance at the LHIN, sub-LHIN and provider levels as appropriate. This data will be provided once the LHINs have identified their sub-LHIN regions and provided postal codes to support data extraction.

The below provides a summary of the data that will be included in these packages. The majority of this data is already provided at the LHIN level in various reports; this package will consolidate this data and will provide it (where possible) at a more granular level.

If any additional data is needed, please note this in the "Data Needs" section of the above template.

- **Population information**
  - Demographics (LHIN level)
  - Enrolment in models (LHIN, sub-LHIN, and practice level)
  - Number of complex patients (LHIN level)
  - Population that receives care outside of their region (LHIN level)
  - Population from outside of the region that receives care within the region (LHIN level)

- **Provider information**
  - Number and age distribution of providers (LHIN, sub-LHIN, and practice level)
  - Number of interprofessional and patient enrolment models of care (LHIN, sub-LHIN, and practice level)
  - Number of physicians by model of care (LHIN, sub-LHIN, and practice level)
  - Average patient panel size (LHIN and sub-LHIN level)
  - Estimated number of days worked by providers (LHIN, sub-LHIN, and practice-level)
  - Number of allied health workers (for FHTs, NPLCs, AHACs, and CHCs)

- **Access**
  - Patient attachment (LHIN and sub-LHIN level)
  - Access to same day/next day care (LHIN level)
  - Access to after-hours/weekend care (LHIN level)
  - % of total primary care visits that are made to the physician with whom the patient is rostered or virtually rostered (LHIN, sub-LHIN, and practice level)

- **Integration**
  - Physician follow-up 7 days post-hospital discharge (LHIN, sub-LHIN, and practice level)
  - Avoidable visits to emergency departments and walk-in clinics (LHIN, sub-LHIN, and practice level)
  - 30-day hospital readmission rates (LHIN, sub-LHIN, and practice level)
  - % of PCPs with an EMR (LHIN, sub-LHIN, and practice level)
  - % of PCPs with electronic access to hospital discharge summaries (LHIN, sub-LHIN, and practice level)

- **Patient Centredness**
  - % of patients who report that their provider spends enough time with them (LHIN level)
  - % of patients who feel that they are sufficiently involved in decisions about their care (for FHTs, NPLCs, AHACs, and CHCs)
  - % of patients who report that they were given an opportunity to ask questions about recommended treatment (for FHTs, NPLCs, AHACs, and CHCs)

- **Effectiveness**
  - Cancer prevalence rates for the four most common cancers: prostate, female breast, colon and rectum, and lung (LHIN, sub-LHIN, and practice level)
  - Cancer screening and follow-up rates for: Breast cancer, colorectal cancer, and cervical cancer (LHIN, sub-LHIN, and practice level)
  - Influenza vaccination rates (LHIN, sub-LHIN, and practice level)
  - Obesity rates (LHIN level)

- **Cost**
  - Per capita health care expenditure (LHIN level)

APPENDIX B
OPERATIONAL DEFINITIONS OF PRIORITY INDICATORS

Access:

- *Attachment to a primary care provider*: Percentage of people/patients who are either enrolled with a primary care provider or regularly see the same provider. This data will be made available at the LHIN, sub-LHIN, and practice levels.

- *Same day/next day access*: Percentage of patients who report that they were able to see their family physician or nurse-practitioner on the same or next day. This data will be made available at the LHIN level and may be made available at the sub-LHIN level if the sample size of the survey data is sufficient for any given region.

- *Access to weekend/after-hours care*: Percentage of patients/people who report that getting medical care in the evening, weekend, or a public holiday was difficult. This data will be made available at the LHIN level and may be made available at the sub-LHIN level if the sample size of the survey data is sufficient for any given region.

Integration

- *Primary care follow-ups post hospital discharge*: Percentage of patients who see their primary care provider within seven days after discharge from hospital for selected conditions

- *Hospital readmission rates*: Percentage of patients who were re-admitted to a hospital following their initial hospitalization within 30 days of discharge for selected conditions. This data will be made available at the LHIN, sub-LHIN, and practice levels.

- *Avoidable emergency department visits*: Percentage of people who report going to the emergency department for reasons that were potentially avoidable. This data will be made available at the LHIN, sub-LHIN, and practice levels.

Effectiveness

- *Cancer compliance rates (adapted from CCO):*
    - *Breast Cancer Screening*: Age-adjusted percentage of Ontario women aged 50–74 who completed at least one mammogram within a 2-year period. This data will be made available at the LHIN, sub-LHIN, and practice levels.
    - *Breast Cancer Follow-up*: Percentage of Ontario screen-eligible women with an abnormal OBSP screening mammogram result aged 50–74 who were diagnosed (benign or cancer) within 6 months of the abnormal screen date. This data will be made available at the LHIN, sub-LHIN, and practice levels.
    - *Cervical Cancer Screening*: Percentage of Ontario screen-eligible women aged 21–69 who completed at least one Pap test in a 3-year period. This data will be made available at the LHIN, sub-LHIN, and practice levels.

- *Certival Cancer Follow*-up: Percentage of Ontario screen-eligible women with a high-grade cervical dysplasia (abnormal) on a Pap test aged 21–69 who underwent colposcopy or definitive treatment within 6 months of the high-grade abnormal screen date. This data will be made available at the LHIN, sub-LHIN, and practice levels.
- *Colorectal Cancer Screening*: Age-adjusted percentage of Ontario individuals aged 50–74 who were overdue for colorectal screening in a calendar year. This data will be made available at the LHIN, sub-LHIN, and practice levels.
- *Colorectal Cancer Follow-up*: Percentage of Ontario screen-eligible individuals aged 50–74 with an abnormal FOBT result who underwent colonoscopy within 8 weeks of the abnormal screen date. This data will be made available at the LHIN, sub-LHIN, and practice levels.

- *Influenza vaccine rates*: Percentage of people/patients who received a seasonal flu shot in the past year. This data will be made available at the LHIN, sub-LHIN, and practice levels.

Patient-Centredness

- *Patient involvement in care decisions*: Percentage of patients who report their family physician, nurse practitioner or someone else in their office involves them as much as they want in decisions about their care or treatment. This data will be made available at the LHIN level and may be made available at the sub-LHIN level if the sample size of the survey data is sufficient for any given region.

APPENDIX C
KEY MESSAGES

- The government is committed to improving performance, accountability, and access in Ontario's primary health care sector. Our shared priority is to "put patients first" by ensuring that primary care providers and services are organized around the needs of the population. This includes ensuring access to a primary care provider for every Ontarian that needs one.

- This work is driven by the evidence we're seeing which shows the need for improvement. The evidence includes academic studies, evaluations and patient-reported experience and shows us that Ontario lags behind international comparators across a range of indicators and domains, particularly in relation to access.

- For example: 56% of Ontarians can't get an appointment on the same day or next day when they are sick, 26% had to wait five or more days to see their primary care provider and 53% had difficulty access after-hours primary care without going to the emergency department. This is not the fault of any particular provider but shows a gap in our system and its ability to respond to what patients want and need. We can do better.

- In addition, an expert committee was convened in 2013 to review the evidence and to make non-binding recommendations to government on how to address performance gaps and where to focus efforts for the next phase of primary care reform. This advice as well informed the government's focus on performance, accountability and access. The report is expected to be released publicly in the Fall of 2015.

- The strategy itself is straightforward. LHINs – as Ontario's local health system managers – will identify planning regions within their LHIN, similar to the Health Links sub-LHIN regions. They will use these regions as the focal point for performance improvement, which includes identifying local primary care leads who can work with providers to implement improvement strategies based on evidence and focused on local patient need. This will be supported by a common set of performance indicators and data showing how local practices and regions are performing against these indicators.

- The key emphasis of this strategy is on primary care access and performance improvement and the focus is on local collaboration and innovation. Applying this to primary care – a foundational part of Ontario's health system – will help to ensure a more responsive sector and can also help in achieving broader health system transformation objectives such as home and community care and integrated delivery models. It is a critical step to reforming out health system to put patients first.