# Fall 2016 *Patients First Act* Area Provider Table Engagements

December 21, 2016

## Emerging themes from feedback on draft terms of reference for sub-region integration tables

On December 7, 2016, Ontario passed the *Patients First Act* that will help patients and their families obtain better access to a more local and integrated health care system, improving the patient experience and delivering higher-quality care. The *Patients First Act* intends to improve access to health care services by implementing system-level changes to allow for faster and better access to care, and put patients and their families at the centre of a truly integrated system. The government is committed to the next stage of the *Patients First: Action Plan for Health Care*, by focusing on improving patient experience and providing more reliable and faster access to care. The *Patients First Act* is part of the government's ongoing work under the Action Plan to create a more patient-centred health care system in Ontario.

The Act strengthens the role of LHINs in order to create more effective service integration and greater equity.

- The mandate of LHINs will be extended to include working more closely with primary care, home and community care, and public health.
- LHINs identified smaller geographic regions that follow recognized care patterns. These LHIN sub-regions will be the focal point for integrated, local planning and service management and delivery.
- LHINs and LHIN sub-regions will assess local priorities, current performance, and areas for improvement to achieve integrated, comprehensive care for patients.
- The expanded LHIN role will be more inclusive of the voices of Franco-Ontarians, Indigenous peoples, and newcomers.

<u>Sub-region development in the South West LHIN</u>

The South West LHIN has been engaging health service providers, primary care providers and public health leaders over the past several months to gain valuable insight and feedback for the creation of sub-region geographies and the structures needed to support integrated planning and service delivery within the sub-regions and across the LHIN.

The LHIN had a full day workshop in October with area provider table co-chairs and members of the Executive Advisory Committee to provide insight and recommendations to develop the terms of reference for three supporting structures: the Patient Family Advisory Council; the Health System Renewal Advisory Committee and the Sub-region integration table.

During November and December, the LHIN held facilitated discussions with each table to receive feedback on the draft terms of reference for the sub-region integration tables. Local health leaders beyond the area provider tables were also invited to these sessions to ensure a balanced, fulsome review. The feedback from these sessions was themed and used to further refine the sub-region integration table terms of reference.

What follows is summary of the themes that we heard at the area provider table sessions. This information along with the previous feedback for the area provider table co-chair/Executive Advisory Panel meeting is being used to create a final set of terms of reference for the Health System Renewal Advisory Committee and the sub-region integration tables.

The goal is for the Board of Directors to approve the terms of reference in February 2017 and member recruitment to take place immediately after approval. The LHIN will be having ongoing dialogue with the area provider tables as the sub-regions are established.

**What Did We Hear?**

**Actions and Deliverables**

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| Questions asked at engagement*:*<br>*What issues and actions are important to be identified and prioritized locally?*<br>*Are any actions or deliverables missing that would be needed for the success of the sub-region integration tables?*<br>*Should any actions or deliverables be changed?* |

Give the tables time to develop
- Need to have space for committee to develop – forming, norming and storming
- Time needed to build understanding and trust
- Need to be realistic about what this committee will be able to address – many people and organizations are at their max capacity – have clear expectations – need for supporting resources

Ensure clarity on role of committee
- Is this just an advisory committee or will it have decision making powers
- Identify what is unique about the sub-region integration tables vs. other local tables
- Decision making  at local level not spelled out clearly
- Performance tracking: clear indicators

Think equity and patient perspective in all work
- Patients and families should verify priorities
- Be deliberate about planning for equity and addressing determinants of health

Build on existing work and resources
- How will priorities be determined
- Actions and deliverables should be less about operations and more about strategic thinking
- Build on existing work: Pick 2 – 3 priorities that table is familiar with for a start – to support the forming, norming and storming: clear manageable set of deliverables and actions
- Utilize current state analysis that is already complete
- Utilize data we have right now about current state to start work but must maintain a current state analysis

Focus on local work that impacts multiple providers and/or organizations
- Collective focus and prioritization via shared or coordinated Quality Improvement Plans (QIPs) (build on what we are already doing)
- This table can be identifying local issues and gaps and making recommendations on responding to them
- Need to sustain regional work

**What Did We Hear?**

**Membership**

| Questions asked at engagement: |
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| *What is the right number of members to ensure the table is functional for decision making?*<br>*How do we balance sector representation, non-health representatives, cultural and geographic representation?*<br>*What is the best way to recruit?* |

To be successful, the Table will need to:

- Have standardized processes to determine who sits at the tables
- Have good/trusting relationship with primary care
- Ensure inter-agency structure to support integrated action
- Link with community agencies as well as health service providers
- Ensure regional programs representation

Size of sub-region integration tables

- Size consensus – 10-15 members

Skills/knowledge of members

- Consider using the term "skills matrix" or skills requirements for members
  - strategic systems thinkers
  - Past experience with system integration
  - No consensus on position within an organizations that members need to have: "Executive level position and/or has organizational decision-making authority" or "low power/not the usual suspects/don't want "suits" – have front line staff as "reality checkers". More about strategic thinking ability, respect by peers and ability to influence peers
  - Ability to focus on objectives, implementation, communication
  - Include rural, urban, community diversity knowledge/perspectives
  - knowledge of social determinants of health
  - Need to represent broader sector – not just individual agency – need to be able to remove organizational hat and represent your group/sector

Membership make-up

- Cross section of system and sector representation – mental health, addictions, primary care, home and community care – includes community support services (CSS) and CCAC, long-term care, hospital, public health
- Need to be mindful that some sectors/organizations have limited capacity (ie. are small) to be on too many tables
- Must include patients/family/caregivers: consideration – health providers get paid to sit at the table while patient/caregivers usually volunteer their time – concern about equity
- Primary care must be around the table – Primary care model administrators are also a wealth of knowledge
- Cultural representation – Indigenous, Francophone, others as needed to support local planning
- Consider flexible or ad hoc representatives based on priorities identified – such as EMS, housing, police, social services

- Representation from people/organizations working to improve social determinants of health
- If more operational consider more front line staff at table – could be recruited through new and/or existing steering committees/work groups/task teams attached to particular initiatives

Recruitment

- Leverage local structures to recruit members
- Consider a nomination process
- Application completed by nominee
- Nomination endorsed by appropriate group
- LHIN appoints

Appointment term: 2-3 year terms, staggered to ensure succession planning

## What Did We Hear?

### Communication/Information Flow

| Questions asked at engagement: |
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| *How do you see the flow of information between members and their sectors/geographies/committees?*<br>*What communication strategies work or could be leveraged in your sub-region?*<br>*If you or your organization are not members, what would your responsibility be to the sub-region integration Table?* |

Sub-region integration table members must have formal mechanisms in place so they can act as a conduit between the sub-region integration table and the sector they represent.

- Clear lines of accountability for sub-region integration table member and the sector agencies they represent are needed
- Sub-region integration tables have to be deliberate and consistent in the flow of information – key messages
- Need to ensure member has the confidence of their sector to be a representative
- Consider a communication process for sectors that have concerns about their representative on the sub-region integration table

Sub-region integration table need stay connected to the work of other tables/programs in the sub-regions to avoid “silos” of work (eg. stroke work, assess and restore, hospice palliative care etc)

- Ensure uniform messaging by issuing key messages broadly following each meeting
- Need formal two-way communication between sub-region integration table and other groups/tables
- Develop a communicators network and a ‘buddy system’ to help build capacity in those organizations with limited communications resources
- A clear work plan which is available on a site which can be accessed by everyone electronically would be useful. There could be an area to make suggestions, share ideas, request items to be discussed at the table”

Sub-region integration tables need to have effective ways of communicating with partners and the broader community about their work

- Leverage existing communication structures and create an overall communication plan which could include: Social media; LHIN website; HealthChat; Radio; OTN (gallery format); Collaborative online space (for interactive communications and chats)

## What Did We Hear?

### Accountability

| Questions asked at engagement: |
| --- |
| *Are there examples of shared accountability in your sub-region that we can learn from?*<br>*What do you see as important factors to consider in pursuing shared accountability?*<br>*What are the risks in pursuing shared accountability? Is the description of shared accountability one that will be able to be implemented?* |

Have a shared vision, a few focused objectives that are relevant to all and measures are necessary at outset to get to shared accountability.

- Need a common focus that is meaningful to all organizations or sectors and involves all members at some level
- Respect and trust are key
- Patient must be the focus
- Shift from outputs to outcomes

Purpose of accountability/ responsibility must be clear at the outset.

- Needs to be formal, clearly laid out roles and responsibilities and clear implementation plan
- Consider shared indicators/ QIPs etc.
- Need a framework for how people will work together; and how sub-region integration table intersects with other tables

Need to clarify the accountability of the sub-region integration table members

- Representatives of sub-region integration table have an obligation to share information at other tables (information flow)
- High level of organizational responsibility and accountability is required
- Important to understand the LHIN's role
- Cross-ministry barriers must be mitigated

Need to be clear on the "authority" "decision making" of this table. Mechanism to support accountability (need formal and informal):

- Consider supporting shared accountability through individual Shared Accountability Agreements (SAAs) - shared accountability indicators that can allow measure of success/ improvement
- Individual organizational Boards need to appreciate the shared accountabilities as they do individual organizational accountabilities

Memorandums of understanding and/or commitment statement between LHIN and providers or all providers may be an option to consider

- Already working in a shared accountability environment: Examples include shared responsibility for Alternate Level of Care rates, ED revisits for mental health and substance abuse, CCAC-Hospital agreement, 'Reach out' partnership, situational tables, Grey Bruce Talisman Agreement (Hospitals, CCAC and Public Health), Georgian Bay Information Network

Shared responsibility needs to be mutually beneficial - Need to be equal partners and share in the risk. Need to address accountability of non-LHIN funded providers

## What Did We Hear?

### Resources and Capacity

| Question asked at engagement: |
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| *What resources and capacity within the sub-region could be leveraged to support the work of the integration tables?* |

Change management resources

- Tables will need resources to support start up and give tables time to create capacity within their own organizations and sectors to support sub-region work
- Resources will need to come from a neutral party to be successes
- Need to understand what committees/groups may not need to continue and this would free up resources

Each sub-region integration table will require resources to sustain their work

- Sub-region administrative lead (LHIN employee) and clinical lead are two resources that will be available to tables
- Currently the LHIN provides administrative assistant support for the area provider tables – will this stay with APTs or move to sub-region tables
- Leverage current capacity in the sub-region
    - Current area provider table for broad communication
    - Patient and family advisory councils already active within local agencies/programs for patient engagement
    - Health Links experiences in shared accountability in changing care
    - Organizations/initiatives that have health equity work underway
    - Consider adding an 'integration coordinator', which could be a quality coach that is already in place

Need to build capacity from within sub-region organizations. Consider completing a matrix of skills needed on the sub-region integration table and map that against skills that might be available in organizations in the sub-region

### Other

- Consider using "person" not "Patient"

- Governance
    - Role of boards of directors in sub-region planning
    - Individual organizational Boards need to appreciate the shared accountabilities as they do individual organizational accountabilities)

- Primary Care Engagement
    - Move from engagement to partnership and be willing to accept primary care direction
    - All organizations must take on responsibility to engage and communicate with primary care for success