Primary Care
Co-Design Session

November 26, 2019
Handout

October 22 Meeting Minutes

October 22, 2019 Meeting Minutes:

- Dr. Kris Martiniuk provided an overview of the history of the Mississauga Halton Primary Care Network describing the structure, intent and accomplishments
- It was acknowledged that the existing PCN has been effective to date in listening to and responding to physician needs
- The concept of by physicians for physicians is important
- Group discussed the potential of evolving the Primary Care Network to meet the needs of primary care within the current landscape (i.e. evolution of OHTs)
- Group were asked three questions to begin to define what Primary Care Network V 2.0 could look like – responses in table below

What is the "why"?	• To be the meaningful, collective voice of primary care • A centralized intake for primary care feedback is needed; this can be shared with the OHTs and other partners • Fix the disconnect between hospitals and primary care due to few PCPs being connected to local hospitals • Be the voice of leadership that comes from the community, not the hospital • Bring together the advocacy role with education and networking (social) • To be "ready"; ready to give our opinions and consult on matters when asked to
What principles do we need to consider?	• **Efficiency** – how can we deliver information across the sector in a timely, efficient way • **Influence** – PCN needs to be recognized as the community PCP voice to influence change • **Representation** – must have positions nominated and votes cast in an electoral process to identify representation of the sector • **Transparency** – needs to be inclusive of physician skills, geographic boundaries and practice models • **Regionalization** – need to consider whether there should be a single body that represents primary care or whether if should follow OHT boundaries or smaller geographies
What do we want to achieve?	• A unified voice for PC in our area that is action oriented toward building solutions, sharing and learning, building relationships amongst PC, system engagement • Actual, concrete, practical solutions; we need to provide more than just another forum for another program with big delays • Sharing "best practices" from individual offices: what's working well in my practice that could be spread • Provide a patient connection: somewhere patients can link to see comments or educate themselves • Understanding of how we work in different practice models (what's good, what's not) • Representation from all sub-regions of the current MH LHIN • Consider a hybrid model: have a core PCN and two sub groups (Halton, Mississauga / Etobicoke)

October 22 Meeting Minutes (cont'd)

- Overall, it was felt that the PCN mandate should include it being the central and singular representative, influence and source of information for PC in relation to the system for the region – needs the moral authority to speak on behalf of primary care with OHTs, hospitals, LHIN, etc.
- Four existing Primary Care "governance" groups were shared for consideration and the group provided feedback on each
    - Hamilton Academy of Medicine – need to show value for cost, prefer PC only without specialists, good build of community and shared resources, consider other funding approaches to support, question of whether this is OMA's role,
    - East Toronto FPN – mandate is currently organized around a specific project only which appears limiting, very newly established
    - Hackney General Practice Confederation – patient representation and using PFAC for patient communication and knowledge transfer, appears like a FHT, need to look at provider experience
    - AB PCN – unclear if it works, appears to be like FHTs, not really what we are trying to achieve at this point
- Group reviewed ideas discussed and generated ideas on design factors and selection process

    <u>Design Factors to be considered included:</u>

    - Representation and advocacy
    - Community of practice/Quality
    - CME – this is value add for physicians
    - Social events
    - Communication - multiple streams and methods needed

    <u>Selection process:</u>

    - PCN core members should be recruited through a clear and transparent process, fair, skills-based and competence
    - Representation should consider geography and practice model balance
    - The common issues among PC are greater than the local differences and there is benefit in a larger unified voice vs. subdividing into smaller groups at this stage
    - Model should allow for local relationship building and nuances
    - Leadership should come from the membership and have the mandate to work for the membership not for an organization
    - Consider ex-officio membership of hospital leaders, OCFP, OMA

<u>Next Steps:</u>

- Group agreed they would like to continue moving forward with the development of this concept
- Discussed options of having a sub-committee create a draft model/terms of reference or hosting a co-design session to have full group input into the development of the model – co-design approach was the preferred approach
- Group agreed to meet November 19th at 6:00 pm for the co-design session with the goal of having a network framework established by January 2020
- LHIN will facilitate the co-design session
- Invitations to the session will be distributed broadly

Post-October 22 Meeting Survey

Why should we create a representative voice for primary care? **(n=10)**	• Primary Care needs a voice on behalf of all community docs (pretty diverse group) - now more than ever, to include docs also that work beyond community hospitals • To improve the services for our patents • To increase representation at discussion tables in the region (OHT/LHIN/etc.); to provide a place hospitals/planning groups can come to access primary care view points • The role of family physicians has diminished over the past few years and we need to have a stronger voice or we would be further marginalized • Because we are front-line clinicians who know what is actually best for our community • Otherwise we are powerless to influence the outcome • There was a vote in Oakville we no longer wanted to continue with Mississauga Halton PCN. We wanted to separate into Oakville without Mississauga and only get together for education purposes when appropriate – Oakville has to refer to CVH for oncology and Trillium for cardiac surgery and some Neurology services etc. • We need a representative voice as we are a scattered group of people who work tirelessly through our days hardly able to speak to in-house colleagues never mind the community at large. A central group or executive elected to represent all of us could help streamline communication and organize ideas. As the system is attempting to change with the OHT, it is vital that we demonstrate that we can provide good comprehensive care to all with adequate supports in place. We are the hub through which allied health can work through to better support patients. • We need a unified voice • Primary care is the backbone of our publicly-funded healthcare system
What principles should be considered in developing this structure for primary care? **(n=10)**	• Respect for all models and look for ways to help / support each other and to identify common goals but also to help with barriers / obstacles... the stronger the voice, the stronger the representation the better • Adequate support from specialist/LHIN services • Determine if it will play an advocacy/system level role, or more community of practice/learning role for physicians - or both • Not sure. Mainly having a stronger leadership role see above. Reestablishing our position in the changing health care dynamics • It should be transparent. It should be in consultation • Equality of access for all patients, no matter which model of care their family doctor is in • Keep Oakville and Mississauga separate • Principles would be who does the structure represent. Geographic boundaries. Representation from all payment models. Voted representatives. Support for doctors peer support conferences. Online meetings to limit time away from office or home. We want an organization that represents the local doctors that supports good comprehensive care, healthy physicians, and helpful accessible resources • Equality, respect, efficient use of available resources • Evidence-based practice, achievable, sustainable and physician-friendly, equitable

Post-October 22 Meeting Survey

What can we achieve through the creation of this group? **(n=8)**	• "Go-to" group recognized – to speak on behalf of community, to represent community docs, and to act as a sounding board on behalf of community docs who at this time function independently and perhaps choose to ignore issues because they have no means to share or collaborate • Cooperation between different disciplines • Stronger position of primary care in the system, less imposition of strategies from outside primary care and more co-design of solutions for primary care by primary care • Someone who represents us • Equality • Support and protection of the role of the family physician. Likely similar roles as the OMA but at a more local level. We could pay a fee to join. Vote for representatives. Ensure all groups are covered and have a voice and work toward helping our unique Halton community • Have influence on how the healthcare will be delivered under the OHT system
Other comments received via email, in-person	• The OHT-Primary Care is rooted in "sustainability/accountability" and is system engaged, while the PCN 2.0 is rooted in "autonomy/collegiality/refining the art of general practice", and is system immune. They are not only complementary but must remain unique to each's own mandate, and build each's own coalition. As OHT-Primary Care takes more shape, the PCN 2.0 will serve as the linchpin and bridge for ideas on success/failure of initiatives experimented by various OHTs. As Danielle Martin wrote, innovations must "scale and spread". Who best to do it than PCN 2.0? • Location – with travel, the meeting tonight will be taking up 4.5 hours of my evening – it's a big volunteer commitment for me to consider. Stipends - I truly feel that a stipend makes people accountable and shows value to their ongoing participation. I'm not sure what our new situation is, but I do feel that this will make a difference to physician participation. Burnout/OHT - personally I am busy with the OHT negotiations/etc. I'm honestly not sure what kind of time I will have to donate to the PCN… organizing events can be stressful to organize. It was a huge success but at great personal cost. I work all day today seeing patients from 9am- 5pm. I started with rounding on my in-patients in the hospital at 7:30 am. Physicians are BUSY- unless there is real value being offered from the PCN - I'm not sure how this will fly.

CASE STUDY:

The Hamilton Academy of Medicine (HAM)

Overview:

- Founded in 1899; local voluntary professional association
- Now a branch of the OMA; can provide a full range of programs, services and benefits to assist Member physicians
- Close to 800 members
- Primarily family physicians (with some specialty physicians from hospital); retired and practicing
- Membership fee: $250/year (discounts for residents and retired physicians*)
- Has an elected Executive Committee / Board of Directors

Membership benefits:

- Website
- Communication
- Mediation
- Education (CME, etc.)
- Practice Management and Maintenance
- Meeting Facilities
- Political
- Social Events
- Honours & Awards
- History of Medicine

*HAM Fees: Residents ($75), retired physicians ($50); physicians also have to pay other licensing fees each year.

The Academy binds the medical community of the Greater Hamilton Area, promoting a spirit of cooperation and unity, while meeting the educational, social and political needs of its members.

https://www.hamiltondoctors.ca/become-a-member/membership-benefits/

HAM Foundational Statements

Vision

A unified voice for a vibrant, healthy and involved medical profession and community

Mission

TO PROVIDE…

Leadership, education and social venues for physicians in their professional and personal endeavours.

TO REPRESENT…

And engage physicians in the development of a local sustainable, accessible, effective health system.

TO ADVOCATE…

For the health of the community.

Strategy

HAM has a 3-year strategic plan.

Priorities include community-based benefits, mentorship of the next generation of physicians, and incentives for families.

OMA could be considered more focused on advocacy and policy (e.g., collective bargaining).

CASE STUDY:

The Hamilton Academy of Medicine (HAM)

HAM Executive Committee

- Executive Committee / Board of Directors (6 people)
  - President
  - Vice President
  - Treasurer
  - Secretary
  - Past President
  - Director at Large (liaison with membership)
- Rotating Board membership (Secretary becomes Treasurer, etc.); so usually only one vacancy each year
- Board members may receive a small honoraria from OMA for their time (1 meeting / month)
- Board gathers input from members through surveys, 1-on-1, although this remains a challenge
- New Board members elected at Annual General Meeting
  - There is a “Call for Applications”
  - A separate Nomination Committee reviews applications and identifies suitable candidates for the open position(s)
  - Candidates are voted in by membership at the AGM
- Nomination Committee seeks to ensure a balance on the Board of:
  - Men and women
  - Early- and late-career physicians
  - Family physicians and specialists

HAM Staff

- With fees (and likely other funding), HAM pays 2 full time staff and several other part-time staff / outsourced activities (e.g., website development, graphic design, bookkeeping / finances, etc.)
  - Executive Director
  - Administrator, Member Services

HAM Committees

- HAM has several Advisory Committees for various areas of focus

HAM Events

- Through fees (and likely cost-recovery and other funding sources), HAM sponsors medical student conferences and hosts many events throughout the year