South West Primary Care Alliance

Thursday October 19, 2017
Lunch Session 12:15 – 2:15 p.m. & Evening Session 6:30-8:30 pm

In attendance

Lunch Session			
Shirley Koch	Lisa Rigg	North Huron and Wingham	Sharon Moore
Kelly Buchanan	Rob Annis	Don Neal	Dan Noel
Dan Eickmeier	Colin	Monique Hancock	Katayun Treasurywala
Mia Segal	Kim	Paul Gill	Mike Dawson
Jane Tillman	Sean Blaine	Debbie Selkirk	
Evening Session			
Jason Bandey	Amanda Brown	Samantha Reume	Maria Moore
Matt MacDonald	Jessie Rumble	Paul Gill	Pete Brooks
	Kenneth Hook	Shirley Koch	Mary

Topic or Subject	**Presenter**	**Minutes/Actions**
Welcome and Opening	Name of Presenter, Position, Organization	**ACTION**: Short description of the action, who is accountable for its completion and the timeline for completion
Introductions	Dr. Gill	• Dr. Gill welcomed participants • Provided an overview of the meeting
Overview of vision for PCA	Dr. Gill	• Dr, Gill discussed Patients First legislation and the local planning via sub regions and population needs planning; review of the SW LHIN leadership team; quadruple aim; • With patient 1st Act, LHIN was separated into 5 sub-regions • Each region has a support team with a physician lead to coordinate population based care at a local level • Vision for PCA – to work together to create a cohesive sector and integrate with other parts of the health care sector to improve patient outcomes and advocate for needs up to the LHIN • Dr. Gill provided an overview of the proposed role and function of the Sub-Region Primary Care Alliances along with the Huron Perth Sub-Region Tables • Review of Chair/co-chair role and election process; participants asked to connect with Paul within a week to indicate their interest in the role of co-chair; Paul discussed support and how this will differ from the previous role of the Primary Care Network; discussion that co-chair who is accountable to the primary sector and not the LHIN is valuable; • PCA will be able to suggest/identify gaps and processes to push forward to SRIT–then information goes to HSRAC for decision making; there are also the board to board reference groups that will help support these groups to have these discussion • SRIT Meeting schedule – intend to have 1 meeting a month alternating between Huron and Perth

		• Will see Dr. Gill or co-chair at local primary care alliance meetings as view this as best level of engagement; but perhaps meet 3 or 4 times per year if there are topics of interest • Plan to engage at local MSF / MAC meetings + quarterly Huron Perth meetings (TBD) • **ACTION**: any primary care provider interested in co-chairing the alliance, please contact Dr. Paul Gill at paul.gill@lhins.on.ca with a short description of your interest in the position
Other topics as outlined on the agenda	Dr. Gill	**South West Primary Care Alliance Website** • South West Primary Care Alliance Website – http://swpca.ca • Working on a comprehensive website for primary care providers where tools and resources can be shared including EMR resources and a specialist directory • The pipeline…(as before) creation of custom forms if you have a form that works well share it; we will post it; should be a very interactive; allow opportunity to ask does anyone have a form for a specific area; and then make the custom form available for Accrue, practice solutions; and Oscar • HQO – My practice reports –if you sign up you will get a report for your practice in comparison to provincial and clinic, need to sign up now for next Opioid report • medical imaging integrated care – everyone now has different MRI requisition; value of being able to use same req. for different sites where wait time is less; **Decision Support Tools** • that have been developed by Choosing Wisely within our LHIN • comment: seems to be physio and chiropractors that suggest to patients that MRIs are needed when they aren't (Dr Bandey) **Hospice Care + HP Palliative Care Outreach** • Hoping to have this services forms turned into EMR friendly forms on the PCA Website • Projected openings - Huron Stratford site December 2018, Huron site between January-February 2018 **Provincial Opioid Strategy** • Ontario Strategy • If you register through HQO coming in November – My Practice: Primary Care allows you to see your own opioid prescribing patterns • Funding is coming from a provincial perspective – how can we best **Medical Imaging Integrated Care (MRI)** • 6 sites in South West LHIN – none are coordinated, all have different forms and wait times vary • Plan for a single requisition by November to optimize access, standardize quality and enhance appropriateness • Will be EMR Friendly and available on the South West Primary Care Website • it will allow physicians to be able to indicate multiple sites; not near the maturity level for e-referral yet; first step is the development of consistent referral' quality of MRI raised as an issue; accessibility and readability are different among sites; will allow a better flow from physician perspective of not having to navigate through different forms; • Query/comment re: centralizing processes and losses local initiative and fundraising – response accessibility to different services is very much determined by what your community has or does not have; patients first initiative is trying to look at things for lens of equity; that said patients will still have choice; • Concern that there will not be as much enthusiasm for people to donate to their local institutions equity lens

		Transforming Musculoskeletal (MSK) Care in Ontario • The 2017 budget committed 17 million for expanding MSK intake and assessments across all LHINs • Model for similar intake for back care/spine – in early days of model ; Comment that ISAAC be placed closed close to the patient; satellite models must be close to patient; assessment group will determine is surgical care is necessary or rather if the patient can benefit from local community programs; concern raised about what are the supports in the community for people who don't need surgery and need physiotherapy but can't afford it/don't have a benefits plan that covers this cost • It would be requested that the funding get closer to the patient than to the specialist • Comment re: bottleneck for hips/knees/low back pain – no resources to suggestion that doubling the number of knees and hips is what is needed; we should see this if the investment is that is the caps need to be adjusted; • if it will get them physio while there are waiting that is good; • ultimately if you need your knee or hip done, you need your need your or hip done; • idea is to referral all in and then the OT decides the patient needs surgery and does a course of treatment before surgery; • the solution will look different in each community; may seem like duplication - another layer; • need feedback from physicians to comment on the realities/dirty stuff; ultimately the shorter the wait the better; • pushing the envelope of comprehensive care; let's ensure that family physicians are more comfortable with some of the things they are not comfortable with now; **eReferral** • EMR Integrated referral system that centrally tracks referral • Plan to start small and expand • will start in our areas with MSK strategy – hope is to take off pressure from primary care to have a portal where patients can see and access referrals for tests/care paths; where there are patients who hope is that the administrator can access and again interact with the patient and take burden off primary care • Q: is this only for our LHIN? • A: many LHINS are starting this work as well; Alberta has something similar; seems that we are following Alberta model; question is how will change our work flow as providers; it is huge amount of time spent now on this that we didn't have before – the patient left the office with a slip of paper with an appointment time on it; • what most would want is a list of specialists and what they do and their wait times; • you search for instance orthopaedics now via southwest healthline; click on find a specialist PHYSICIAN - pick specialty for example
Discussion, Questions, Concerns		• Q: Feel that it is an interesting idea but this type of meeting has existed before, with keen individuals but things always petered out. How do we know this will continue? • A: this structure was born out of recognition that a lot more back end administration support is needed to make this work. Dr. Gill has requested to attend all MAC and FHT meetings to engage with physicians within their own workflow. • Comment: The feeling from a lot of primary care providers is that the people who support organizations like the LHIN have "drank the cool

		aide" so to speak and have switched sides. Providers need to see that discussion is happening – that their voice is at the table with their priorities in mind and not be clouded by working for the LHIN. • A: understandable that this would be the feeling – that's why a co-chair model was created to ensure that one individual of the PCA would not be accountable to the LHIN • Q: In the vision is there funding that will be brought forward to fill some of the gaps in primary care • A: If there are gaps that need to be addressed, they can be identified and brought back to the Sub-Region Integration Table. The SRIT doesn't have the capacity to make decisions on the funding but could bring this forward to the bodies that could. • Q: with the new legislation the LHIN has control over the FHT budgets – to what extend can the LHIN exert levers to the 75% of primary care that it's budget doesn't have any impact on • A: this table is to look at innovative ways to look at ways to support primary care providers and how do we get there. As far as I know, the LHIN is not looking to change how FHT's are operating. • Q: A lot of teams are on practice care reports – do you know whether the opioid prescription patterns are available for teams or just individual practice? • A: my understanding is that it is practice based, not team based but can look into this. • Q: will the one EMR referral help to reduce replicating MRI's when they say they need to repeat them? • A: we would look to reduce this and improve the workflow but it is sometimes a question of accessibility of images by specialists and not readability so that is something that could be addressed • Q: question re: centralizing processes and how it is that you would lose local initiative and local fundraising as a result of this • A: the main focus is to create equity and accessibility across the South West LHIN. That being said, the patient always has the right to choose which site they want to be considered for and move in that direction **ACTION**: will send with the minutes, screen shots to show the specialist directory; specifically how to access this; link to specialist and their wait time; • On a broader scale is good to apply to this – some use CPSO? For this information; right now the healthline is a bit cumbersome; takes a lot of clicks; • where possible the healthline has asked surgeons to have their forms on the healthline; suggestion that college needs to indicate all referrals have proper information and can't say no because it is the wrong form; • Q: eConsult; yes part of PC alliance is to come you physicians and talk about new tools; • Grand bend A CHC still works with nightingale and demand – will be phasing out – idea is to integrated this into the Big 3; Accuro; Practice solutions and Oscar **ACTION:** Dr. Gill to look into the practice reports to find out if they are team based as well as individual practice based
Feedback	All	**What Do You Consider the Priority Areas/Thing for Huron Perth** • Referral Forms: Frustrating that all providers have different referral forms - even though the same information is there, at times it get bounced back, but getting agreement is key Would like to have a better referral system that is more unified. • Feel that patients having access to all their own records could has potential but could also have huge pitfalls. • Response Dr. Gill - Alberta has "NetCare" we will likely start with very clear types of referrals such as MSK, and then move to where there

	Dr Bandey	are very clear standard processes for example renal failure; hopefully more can be added to the eReferral; process; are meeting in a few weeks with waterloo Wellington to understand what the options are; what are the options for patient access • Opioids, the addiction is the problem. We as primary care providers should be a lead in liaising with non-traditional health providers like food banks that could help with the addiction piece • The hospitals are doing some work on choosing wisely – think it's a great program and potentially great at meaningfully reducing cost for patient care but we need to have more on the ground stuff in the community vs. just in the hospital • How do we through Practice facilitation" leverage our partners for example Partners for Quality to facilitate our practices to align with these initiatives and tools – spread to use them • Think it would be beneficial to look at the clinical gaps to see where things could be improved • What will help is anything that will make the job easier – if changes are made that make the job more difficult it won't be left with a lot of support. In the end those who want to participate will participate and eventually maybe more will see the value • Would encourage more connection on what AFHTO is doing around measurement pieces and ground level work with their decision support people; push this type of technology out to the FHT • OMA/Government piece is unknown right now. The OMA family agreement will have new accountabilities and this will have an impact about how we work together in the future • Feedback from K Treasurywala MD CCFP EM o EMR messages direct to co-lead within a chart so it can all be followed/ documented. o Social gatherings to network. o Idea: public health initiative to have physiotherapy class in high school • Q: will each LHIN have a PCA website? • A: we are very proactive; lots of discussion on other areas; hoping we may the same example that others follow; comment that this is very positive • **Dr. Bandey**: Dr. Bandey presented information about the cardiac rehab model pilot initiated with his team; • Q: as a sub-LHIN group, what is something we could do: demonstration project? • A: cardiac rehab is pretty neat and tidy; it is evidenced based; the guidelines are there; they looked at the gap they have; put a pilot together of 15 people; in the Spring after; exercise; optimizing medications; just finished the first cohort; thinking regardless of patient location it is great if most of cardiac rehab can be available locally; there are validation tools online to help with this • Q: Where did they get the resources; • A: they shuffled them; they had one program that was a bit similar (metabolic) put it on the shelf temporarily; this was a bigger fish we did find new resources; they shelved others; not a lot of new resources, so there is some degree of sacrifice; candidates post- cath stent by pass; medically managed angina; stable; • Q: What is the rehab part? • A: Their meds are typically not optimized at this point; people often don't get the diet and the exercise piece; the goal is continuing to do the exercise for the rest of your life; these people were getting referred into the program the FHT nurses did an intake assessment; they then

		went to get a stress test to determine how much could they endure; then they started twice a week exercise program with education; a kinesiologist was contracted for the exercise program; if this is spread throughout Huron and Perth; then perhaps exercise would be funded for those in a cardiac rehab program; pay for Y membership for instance and perhaps pay for kinesiologist; if people are interested, perhaps they can reach out to quality improvement people for example, Partnering for Quality or others to support this work; to show outcomes; others may say this is not realistic because of the cost, so if we can collectively work together to offer this free; Paul will use the minutes and structure he is creating to encourage those interested; in Grand Bend they have a model which is a CHC model; they have a gym there; this model is not far off what Dr. Bandey is describing; they do the 6 minute stress test; they have a cardiologist on site having GBACHC along to help would be great; there is a lot of appetite for this; Partnering for quality has been a great help and perhaps could help with this; idea to start piloting throughout HP in 2018; • Q: how do we start prescribing exercise –that' where they started with the kinesiologist; in Grand Bend they have a kin and PT, so the kin with the PT can write prescriptions; • Pulmonary and cardia rehab are issues across HP; patients really liked it; it is exciting and makes the primary care ball bigger; this with opioid management; • Concept of spread is easier here too because most on a few EMS (Bandey, MacDonald on Accuro sfht); • Suggestion that next issue to tackle is pulmonary (COPD); Jason has an RN doing this at the Y; have been doing this for almost 10 years; they can put patients in to run a program ; FHT nurses fun the chronic disease programs; there are clinics within our region to create sub-specialties for example in NP they have a palliative care navigator; • This PCA presents an opportunity for physician groups to highlight and demonstrate what they are doing; with cardiac rehab it is a nice guinea pig; idea needs to go to the SRIT tables for help to spread and support and funding support is likely needed; **ACTION**: Dr. Gill will connect with Jason and Shanil to get a working group; **ACTION**: Aim to host a meeting mid-January/February; Paul will send power point to all **ACTION:** Minutes will be distributed to group and information will be distributed to group around selecting a co-chair **ACTION:** Anyone interested in becoming the co-chair contact Dr. Gill **ACTION:** Any other feedback around Primary Care Alliance participants can contact Dr. Gill **ACTION:** Dr. Gill to contact Dr. Annis with regard to what AFTO is doing **ACTION:** Dr. Gill to contact Jane Tillman to bring forward data to the next meeting to show where gaps are
Next meeting date: TBD/ suggestion twice/year is good; at least quarterly Dr. Gill will try to come to their meetings at FHT or hospital; likely do OTN every 6 months and at 12:15 lunch time is preferable; face to face is always more engaging;		