## **Primary Care Networks in OHTs**

Webinar

January 24, 2024



## Webinar General Housekeeping



All participants have been muted given the large number of viewers – we appreciate you taking the time to connect



If a presenter loses connection, we will wait for them to reconnect



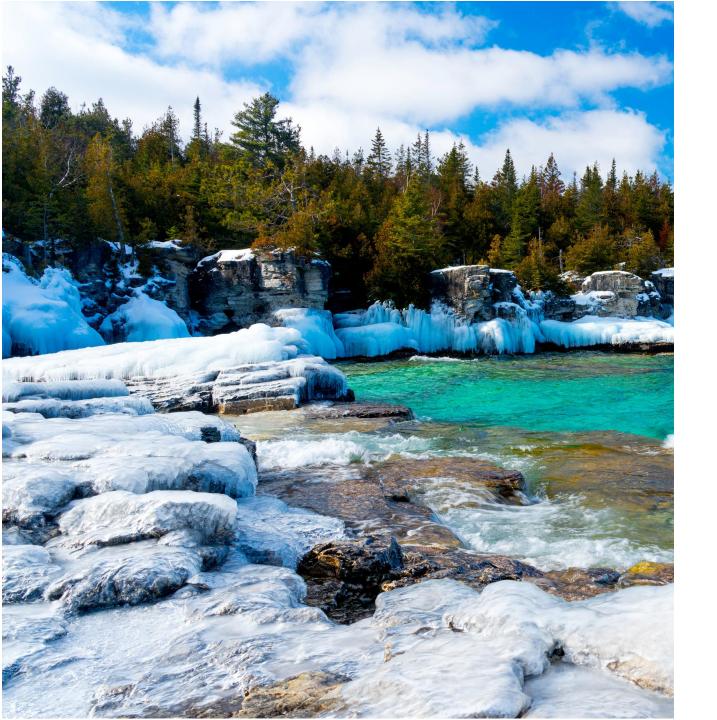
Have a question? Please use the Zoom Q&A function to pose your question for a moderated discussion



This webinar is being recorded and the recording and slides will be made available after the session







# Opening Prayer and Land Acknowledgment

#### ELDER, ADELE MADIGAN

Adele Madigan is an Elder from the Batchewana First Nation of Ojibways whose traditional lands stretch from Bawating (Sault Ste Marie) along the shores of Lake Superior to Pukaskwa National Park. Adele graduated from Laurentian University (Algoma Campus) with a degree in Human Services and is proud to have served her people in a kind and respectful way for the past forty years.



## **Overview of Today's Webinar**



#### Welcome, Land Acknowledgement & Opening Prayer

Elder Adele Madigan, Batchewana First Nation of Ojibways Rhonda McMichael, Assistant Deputy Minister, Strategic Partnerships Division, Ministry of Health Dr. Sacha Bhatia, Senior Vice-President, Population Health & Value Based Health Systems, Ontario Health



#### **Primary Care Network Vision & Value Proposition**

Dr. Elizabeth Muggah, Senior Clinical Advisor, Ontario Health Dr. Catherine Yu. East Toronto Health Partners OHT



#### **PCN Core Functions, Clinical Priorities and Readiness Assessment**

Allison Costello, Director, OHT Policy and Operations Branch, Ministry of Health Zahra Ismail, Vice-President, Primary Care and Patient Measurement, Ontario Health



#### **Reflections from the Primary Care Sector**

Dr. Briana Yee-Providence, OMA OHT Physician Leadership and Engagement Co-Chair Sarah Hobbs, CEO, Alliance for Healthier Communities, Primary Care Collaborative Chair



#### Facilitated Q & A and Wrap Up

Jessica Riehm, Manager, Integrated Supports Unit, Ministry of Health David Pearson, Director, Primary Care, Ontario Health





## **PCN Vision and Value Proposition**



**Vision**: PCNs will connect, integrate, and support primary care clinicians within OHTs to improve the delivery and coordination of care for patients.



Value for Patients, Families and Communities

Improved access and attachment to primary care

Patients at higher risk of poor health outcomes are identified early and primary care providers provide chronic disease prevention and management supports (aligned with integrated clinical pathways).



Value for the Primary Care Sector Have collective "voice" – unified, strong, and effective input from the primary care providers in OHTs Benefit from improved connections between the primary care sector and specialists, home care services and other community providers to improve patient care and provider experience

Lead access to integrated clinical and digital solutions for primary care providers to support delivery of care



Value for OHTs

"One door" to partner with primary care to implement clinical priorities and integrated care

Patient care is improved because a strong clinical primary care perspective is embedded across the OHT

Supports effective retention initiatives for primary care



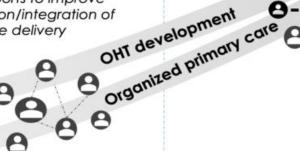


## EasT-FPN and ETHP: Advancing Together

## Aligning OHT and primary care maturity to co-lead system change



Collaborative partnerships and supports to improve coordination/integration of care delivery



Formalized partnerships, structures and governance design and implementation of integrated delivery models



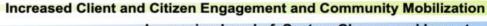


Integrated accountability, leadership, structures, governance, and resource allocation. System-level design and delivery of integrated health and social care

Primary care is at the core of integrated health and social care systems.

Maturity for OHTs and organized primary care leadership (e.g. Primary Care Networks) are linked. One cannot happen without the other.

Increased Intensity of Coordination, Integration and Collaborative Partnerships



Increasing Level of System Change and Impact

Increasing Investments Re-directed into OHTs







## **PCN** in OHTs Guidance



**Vision**: PCNs will connect, integrate and support primary care clinicians within OHTs to improve the delivery and coordination of care for patients.



#### **Objectives**

- Organize the local primary care sector in OHT planning and provide a voice in OHT decisionmaking;
- Serve as a vehicle to support OHTs in the implementation of local and provincial priorities.



#### **Functions**

- 1. Connects primary care within the OHT
- 2. Serves as a vehicle for providing the primary care sector's voice in OHT decision making
- Supports OHT clinical change management and population health management approaches
- 4. Facilitates access to clinical and digital supports and improvements for primary care
- 5. Supports local primary care health human resource planning in the OHT





## Clinical Priorities Advanced through PCNs

PCNs are not an additional layer of system administration, rather, they will intentionally connect the primary care sector within an OHT to improve clinical outcomes for patients using population health approaches.

### Ontario Health has identified priorities for OHTs to advance through their PCN:

Access and attachment to comprehensive primary care, with a focus on equity deserving populations (e.g., rural and remote communities, Indigenous, Black, Francophone etc.)

Integrated chronic disease prevention and management, with a focus on equity deserving populations (e.g., rural and remote communities, Indigenous, Black, Francophone)

Additional local priorities as defined by the OHT and PCN





## **PCN Readiness Assessment**

## **Readiness Assessment**



**Purpose**: Support OHTs to understand their readiness in establishing a PCN and help them plan for PCN advancement aligned with guidance.

**Process:** PCNs to consider functional improvement association with developmental themes through a reflective review and develop improvement actions.

#### **Example:**

Integrated Chronic Disease Prevention and Management, with a Focus on Equity- deserving Populations (e.g., Indigenous, Black, Francophone, etc.)	1	Has the PCN identified Clinical Lead(s) to participate in planning of OH Integrated Clinical Pathways within the OHT?
	2	Does PCN membership feel that the Integrated Clinical Pathways in the OHT have been co-designed with primary care in mind, and that the primary care voice has been equally considered during the planning of Integrated Clinical Pathways within the OHT?
	3	Is there evidence of primary care clinician participation in the delivery and implementation of Integrated Clinical Pathways within the OHT?
	4	Are most PCN members actively adopting the Integrated Clinical Pathways within the OHT?





# Reflections from the Sector

Dr. Briana Yee-Providence, OMA OHT Physician Leadership and Engagement Co-Chair

Sarah Hobbs, CEO, Alliance for Healthier Communities, Primary Care Collaborative Chair

## **Facilitated Q&A**

Please use the Zoom Q&A function to pose your question

Jessica Riehm, Manager, Integrated Supports Unit, Ministry of Health

David Pearson, Director, Primary Care, Ontario Health

## Wrap-up

PCN guidance and readiness assessment template to be made available to all OHTs following webinar

• Following the release of the PCN guidance and readiness additional collaborative learning sessions will take place, supported by regional and/or provincial teams and partners.

• Completing the readiness assessment is an expectation for Initial 12 OHTs in FY 23/24. For all other OHTs, completing the readiness assessment is optional, but encouraged.

• Ontario Health working with provincial partners to develop/curate a PCN implementation toolkit.

Further questions can be sent to <u>OntarioHealthTeams@ontariohealth.ca</u>



