ONTARIO
PRIMARY CARE
COUNCIL

Framework for Primary Care in Ontario

Version 2.0

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Contents

This document was developed through a collaborative process by the Ontario Primary Care Council. The OPCC is a group of associations who provide leadership, through relationships, to advance person-centred primary care in Ontario and develop actionable plans informed by pressing provincial priorities and trends.

The information, views and recommendations expressed in this document do not necessarily reflect the opinions of all individual member organizations involved in the Council.

'Framework for Primary Care in Ontario' has been endorsed by:
Association of Family Health Teams of Ontario (AFHTO)
Association of Ontario Health Centres (AOHC)
Nurse Practitioners' Association of Ontario (NPAO)
Ontario College of Family Physicians (OCFP)
Ontario Pharmacists Association (OPA)
Registered Nurses' Association of Ontario (RNAO)

Our mission and mandate

The Ontario Primary Care Council (OPCC) is a partnership comprised of seven provincial associations that represent primary care providers in the province:

- Association of Family Health Teams Ontario (AFHTO)
- Association of Ontario Health Centres (AOHC)
- Nurse Practitioners' Association of Ontario (NPAO)
- Ontario College of Family Physicians (OCFP)
- Ontario Medical Association (OMA)
- Ontario Pharmacists Association (OPA) and the
- Registered Nurses' Association of Ontario (RNAO).

The Council's mandate is based on primary care being the foundation of Ontario's healthcare system. The Council provides leadership, through relationships, to advance person-centered primary care in Ontario and develops actionable plans informed by pressing provincial priorities and trends, as well as legislative mandates and reports such as the *Excellent Care for All Act*, the Minister's Action Plan for Health and the Primary Health Care Planning Group Reports on Access, Accountability, Efficiency, Quality and Governance.

GUIDING PRINCIPLES

The Council's guiding principles include:

- primary care is central to the performance of whole health system effectiveness;
- planning for the system needs to be based on population needs;
- programs and services must be appropriate, accessible, timely, high-quality, comprehensive, continuous, evidence-informed, equitable and culturally competent;
- care coordination is a core function of primary care; and
- collaborative interprofessional teams working to full scope of practice are key to success.

A growing unity of purpose within the Council provides government and other stakeholders with an unprecedented opportunity to gather expert advice on how to strengthen primary care. For the first time ever primary care associations are developing common positions on how primary care can be strengthened. This collaboration provides decision makers with an invaluable new forum --- a place where they can prioritize issues and explore the pros and cons of new policies and practices under

consideration. In particular, the provincial government's efforts to improve quality, access and value for money in the province's health system can be enhanced by tapping into the Council's expertise. Shared positions, such as the Council's statement on care coordination (See Appendix One) can help guide the development of health system transformation.

Active engagement of the Council and its members during planning, development and implementation phases will also lead to more coordinated and comprehensive participation of primary care providers in province-wide initiatives designed to improve health and wellbeing.

About this document

This document builds on the Council's Terms of Reference (See Appendix Two), providing an overarching framework, as well as further details, with respect to how the Council envisions the delivery of Primary Health Care evolving and improving in the province in Ontario. It is aspirational in nature. In other words, it sets out major directions for change: changes which will significantly alter the status quo of primary care delivery in Ontario, but changes which can be phased in using an evolutionary approach over a five to ten year time period.

As evolution of primary care in Ontario continues, Council members will work in an aspirational way with provincial decision makers to ensure Ontario implements the enablers and moves closer to the goals identified in this document.

Defining Primary Care

As the Council moves forward working with decision makers and other stakeholders to positively shape the evolution of primary care in Ontario, there are several definitions of primary care that will guide our efforts.

- In the work of Dr. Barbara Starfield, primary care is defined as " first-contact, continuous, comprehensive, and coordinated care provided to populations undifferentiated by gender, disease, or organ system."[1]
- The Council is also guided by the definition applied in the *Strategic Directions for Strengthening Primary Care in Ontario,* a paper released in December 2011 by a Primary Healthcare Planning Group (PHPG) convened by Ontario's Ministry of Health and Long-Term Care:

  > Primary care is that level of a health service system that provides entry into the system for all new needs and problems, provides person-focused (not disease-oriented) care over time, provides care for all but very uncommon or unusual conditions and coordinates or integrates care provided elsewhere or by others.
  >
  > It thus is defined as a set of functions that, in combination, are unique to primary care. Primary care also shares characteristics with other levels of health systems: accountability for access, quality and costs; attention to prevention as well as therapy and rehabilitation; and teamwork.

> Primary care is not a set of unique clinical tasks or activities; virtually all types of clinical activities (such as diagnosis, prevention, screening and various strategies for clinical management) are characteristic of all levels of care. Rather, primary care is an approach that forms the basis for and determines the work of all other levels of health systems.
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> Primary care addresses the most common problems in the community by providing preventive, curative and rehabilitative services to maximize health and well-being. It integrates care when there is more than one health problem and deals with the context in which illness exists and influences the responses of people to their health problems. It is care that organizes and rationalizes the deployment of all resources, basic as well as specialized, directed at promoting, maintaining and improving health.

- The Council also sees primary care as a core component of Primary Health Care, an orienting philosophy and overarching strategy for promoting and protecting people's health. In the World Health Organization's 1978 Alma-Ata Declaration as Primary Health Care is described as addressing "the main health problems of the community, providing promotive, preventive, curative and rehabilitative services" and involving "in addition to the health sector, all related sectors and aspects of national and community development…."

OPCC's principal goal: primary care must serve as a strong foundation of the health system

During the next four years, Ontario's Primary Care Council will be guided by an overarching principle:

> To improve population health, deliver people-centred services and strengthen our publicly funded health system, Ontario must create a stronger foundation for the delivery of primary care in this province.

This principle is based on a large volume of evidence which demonstrates investment in primary care is associated with improved system quality, equity and efficiency (reduced cost)[1,2,3,4].

What constitutes a strong primary care foundation for Ontario?

As decision makers move forward with health system transformation, they must be guided by a clearly defined understanding of what would constitute a strong primary care foundation in Ontario.

The OPCC proposes the following description for a strong primary care foundation:

- Serves as a foundation on which Ontario's health system firmly rests; that is, with a strong primary care system as the foundation, the effectiveness and efficiency of the rest of the system can be fully realized.
- Strictly adheres to the principles of universality and access to services based on need.
- Focuses on population health and should work to prevent sickness and improve the health of people living in Ontario. For this reason, a strong primary care foundation delivers, or enables access to, a comprehensive set of services that are designed to prevent illness and promote health.
- Focuses on health equity and reduces health inequities and disparities.
- Supports evidence-informed decision making at the point of care, as well as at the organizational and provincial levels.
- Strong in all parts of the province, with a firm footing across all geographic areas and populations.

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[1] Shi L, Starfield B, Kennedy BP, Kawachi I. Income inequality, primary care, and health indicators. J Fam Pract. 48 (1999), 275--84.

[2] Starfield B. Family medicine should shape reform, not vice versa. Fam Pract Man. May 28, 2009; Global health, equity, and primary care. J Am Board Fam Med. 20(6) (2007), 511--13; Is US health really the best in the world? JAMA. 284(4) (2000), 483--4; Research in general practice: co-morbidity, referrals, and the roles of general practitioners and specialists. SEMERGEN. 29(Suppl 1) (2003), 7--16, Appendix D.

[3] Starfield B, Shi L. Policy relevant determinants of health: an international perspective. Health Policy. 60 (2002), 201–18.

[4] Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Quarterly. 83(3) (2005), 457--502.

- Responsive to local needs and contexts providing comprehensive and coordinated services.
- Effectively linked and connected to the broader health and social system.
- Made up of interprofessional health providers and organizations that are responsible, responsive and accountable.
- Fosters a culture of innovation that supports the quality of care and services to continuously improve.
- Economically sustainable – that is, it uses all of its assets appropriately and efficiently as possible so that it is sustainable and effectively supports the system as whole.

A strong primary care foundation is people-centred

Perhaps the most important indicator of primary care's strength is the extent to which it is designed around the needs of those it serves---the extent to which is a person-centred or people-centred system. Person-centred care can be viewed as: "An approach in which [people] are viewed as whole persons; it is not merely about delivering services where the [person] is located. [Person] centred care involves advocacy, empowerment, and respecting … autonomy, voice, self-determination, and participation in decision-making."[5]

OPCC proposes that a strong, people-centred primary care foundation will demonstrate the following attributes:

- People are experts for their own lives and should be leaders in the care delivery process. The person's goals should drive service delivery and co-ordination of care.[6]
- People can be confident their primary care providers are promoting health and treating illness in the most effective ways ---ways that are based on the best available scientific evidence.

[5] Adapted from definition of client-centred care in the Registered Nurses' Association of Ontario (RNAO)'s (2006) Client Centred Care Nursing Best Practice Guideline (currently under revision with an update expected in 2015).

[6] Adapted from Registered Nurses' Association of Ontario (RNAO)'s (2006) Client Centred Care Nursing Best Practice Guideline (currently under revision with an update expected in 2015).

- Both individual people and the communities they serve, will know their primary care providers are accountable for the services that are delivered and that they have someone they can turn to if they have questions or concerns about the care or services they are receiving.

- People will be able to access their services from the right provider, at the right time and place and everyone will have equitable access to the services they need, no matter where they live in the province.

- When people require multiple services to maintain and/or manage their health, their primary care provider will work with them to ensure they have coordinated care plans. These plans will enable and assist them to access all the appropriate services they need to manage their health.

- When people require multiple supports, they will not fall through the cracks in uncoordinated hand-offs between primary care providers and other parts of the system. If a person experiences episodes of acute illness that require specialty care, or admission to hospitals, they should expect their primary care provider to be provided with the correct information at the right time. There should be no gaps in information, communication or services as the person transitions from another part of the system back to the primary care provider. Care will be shared, not simply handed off back and forth between primary care and other parts of the health system

- People's primary care provider will be equipped with all the tools they need to assess their health risks and respond with services or referrals to services that address social, economic or environmental factors affecting people's health and wellbeing.

- People living in Ontario will be able to access primary care services equipped to support a complete sense of health (mental, emotional and physical) not just the absence of illness.[7]

What are the functions of a strong primary care system?

Health system transformation must also be guided by a clear understanding about the functions of primary care. The Council's understanding on this question has been guided by a wide range of sources.[8]

[7] Based on World Health Organization's definition of health.

[8] Barbara Starfield, *Is primary care essential?,* The Lancet, 1994; A Vision for Canada, Family Practice, The Patient's Medical Home, Canadian College of Family Physicians, 2011; Primary Solutions for Primary

- Comprehensive care assumes that care is delivered across a person's lifespan and provides care within the context of their social environment and family. It includes the creation, management and maintenance of an appropriate medical record managed by the most responsible provider.
- According to the opening statement of *Strengthening Primary Health Care in Ontario- Summary of the Recommendations of the Primary Health Care Planning Group – 2011* a strong primary care foundation is robust across all of its dimensions of care: primary and secondary prevention, screening and early detection of illness, coordination of acute care with appropriate follow up, smooth transitions across clinicians, settings, and services.
- Drawing from the 1996 Provincial Coordinating Committee on Community and Academic Health Science Centre Relations (PCCCAR) Basket of Services, [9] Patient Enrollment Model contracts specify the minimum requirements of comprehensive primary care as follows:

1. Health assessment
2. Clinical evidence-based illness prevention and health promotion
3. Appropriate interventions for episodic illness and injury
4. Primary reproductive care
5. Early detection, as well as initial and ongoing treatment of chronic illnesses
6. Care for the majority of illnesses (with specialists as needed)
7. Education and supports for self-care
8. Support for hospital care and care provided in-home and in long-term care facilities
9. Arrangements for 24/7 response
10. Service coordination and
11. Maintenance of comprehensive patient health record
12. Advocacy
13. Primary mental health care including psycho-social counselling
14. Coordination and access to rehabilitation
15. Support for the terminally ill

As Ontario continues health system transformation, the Council asserts the role of primary care providers to lead care coordination and access to appropriate programs or services – core functions of primary care as defined above.[10] The desired outcome is that throughout a person's lifetime, care coordination is provided through that person's primary care organization. As Barbara Starfield has highlighted, primary care is one level of a health system and therefore one of its key functions is to connect with other levels of care that include secondary, tertiary and emergency care.

It is important to point out that, because primary care has many different functions and health issues can be very complex, people need access to interprofessional teams staffed with different types of providers with complementary roles and responsibilities. Each person requires a clinical lead for their on-going comprehensive primary care – i.e. a family physician or a nurse practitioner. Other important

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Care, Registered Nurses' Association of Ontario (RNAO), 2012; Enhancing Community Care for Ontario, Registered Nurses' Association of Ontario (RNAO), 2012.

[9] Subcommittee on Primary Care of the Provincial Co-ordinating Committee on Community and Academic Health Science Centre Relations (1996) *New Directions in Primary Health Care.* PCCCAR report to the Minister of Health of Ontario, 21-31

[10] Registered Nurses' Association of Ontario (RNAO)'s Enhancing Community Care for Ontarians (ECCO) Model V2.0. Accessible at: www.rnao.ca/ecco

roles within the team, such as care coordination and system navigation, may be provided by other members in the primary care team.[11]

Additional principles and desired outcomes that have been adopted by the Council in relation to care coordination can be found in Appendix One.

What will enable a strong primary care system for Ontario?

To achieve the strongest possible Primary Care system for Ontario, the OPCC has identified the following enablers:

- Leadership:
    - From the provincial government, a strong and explicit commitment to strengthen primary care in Ontario and make it the foundation of the system.
    - Strong stewardship by the Ministry to ensure the application of values, principles, policies and standards in the planning of primary care are applied in a consistent way across the province at the LHIN and local level.
    - Decision making that is informed by meaningful engagement with associations representing primary care providers, the public and other stakeholders, and accompanied by proactive strategies to strengthen primary care in places where it lacks capacity.
    - Strategies to strengthen leadership within primary care organizations and practices that are focused on both providers and managers.

- Infrastructure:
    - Infrastructure in place across the province to enable the capacity to establish and support processes that fulfill all the functions of primary care, including care coordination, access to the right provider at the right time[12], and the ability to measure, evaluate and improve performance.
    - Support and ongoing training and time for quality improvement that builds the knowledge and skills of primary care providers as well as ongoing performance measurement
        - Standardized measurement for quality improvement
        - Standardized measurement for accountability.
    - Appropriate resourcing:

[11] The College of Family Physicians of Canada, *A Vision for Canada: Family Practice – The Patient's Medical Home*, September 2011. Accessible at: www.patientsmedicalhome.ca

[12] Registered Nurses' Association of Ontario (RNAO)'s Primary Solutions for Primary Care. Accessible: www.rnao.ca/primary_care_report

- Equitable access to interprofessional teams that facilitate the provision of comprehensive, continuous and people-centred care, mobilization of healthcare resources and patient navigation of the healthcare system.
- Human resources and staffing strategies that supports the right numbers and mix of quality providers and enable interprofessional teams to work to their optimal scope of practice.
- Appropriate funding for information management, technology equipment, supplies and facilities that maximizes effectiveness and efficiency

- Governance and Accountability:
    - A long term vision and plan for how people, institutions and resources in primary care should be organized and self- governed to ensure the best possible health and wellbeing for everyone living in the province.
    - Population needs-based planning for primary care that creates access to people-centred, appropriate, timely, continuous, comprehensive, and culturally safe services and takes into account populations that have especially complex needs or regions that lack services.
    - Clarity around the role of responsibility relative to other parts of the health system
    - Strong connections between community-based providers and the health system partners to ensure optimal coordination, and smooth transitions of care.
    - Capacity building to enhance leadership, managerial and organizational development competencies.
    - Systematic strategies to ensure people centred services that enable people to participate actively in their own healthcare, as well as the design and planning of community-based health services.

- Research and Education:
    - Evidence-based decision making informed by the large volume of evidence which demonstrates that investment in primary care delivers strong outcomes.
    - Enhanced research and knowledge transfer capacity that produces a constant flow of research evidence to inform primary care policy and practice.
    - Public education strategies to build understanding about the foundational importance of primary care.

Appendix One: Ontario Primary Care Council 's Statement on the role of primary care in care coordination.

Approved by Ontario Primary Care Council July 14, 2014

Position on Principles of Care Coordination Leading to Seamless Transitions for Patients and Families

Background

The Ministry of Health and Long-Term Care is transforming how care is delivered to Ontarians. The Ontario Government's *Excellent Care for All Act* and the *Action Plan for Health Care* aim to enable a health system that better responds to patient needs and delivers high quality care that is both accessible and affordable. Central to achieving elements of the Action Plan for Health Care is robust and well-coordinated primary care. Primary care is an anchor for patients and families and is well positioned to support better care coordination in primary care, including system navigation across the health system and social services.

The Ontario Primary Care Council affirms effective care coordination as a dimension of quality primary care that is patient-centered and leads to effective and more seamless transitions in care between settings and among providers. Care coordination would ensure continuity of care for patients regardless of setting, including home, community, hospital, long-term care facility or their family practice, among others. The Council has identified coordination of care as an area of shared focus because of its potential for significant positive impact on patient outcomes, health care delivery, and enabling Ontario's *Action Plan for Health*.

Position Statement

The Ontario Primary Care Council (OPCC) asserts the role of primary care providers to lead care co-ordination and access to appropriate programs or services. Primary care providers will work to ensure access to interprofessional care for patients and will identify a point of contact, to help patients and families navigate and access programs and services.

Effective care coordination will lead to more seamless transitions for patients and families, reduce duplication, increase quality of care, facilitate access, and contribute to better value by reducing costs. The OPCC believes care coordination requires dedicated funding and leadership support through training and education.

Definition of Care Coordination

To facilitate the appropriate delivery of health services, care coordination is the deliberate organization of care, services and programs that involves two participants (including the person receiving services and their family). Organizing care involves the marshaling of personnel and other resources needed to carry out all require activities, and is often managed by the exchange of effective and timely information among participants responsible for different aspects of services the person requires.[13]

[13] Definition is an adaptation of the Registered Nurses' Association of Ontario (RNAO)'s definition from *"Enhancing Community Care for Ontarians 1.0"* (www.rnao.ca/ecco) and the Agency for Healthcare Research and Quality (US) working definition of care coordination from "*Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies (Vol. 7: Care Coordination)" 2007 Jun.*

Principles of Care Coordination and Desired Outcomes

The Council's focus is guided by five principles of person-centred care coordination. These principles are shared by member organizations of the Council, and generally guide many primary care transformation initiatives. Desired outcomes are identified against each principle.

Principles of Care Coordination	Desired Outcomes
1. Care coordination is a core function of primary care and a hallmark of a high-performing primary care system.	Care coordination is provided through the patient's primary care organization throughout their life span.
2. Care coordination includes communication and planning with the patient and family.	Patients are at the centre of their plan of care. Their perspectives are fully integrated in the formulation of this plan
3. Care coordination requires a population needs based approach to planning.	A comprehensive needs assessment that includes demographics, community resources, health planning data and human resources trends informs the development of the health system, primary care and care coordination
4. Care coordination will emphasize the timely and continuous delivery of high-quality, person-centred, equitable, timely and continuous services and programs that are comprehensive, evidence-informed, culturally competent and appropriate.	There is evidence that patients receive high quality care that reflects services and programs that are comprehensive, evidence-informed, culturally competent and appropriate.
5. Care coordination focuses on the provision of comprehensive services across the health and social services continuum as needed.	There is evidence that patients experience timely access to services and seamless transitions in care.
6. Care coordination is predicated on collaborative inter-professional teams working to full scope of practice.	There is evidence that patient care is optimized when all health-care professionals are working collaboratively each at their full scope of practice.

Appendix Two

ONTARIO PRIMARY CARE COUNCIL TERMS OF REFERENCE

MANDATE

Primary care is the foundation of Ontario's health-care system. The Ontario Primary Care Council (OPCC) provides leadership, through relationships, to advance person-centred primary care in Ontario and develops actionable plans informed by pressing provincial priorities and trends, as well as legislative mandates and reports such as the *Excellent Care for All Act*, the Minister's Action Plan for Health and the Primary Health Care Planning Group Reports on Access, Accountability, Efficiency, Quality and Governance.

GUIDING PRINCIPLES

The Council's guiding principles include:

- primary care is central to the performance of whole health system effectiveness;
- planning for the system needs to be based on population needs;
- programs and services must be appropriate, accessible, timely, high-quality, comprehensive, continuous, evidence-informed, equitable and culturally competent;
- care coordination is a core function of primary care; and
- collaborative interprofessional teams working to full scope of practice are key to success.

SCOPE OF AUTHORITY

The Council's scope of authority is confined to the following areas in relation to primary care policy, funding and programmatic developments:

- To position the Council as a co-ordinated association committee that is proactively engaged by government and its agencies for consultation.
- To collectively strategize to inform individual organizational responses.
- To strive for a unified voice through collective response.

The Council will focus its efforts by building a strategic common vision for a primary care system and collectively address priorities that are identified and approved annually.

COMMITTEE COMPOSITION

Founding members of the Council are:

- Association of Family Health Teams Ontario
- Association of Ontario Health Centres
- Nurse Practitioners' Association of Ontario
- The Ontario College of Family Physicians
- Ontario Medical Association
- Ontario Pharmacist's Association
- Registered Nurses' Association of Ontario

The representatives of the Founding Members are the Board Chair, and the CEO or Executive Director. While delegates will be accepted on occasion, the senior leadership is expected to a
One staff person from each Founding Member organization may attend the meetings in an observer or resource capacity.

OTHER PARTNERS:
The Council endeavours to engage with the Ministry of Health and Long-Term Care and its agencies (e.g. HQO and LHINs) at least twice a year. On occasion, the Council may need to engage other partners (individuals/organizations) or subject matter experts to advance its priorities.

OPERATIONAL PRINCIPLES
The Council will:

- Strive to operate by consensus and collaboration;
- When engaging in collective response exercises, organizations reserve the right to opt-out.
- When speaking as a collective, if consensus is not achieved, the Council will specify which members have provided their endorsement.
- Recognize and value each Association;
- Utilize open, effective, timely, and transparent communications;
- Function through the active participation of all members;
- Openly debate perspectives and issues in a confidential manner; and
- Communicate outcomes, not the process or particular organizational positions.

CHAIR ROLE:
The Council will always be co-chaired by two founding member organizations on a rotating two year term. During the inaugural term, one co-chair will agree to serve for a single year to provide staggered continuity. The Council will strive for continuity by electing an incoming co-chair 12 months in advance of the expiration of the outgoing co-chair's term.
Founding members are invited to submit their organizational nomination by notifying the current co-chairs. The Council will appoint co-chairs through a majority vote. Each founding member organization has one vote. The Council will strive to ensure that the co-chairs have access to the capacity needed to assume the secretariat role and represent the diversity of the founding member organizations. Upon expiration of a co-chair term, one year must elapse before the same organization can assume the co-chair role again.

The responsibilities of the co-chairs will alternate and include:

- Chairing meetings;
- Tracking action items and ensuring continuity of issues between meetings;
- Preparing and distributing the meeting agenda and minutes;
- Co-ordinating meeting materials and uploading them to the online repository.
- Inviting guests;
- Scheduling meetings 12 months in advance; and
- Securing meeting space and refreshments.

The elected organization will decide which person will serve as the co-chair, however, it must be either the CEO/ED or President/Chair.

The co-chairs are not automatic spokespersons for OPCC. The co-chairs can serve as spokespersons on matters relating to OPCC, however, only with the approval of founding members. Only approved messaging will be communicated and organizations that have 'opted-out' will be noted.

COMMUNICATIONS
When engaging in collective response, the Council will appoint a founding member to provide leadership in co-ordinating the response.

Minutes from the meetings will be distributed within two weeks following the meeting and will focus on outcomes, actions and decisions.

Approved meeting minutes may be shared by Council members with their own constituencies; and with other stakeholders through the Council co-chairs.

An online document repository will be hosted by the Ontario Medical Association (OMA). The co-chairs will provide the OMA with materials for publication in advance of the meeting and are responsible for ensuring that the repository is complete. One secure account will be provided to each founding member association.

FREQUENCY
The Council will meet in person a minimum of six times per year. The Council will aim to schedule half-day meetings the morning of the third Wednesday of every second month.

WORKING GROUPS
The Council may appoint time-limited and task-based working groups to focus on particular projects or responses. The mandate will be defined by the Council and the working group will report to the Council. The working groups will be chaired by a Founding member that is approved by the Council.

Approved: August 2012
Revised: December 2014