



Ontario College of Family Physicians

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A Chapter of the College of Family Physicians of Canada

Response to *Patients First: A proposal to strengthen patient-centred health care in Ontario*

Submitted to: health.feedback@ontario.ca

February 29, 2016

The Honourable Dr. Eric Hoskins
Minister of Health and Long-Term Care
Ministry of Health and Long-Term Care
80 Grosvenor Street
10th Floor, Hepburn Block
Toronto, Ontario
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Dear Minister Hoskins,

The Ontario College of Family Physicians (OCFP) is pleased to provide a response to *Patients First: A proposal to strengthen patient-centred health care in Ontario*. We consulted with our Board of Directors and members, attended the Maternal Child Health Summit and a Ministry Consultation with stakeholders, and also had the opportunity to participate, with several of our board members, in many LHIN primary care physician engagement meetings across the province. The OCFP believes that a high-functioning primary care sector is the foundation for a high-performing and effective health-care system that Ontario citizens need. We agree with the need to improve access to primary care and recognize that there are inequities in access to health services for many Ontarians. There is also currently a mal-distribution of resources available for both patients and providers. A population-based approach to determining access to these resources can enhance provision of services for patients and families across communities.

In particular, Ontarians need access to comprehensive, well-coordinated care in the context of continuous relationships with family physicians in the ‘patient’s medical home’. Dr. Barbara Starfield and others identified the value of this type of primary care in high-performing health systemsⁱ. The linkages of public health and community and home care to this primary care home ‘home’ have the potential to create an even more highly-functioning and integrated system.

The OCFP commissioned an Evidence Briefⁱⁱ released in October 2015 in anticipation of a devolved population-based approach to primary care. The brief emphasized that for transformation in primary care to be successful, it is imperative to meaningfully engage family physicians, provide them with necessary tools and practical supports, and support their time to participate in local planning and implementation efforts. Other jurisdictions’ experience with significant health system transformation underscored the importance of clinical leadership – leadership anchored in practices - beyond the Primary Care Physician LHIN Lead model. Importantly, a key lever for any system change is to recognize that a change in culture is required, and in Ontario we need to support and embrace a culture of change as part of ongoing system transformation and improvement.

As noted in the Evidence Brief “a culture of change has been described as one that engages people in decision-making based on co-produced organizational values and a motivated workforce that responds to the vision and opts in by committing to improvement activities.” Family physicians who work in their practices across the system have brought and continue to bring forward excellent ideas and solutions to current health-care challenges. Many are implementing changes in their practice contexts to improve care and care delivery to the

people that they serve. Building a better system, particularly in primary care, will best be done by finding ways to bring the best ideas forward, and support their implementation and spread.

Clearly, an existing barrier to physician engagement in Ministry driven transformation is the ongoing lack of a Physician Services Agreement between the Ontario Medical Association and the Ontario Government. The OCFP supports the need for negotiations to resume and strongly encourage that an Agreement be reached. We know that many family physicians are angry about the fee cuts and funding changes and we have heard from many of our members that there is a great deal of mistrust in the overall plan for health-care reform. Many believe that the current engagement is not sincere. There is work to be done to re-build relationships and re-establish the level of trust that can enable the kind of work that this system transformation will entail.

While the OCFP believes in provider accountability, the importance of stewardship, and the value of our health system, we know that such things as elimination of duplication and reducing unnecessary testing are not going to be achieved through providers alone. The Ontario Government must undertake public education about appropriate use of our health-care resources – aligned with initiatives such as Choosing Wisely. Based on the experience of hospitals and the work of The Change Foundation, public engagement at the system planning level (LHIN and sub-LHIN level) as well as the service level will both enhance ownership and stimulate creativity to inform solutions and promote stewardship of the health system.

The government and the LHINs need to work with family physicians, and identify the practice models that they feel best serve citizens and communities. The OCFP was pleased to note the inclusion of the ‘medical home’ model in *Patients First*. If comprehensive family practices that provide continuity and coordinated care as envisioned by our National College and through the pillars of the Patient’s Medical Homeⁱⁱⁱ is the desired state, then there needs to be alignment of the primary care capacity to support this approach to care. The establishment of more formal collaborative networks, supported by lead organizations that have the ability and accountability to build this capacity with their peers will be critical. Since family physicians play an integral role in enhancing equitable access, they should be provided with the data being used as the basis for the proposed changes by the Ministry and LHINs to help inform appropriate solutions based on evidence.

Generalist family physicians are the most important innovation healthcare has to offer patients with multiple chronic conditions” (Freeman, Wetmore, CFP Feb 2016, p. 125)

As the OCFP considered the Discussion Paper, several gaps emerged that were not fully articulated in the proposals and for which there needs to be more focus in LHIN planning discussions. Several of these gaps were identified by various stakeholders and family physicians during the consultation process and these are detailed below.

We celebrate the fact that significant progress has been made in family medicine and primary care over the last decade – from embracing new interdisciplinary team-based models, to high levels of patient attachment to a family physician, to the fact that more graduates from medical school are choosing family medicine as their career path of first choice. We need to continue to build on the successes of the past decade, recognize the importance of family medicine as a critical component of primary care, and also see family physicians as key integrators across the health system.

Identifiable Gaps in the Discussion Paper:

Mental Health and Addictions

- While there is mention of the need to address mental health as a priority, notably absent is an overall framework for mental health and addictions services. How these services could work with primary care, both for children, adolescents and adults across the spectrum of care requires further detail, discussion and planning between existing mental health advisory tables, the Ministry, and relevant stakeholders including those providing primary care. In several LHIN meetings, access to psychiatric referrals and to social workers in non-FHT models has been identified as a significant issue in primary care. Better connections with robust and sustainable community based mental health and addictions programs are also required.

“Accessing mental health services, especially psychiatry and psychotherapy, is the most frustrating part of my job and the lack of service I believe is detrimental to the whole population and likely the economy.”
OCFP member

Maternal and Child Health

- We heard from family physicians practicing maternal and newborn care (reproductive health, obstetric care, and care of newborn babies and children) as well as from families, that the paper is very focused on the adult and seniors’ population who are high users of acute care services. The paper references vulnerable adult populations but does not address children and families and the range of services across other Ministries that are crucial to their development. We need to ensure that there is ready access for all providers of maternal and newborn care to the specialty care that their patients may need during pregnancy. We also need to ensure that there is ready access to the kinds of public health resources that support community-wide healthy child development.

First Nations, Inuit and Métis Populations

- *Patients First* recognizes the significant disparities faced by Indigenous Peoples in Ontario and supports the need for a process that fully engages these populations in planning that recognizes the cultural differences and traditions that can inform culturally safe care. The paper references the importance of developing relationships and “identifying the changes needed to ensure health care services address the unique needs of (Indigenous) peoples...”. We anticipate that you will hear from many First Nations, Métis and Inuit people in the province about many of the specific issues which they face. The input from each of the First Peoples must inform LHIN planning and be addressed through unique approaches and solutions that are embraced and enabled by communities, and supported by the health system and providers. These solutions must include social determinants of health which create inherent barriers around access to care, notably for Aboriginal populations in rural and remote communities, and those living on and off reserve. In each of the priority categories noted in the paper, family physicians who serve Indigenous populations have identified not just the need to “build relationships” and “identify changes needed” (as are noted in the discussion paper) but in fact to implement urgently the solutions that will address the challenges that their patients face in order to address the significantly worse health outcomes that those challenges create. Many committed family physicians in Ontario have long advocated to address the challenges that exist in terms of access to primary care resources, access to basic public health services, and access to home based care services, including palliative and end-of-life care. Culturally-relevant and appropriate resources and communication tools and skills are needed to ensure coordination between hospitals and primary care providers within communities and between the federal government First Nations and Inuit Health Branch and provincial services.

Care Coordination

- Transitions in care emerged as a significant gap in the paper. Excellence in transitions in care support both relational and information-based continuity and improve care. Given the LHINs proposed expanded role to include primary care, home and community care and public health in integrated health systems planning, the lack of mention of the role of hospitals to help inform solutions within and across settings of care based on their infrastructure, experience and leadership – both administrative and clinical - is a lost opportunity. In particular it is very clear to community based family physicians and others in the system, that there is work to do to improve discharge planning and coordination between hospital specialists and family physicians and community services. This was a key area highlighted by a Citizen Panel in February 2016 that the OCFP funded through the McMaster Health Forum. The OCFP asserts the importance of care coordination in primary care, in alignment with the Ontario Primary Care Council’s initial response to Minister Hoskins^{iv}. Streamlined solutions, such as standardized forms for use between hospitals and family physicians would be useful and support better integration. As an example of a current missed opportunity in care coordination, the Quality-Based Procedures and Bundled Payment pilots have not included all the key partners, have only addressed specific complex conditions, and are not connected to the family physician as the comprehensive and continuous provider.
 - LHINs should work with hospitals to support transitions in care for patients at the time they leave the hospital. Patients frequently arrive at family physician offices without the hospital discharge information required to provide bridging care. Providing the patient with a hard copy of their records is an interim solution until integrated EMRs are widespread.

Data, Metrics & Health Human Resources

- The lack of effective interoperable EMR and data systems is a huge barrier to integration of services and effective care management for complicated patients by family physicians and other providers.
- Performance indicators for primary care need input by family physicians at the time of development in order to provide quality metrics for planning purposes. Currently, some performance indicators are not effective measurements of quality care provided, nor do they keep up with the best evidence. The creation of performance indicators for primary care requires the participation of family physician providers from multiple sectors so that they focus on meaningful and realistic measurements and ideally so that they have impact downstream in the system (e.g. strategic visit in primary care within seven days of discharge from hospital closes the gap in the transition, ensures that patients are reconnected back to their primary care ‘home’ and decreases the risk of readmission to hospital within 30 days).
- For the majority of family physicians, there is no support for data mining and this takes time. Since QI efforts rely on a foundation of good data, there needs to be consideration for in-office support for data extraction and use.
- The paper is silent on “whole system metrics” and we have identified the following issues that pertain to that gap:
 - Measurement using a whole system perspective that is patient centered, not pitting one part of the system against another will be an important approach to consider. (*The Kings Fund: Place-based systems of care*)^v
 - Public reporting can be seen as punitive, whereas peer review may be more effective and palatable for providers.

“Same day/next day appointments may get offered but the open slot provided may not be convenient for the patient. These nuances must be considered in patient experience surveys.”
OCFP member

- The Southcentral Foundation of Alaska^{vi}, (“The Nuka System of Care”) has adopted a customer-driven rather than bureaucratic approach to transformation of their health system. The relationship-based, customer-owned system outperforms many known health-care systems on a range of results including same-day access, reducing ER and urgent care use.
- The Ontario Hospital Association *Creating a High Performing Healthcare System for Ontario: Evidence Supporting Strategic Changes in Ontario*, October 2015^{vii} describes the importance of quality and system improvement by allowing for local adaptation of quality agendas to fit the local context and settings.
- Considerably more work needs to be undertaken to realign the health human resources of the province.
 - There are significant challenges in understanding the health-care needs of patients in any given community (depending on demographics, disease burden and social determinants of health).
 - The Health Human Resource data that needs to inform the LHIN and sub-LHIN planning must be built on a sophisticated framework common across all the LHINs and based on the recognition of how and where physicians are working. This must include practice realities, including family physicians working PT/FT, in Emergency Medicine or other focused practices (e.g. palliative care, sports medicine), working in long-term care facilities, teaching, and recognizing the complexity of populations and the mal-distribution of other professionals to support their practices. In addition to family physicians, there is also a need to align nurse practitioners, social workers, nurses, midwives, practice-based pharmacists, and specialists to serve the population and the patients.

Clinical leadership -

- There is a need to define what is meant by clinical leadership. Clearly in the context of *Patients First*, it goes beyond the traditional ‘Most Responsible Provider’ leadership role that we understand in the physician-patient dyad. The role of the clinical leader in system transformation needs to bridge from practice to community, to understand and embrace the vision for the system, and help communicate and support movement toward that vision. Family physicians are very well placed to play this role. Leadership is a process, not a title, and is about attaining goals.
- Clinical leadership also needs to include decision-making power and not simply be a consultative role.
- Both the OCFP’s Evidence Brief and the OHA paper describe the importance of physician leaders who take on leadership positions and work to engage their peers and other staff members in system transformation efforts. The importance of supporting clinical leaders with tools, time and resources in order to optimize transformation effort success cannot be underestimated.
- The MOHLTC and LHINs need to consider the cost-benefit of a physician’s time in administration and planning including leadership time, supporting quality improvement, and other administrative tasks – these activities take time away from the physician’s important clinical work and ‘teaching’ role with patients and students and it is time that must be valued.

“Clinical leadership is helping physicians to promote high value medically appropriate care, and helping them work more effectively with inter-professional providers in a system that emphasizes collaborative care.”
OCFP member

“[A clinical leader] offers clinical context and direction from a physician and patient advocate point of view. Allows for time away from my practice to offer advice, and consequent reimbursement.”
OCFP member

Specific member feedback on the four proposals in *Patients First*:

The Discussion Paper sought feedback on specific proposals. Below is a summary of what the OCFP heard from members, the Board of Directors and through a series of meetings over the past two months.

Proposal #1: More effective integration of services and greater equity

- The government is proposing that the LHINs be responsible and accountable for all health service planning and performance. It is not clear how the governance of the LHINs will be strengthened to encompass the breadth of their new role and what management capacity will be required to undertake the direct delivery of services, the new contract management of services, as well as all health services planning. Additionally, there needs to be clear LHIN accountability from the Boards and frontline providers for streamlining and improving services. As the MOHLTC pursues a more integrated and organized system, it is important to recognize that for providers and patients alike, there is no desire for a more complicated or bureaucratic system with additional layers of administration. The challenge will be to organize governance and management in such a way that it makes the work of providers easier and is creating more direct patient care capacity and accessibility. We have heard considerable concern about the inherent conflict between being a service delivery agent and the role of governing the distribution of resources and measurement of performance. The LHINs need to develop effective mechanisms to address this and be transparent to the community.
- There is a recognized mal-distribution of physicians in the province. The current managed entry program has destabilized young graduates in family medicine and is counterproductive to supporting comprehensive, coordinated care throughout Ontario due to the caps placed on fee-for-service and stipendiary work in a non-rural setting. For greater equity to be achieved, more family physicians must practice comprehensive family medicine throughout Ontario, not only in rural areas, and this must be supported by the province.
- Equity issues have arisen amongst providers with the introduction of the FHT and paid IHPs. An appropriate primary care budget and resources must be aligned with population-based planning. Family physicians need to be at the table in order to both understand the resources available and inform the planning through a transparent process. For those physicians with limited experience working in primary care with other providers, it will be important to take the opportunity now to ensure that the tools for collaboration are developed and educational opportunities are created.
 - The Nuka model in Southcentral Alaska has had great success with “teamlets” consisting of a physician, nurse, office administrator and a shared behavior change expert between practices. As a province, we need to determine the minimum resources expected in every family practice setting and how additional resources will be equitably distributed.
- For greater integration, the contracts for the ministry-paid staff in FHTs should be transferred to the LHIN in order for population planning and resource allocation on interprofessional providers to be optimally aligned across communities. Community Care services overseen by the LHIN should be embedded in primary care settings to ensure tight linkages between family physicians and the primary care team, and the community. LHIN based performance management and monitoring needs to be informed by key indicators that are clinically relevant and meaningful to both family practice and to patients. Most importantly, they must also be evidence-based. Greater coordination and integration of information back to the family physician for ongoing management of care is required. For example, patients now have access to flu shots in a variety of settings – family physician offices, pharmacies, public health clinics, etc. There is no link back to the family physician’s office in many cases, and yet there are performance indicators around immunization rates for flu shots. A thorough assessment of performance measures, monitoring and the public reporting of these needs to be reviewed and assessed by the providers who have accountability for the indicators.

- The paper and the LHINs have made the leap to sub-LHIN planning without a clear definition of their purpose, and whether the intent is to create coordinated services in a smaller and more manageable geography or build around primary care service patterns. In many regions, the planning parameters seem artificial with limited evidence to support how these will improve patient care. Feedback from family physicians included the potential to organize services around key areas of population needs that could be neighbourhood hubs for COPD, CHF, maternal and child health, seniors and mental health and addictions. Additionally in many areas, patients come from outside the sub-LHIN and referral patterns are not fixed in the same geography. Systems will need to be in place to track the patients who are getting care inside and outside sub-LHINs and potentially across LHINs and how access across LHINs or sub-LHINs affects negation.
- Better integration requires a process with consistent elements that can be applied in the same way across all LHINs and then further adapted to fit the needs of the LHIN and the sub-LHIN regions. This will be critical to ensure that while we improve equity within sub-LHIN populations, we do not exacerbate gaps that exist between sub-LHIN pockets of the population within the province.
- The ministry and LHINs must work to align financial incentives that aim to drive performance. Some contract incentives result in improvements in targeted areas of care, but may be ill-suited to broader system level goals. The OCFP’s Evidence Brief found that in the U.K., GPs were overwhelmed by the combinations of incentives, many of which had competing priorities. A report on family practice in the U.K. found that “a different balance is needed between initiatives focused on clinical quality and outcomes and those which seek to redefine the role of primary care in whole-system changes. It is vital that policy-makers understand the impact of the various levers that they use and how they interact with each other.”

Proposal #2: Timely access to primary care, seamless links between primary care and other services

- Many clinicians can be leaders, but clinical leadership to drive system change in family practice and primary care must come from family physicians. The importance of clinical leaders being engaged in both developing and driving the long-term vision and holding peers accountable to it, is an essential element to transformation efforts. This leadership role should be aligned with, but must also go beyond, the current PCPLL in the LHIN. Meaningful education, necessary skills and leadership scope may be different in different locations/populations. The OCFP can play a role in facilitating and supporting education based on our experience with family physician collaborative care networks.
- Clinical leadership in each of the sub-LHIN regions must be provided by family physicians. Clinical managerial leadership is different than governance, and different from strategic leadership. Primary care LHIN Leads will fulfill a particular role in assuring consistency in primary care across the system. The role of the quality lead may be best for ensuring consistency in quality measurement and performance across the system. Within the sub-LHIN region there will be value to looking at some of the existing models of leadership success such as the dyad of clinical lead and an administrative lead or a triad of clinical lead, administrative lead and Board chair that exists in FHTs and hospital settings. We need to reduce duplication in the leadership roles for Health Links, quality improvement and champions for the CPSO and Ontario MD. These precious resources need to be coordinated.

“Increased access to healthcare, and patient satisfaction does not always equate to good health outcomes. The public must have some accountability in their demands and use of the healthcare system.”
OCFP member

- Expectations of access to a family physician need to be better defined and accurately measured against targets that are informed by family physicians. All primary care resources in LHINs need to be engaged, including walk-in and urgent care clinics. It is not constructive to pit one model against another however it will be important to develop a shared understanding of what we value in primary care and ensure that models of care and resources attributed to them align with those values.
- We must build on the capacity and innovation that exists in all models, not just the FHTs. Many FHGs and other practices have identified and funded resources based on their practice populations. These innovations should be recognized in sub-LHIN planning. Some of the access issues described are not about getting in to see the doctor, they are about waiting too long in the doctor’s office before being seen. This drives patients to walk-in clinics when it is more convenient for them. Walk-in clinics often provide accessibility to primary care services for those without a family physician or when the family physician is away. Walk-in clinics need to be engaged in planning in communities where they exist and also need to be better integrated with primary care and LHIN health system planning.
- The MOHLTC has created unnecessary competition and conflicting bonus structures through all of the primary care models. The current pay structures discourage true complex care and the rostering of complex patients – the very patients who need excellent, coordinated primary care the most.
- Patient accountability through education must be part of addressing access. Many family practices often offer same day/next day appointments however when the times are not convenient, patients may opt to go to a walk-in or an urgent care clinic. Adding patients experience survey questions that include not only seeing the provider, but whether an appointment was offered, need to be considered.

“Truly integrated and functional EMR technology would help.”

OCFP member

“Have the LHINs work with hospitals to create one consistent referral form for all diagnostics/imaging.”

OCFP member

Proposal #3: More consistent and accessible home and community care

- Care coordination embedded in primary care is essential to ensure seamless transitions in care for those who need it, particularly patients with complex care needs.
- Care coordinators in primary care practices should have a clinical skill set in nursing and have an ability to do case management and system navigation.
- Effective home care must include other services such as Meals on Wheels, transportation, etc.
- Effective home care also requires family caregivers. The needs of caregivers must be recognized and supported.

Proposal #4 Stronger links between public health and other health services

- Family physicians support the need to fully engage public health, and access to population data will support better planning and delivery. However, in order to facilitate better linkages between public health and primary care, there needs to be better alignment with municipalities and other ministries. Public health brings the important understanding of healthy public policy together with the determinants of health. This will be a tremendous asset but must be linked to the other sectors that more directly address these determinants. Family physicians and the health-care system are one small piece of this equation. These linkages are vital if the government is committed to addressing inequities in health status in addition to inequities of access to health services.
- The health equity agenda is referenced but not developed. This will need to be consciously addressed through the LHIN planning and an examination of the vulnerable populations in the community.
 - Stronger public health planning is required particularly in immigrant communities regarding such things as immunizations and other screening.
 - There needs to be a focus on other populations including seniors, women’s health, child and adolescent mental health.
 - Identify common targets between public health and primary care, e.g. baby and child immunization, breastfeeding for six months, reduction in tobacco use and alcohol consumption.
 - Look at population planning through an equity lens and at the sub-LHIN level between public health, primary care and other ministries including inequity related to income, housing, employment, school nutrition programs and transportation.
- Investments in public health have a tremendous impact on downstream health costs. For example, for every \$1 spent on tobacco use prevention, the MOH saves \$20 on future health-care costs, a ROI of 1900%. Similarly, \$1 in booster seats promotion saves the MOH \$40 in avoided medical costs, an ROI of 3900%. For every \$1 invested in community water fluoridation, the MOH saves \$38 in avoided dental treatment, an ROI of 3700%. Every \$1 spent on MMR vaccines saves the MOH \$16 in health-care costs, an ROI of 1500%. Using the kinds of costing and return on investment thinking of the public health sector and applying them to primary care may help us to understand the value that a variety of interventions in primary care can have on the population.^{viii}

“Easier access to public health and population data will influence our clinical decisions.”
OCFP member

“Ontario needs to have a central public health database for drugs similar to Nova Scotia and Newfoundland. Vaccination dispense reports are provided on a monthly basis before vaccines are delivered to offices. The central database is managed by public health and accessed by all doctors.”
OCFP member

“Incorporate social welfare with medicare – often it is the lack of finances that limit access to resources – social workers need to know the diagnosis in order to help clients. LHINs should provide experts in the community to bridge resources to the patients.”
OCFP member

In summary:

Family physicians are uniquely placed across the entire health system unlike any other health-care provider and can play an integral role to enable more effective vertical and horizontal integration. If primary care is seen as the foundation of the health system, family physicians are the linchpin to ensuring comprehensive, coordinated and continuous care.

While the paper suggests that the MOHLTC intends to strengthen primary care, this message is not being clearly heard and is overshadowed by the lack of a negotiated agreement between the Ontario government and the Ontario Medical Association. Unfortunately, the OCFP fears that the chasm created by the lack of a PSA will impair real opportunity to bring forth system change without meaningful engagement of family physicians. As one OCFP member noted, “physicians need to feel valued and appreciated by government. The majority of physicians provide excellent and relatively expedient care to patients. The existing system needs to be funded and administration needs to be reduced....”

As with any proposed vision for system transformation, the devil is in the details of good planning based on best evidence and data. An implementation plan with an evaluation that considers a step-by-step approach and the magnitude of change management will be a crucial next step. This change management approach would ensure those most directly impacted by the change and providing frontline care for patients are at the table designing and developing the plan, and are also invested in ensuring its success.

The Ministry will no doubt have a significant amount of input and feedback to consider, and yet the LHINs are continuing to explore sub-LHIN planning. This is an important juncture for the next phase of the Ministry’s plans and the determination of the elements within the proposals that will move forward. The OCFP respectfully requests that the Ontario government provide its own update on how the consultation feedback has been considered, what the step-by-step roadmap for planning and implementation will be, and what the proposed timeline is for next steps, including the introduction of new legislation.

On behalf of the OCFP’s over 10,500 family members, we will continue to listen to our members and reflect their perspectives, and seek constructive ways to advance equitable access to comprehensive family medicine for the benefit of all Ontarians.

Sincerely,



Dr. Sarah-Lynn Newbery
President



Ms. Jessica Hill
CEO

ⁱ http://www.commonwealthfund.org/usr_doc/Starfield_Milbank.pdf

ⁱⁱ http://ocfp.on.ca/docs/default-source/default-document-library/pbfm_evidence_brief_oct2015.pdf?sfvrsn=0

ⁱⁱⁱ <http://patientsmedicalhome.ca/>

^{iv} http://ocfp.on.ca/docs/default-source/default-document-library/letter_opcc_to_minister_-jan2016.pdf?sfvrsn=0

^v http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Place-based-systems-of-care-Kings-Fund-Nov-2015_0.pdf

^{vi} <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3752290/>

^{vii} <http://www.oha.com/News/Documents/OHA%20High%20Performing%20Healthcare%20System%20Paper.pdf>

^{viii} <http://www.cpha.ca/en/programs/social-determinants/frontlinehealth/economics.aspx>