Ontario College of Family Physicians

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A Chapter of the College of Family Physicians of Canada

Bill 74: *The People's Health Care Act, 2019*

Submission to the Standing Committee on Social Policy

April 2, 2019

Introduction

The Ontario College of Family Physicians (OCFP) represents 12,500 family physician members across Ontario providing primary and secondary care across all settings. We are pleased to provide a response to Bill 74: *The People's Health Care Act, 2019*.

The OCFP strongly supports Bill 74's commitment to placing the patient at the centre of a connected care system in communities across the province, and offers the following recommendations to ensure the transformation is a success.

In formulating this submission, we referenced ongoing member feedback we are receiving as well as prior member research, participated in several Ministry briefings with stakeholders, and consulted with our Board of Directors, advisory committees, primary care partners, and family doctors on the frontlines of care and in system leadership roles. We also drew on a previous review of jurisdictional evidence on how to optimize success of the government's new framework for integrated health care in Ontario.

Executive Summary

In the draft Bill, "primary care services" is included among the potential components of an integrated care delivery system (Ontario Health Team). A robust primary care sector, led by family physicians, is in fact integral to successful reform. High-performing health systems worldwide are marked by strong primary care foundations, in terms of better opportunities to control costs, improved quality of care, better population health, and less socioeconomic inequality in health.[1,2] In Ontario, family doctors see more patients by far every day than any other part of the health system – individuals with a mental health need, for example, are more likely to consult a family doctor than any other health practitioner.[3]

Effective transformation also requires family physician leadership in system co-design and implementation. As illustrated in the OCFP's jurisdictional review (2015 Evidence Brief, *Preparing for a Devolved, Population-Based Approach to Primary Care*)[4], 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.

Furthermore, as the government looks to implement reforms, the Patient's Medical Home (PMH) provides the framework to do this. The PMH vision is for every family practice to offer the medical care that Ontarians want — readily accessible, centred on the patients' needs, provided throughout every stage of life, and seamlessly integrated with other services in the healthcare system and the community. The PMH also supports the Quadruple Aim, consistent with the Ontario government's goals being addressed through Bill 74.

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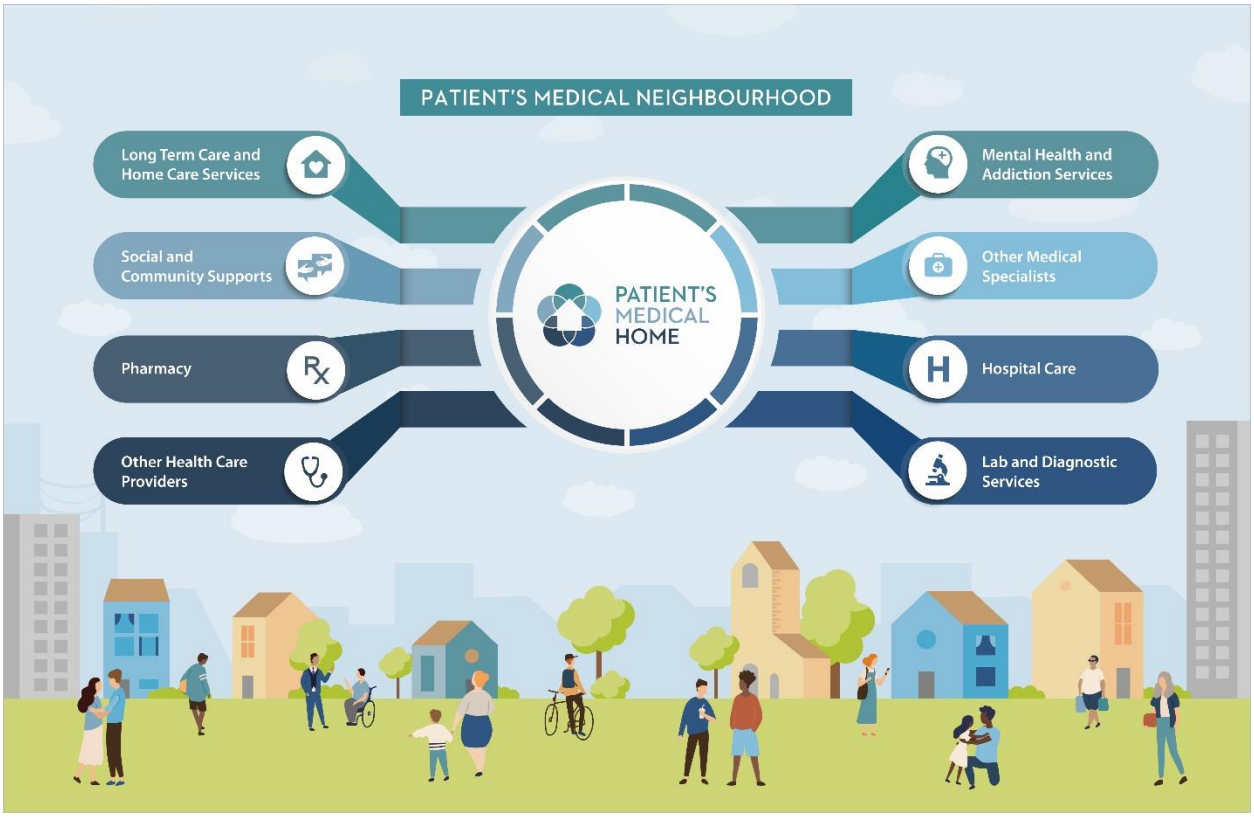
[1] Starfield B. Is primary care essential? *Lancet*. 1994;*344* (8930):1129 – 33. Crossref, Medline , Google Scholar
[2] Delnoij D, Van Merode G, Paulus A, Groenewegen P. Does general practitioner gatekeeping curb health care expenditure? *J Health Serv Res Pol*. 2000;*5* (1): 22 – 6. Crossref, Medline, Google Scholar
[3] Mental Health Commission of Canada. Collaborative Mental Health Care at Work: Recovery-Oriented Practice and the Patient's Medical Home. Ottawa, ON: Mental Health Commission of Canada; 2018. (unpublished).
[4] https://ocfp.on.ca/docs/default-source/default-document-library/pbfm_evidence_brief_oct2015.pdf?sfvrsn=f075f689_2

Embedding PMH principles, which include team-based care through family physician leadership, comprehensiveness and continuity, will enhance success. The PMH vision for integrated primary care is focused around the patient and built on a foundation of empirical evidence[5] in other jurisdictions. By linking other health provider services such as acute care and home care to this primary care 'home' through a connected 'neighbourhood' (i.e., the Ontario Health Team), Ontario has the potential to create an even more highly functioning and integrated system for individuals– no matter where they are within the healthcare journey.



The OCFP has five priority recommendations related to successful implementation of the legislation.

1. Amend the wording in Bill 74 to specify that Ontario Health Teams must be anchored in primary care, led by family physicians, and voluntary;
2. The Patient's Medical Home should be the framework to support primary care as the anchor in Ontario Health Teams;
3. Support the inclusion of family physicians and their patients, regardless of their practice model, to benefit from access to core team-based care;
4. Ensure family physician leadership and co-design in planning and implementation of Ontario Health Teams;
5. Amend the wording in Bill 74 to exclude family physicians as Health Service Providers.

[5] https://patientsmedicalhome.ca/why-pmh/

1. The Importance of Primary Care, Led by Family Doctors, within Ontario Health Teams

Although primary care is not currently mandated as part of the Ontario Health Team in Bill 74, research reinforces the importance of physician-led, and voluntary participation in Ontario Health Teams, with primary care at the core:

- In the U.S., for example, the integrated care teams (Accountable Care Organizations or ACOs) that are most successful are voluntary, led in primary care through Patient-Centred Medical Home practices, and with family physician leadership.[6,7] Of note, physician-led ACOs can apply to receive payments in advance to help them build the infrastructure necessary for coordinated care.
- In instances where integrated care organizations have been led by independent hospitals, without physician governance, the performance of the organizations has been varied. Physician-led ACOs appear to hold the most promise in terms of quality and cost outcomes. For hospital-led ACOs, financial integration with physicians is associated with increased chance of success.[8]
- Family doctors are central to ensuring continuity for the patient. Continuity of care, in which the patient and his/her physician-led care team are cooperatively involved in ongoing healthcare management, is a key line of defense against hallway medicine (reduced hospital admissions; better patient satisfaction; reduced system costs).[9]

If primary care is the foundation of effective health systems, family physicians are the linchpin to ensuring comprehensive, coordinated and continuous care. While some family doctors already have built-in connections to other healthcare providers and community resources (e.g., those working in Family Health Teams or Community Health Centres), the majority of family physicians work more independently, and thus the nature and timing of their engagement in Ontario Health Teams will depend on their circumstance and capacity.

Recommendation #1: Amend the wording in Bill 74 to specify that Ontario Health Teams must be anchored in primary care, led by family physicians, and voluntary

2. Embedding Patient's Medical Home (PMH) Principles in Ontario Health Teams

In a Patient's Medical Home family practice, patients have access to a responsive medical home or health hub, anchored by a family doctor, that is well connected to the rest of the healthcare system through a medical neighbourhood (e.g., hospitals, long-term care, home and community care, mental health and addictions services, etc.).

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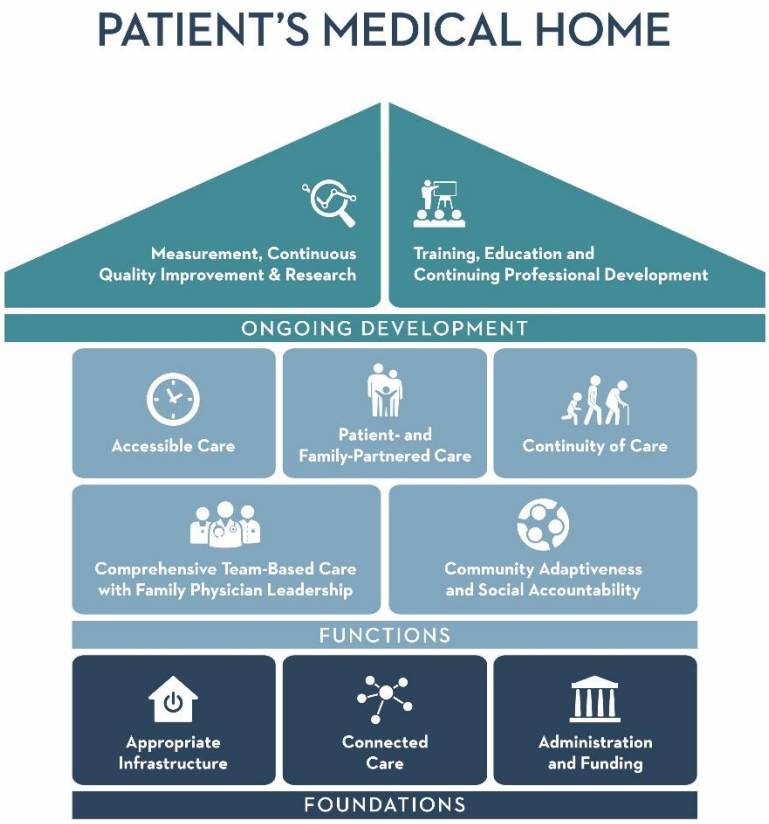
[6] Peckham A, Rudoler D, Allin S, Bhatia D, Abdelhalim R, Kavelaars RA, Marchildon, G. Rapid review 12 - Accountable care organizations: Success factors, provider perspectives and an appraisal of the evidence. North American Observatory [Internet]. 2019 March [cited 2019 March 21] Available from: https://ihpme.utoronto.ca/wp-content/uploads/2019/03/NAO-Rapid-Review-12_EN_1.pdf

[7] https://www.milbank.org/wp-content/uploads/2018/08/advanced_primary_care_report_080118.pdf

[8] Peckham A, Rudoler D, Allin S, Bhatia D, Abdelhalim R, Kavelaars RA, Marchildon, G. Rapid review 12 - Accountable care organizations: Success factors, provider perspectives and an appraisal of the evidence. North American Observatory [Internet]. 2019 March [cited 2019 March 21] Available from: https://ihpme.utoronto.ca/wp-content/uploads/2019/03/NAO-Rapid-Review-12_EN_1.pdf

[9] British Medical Journal. Association between continuity of care in general practice and hospital admissions for ambulatory care sensitive conditions: cross sectional study of routinely collected, person level data. BMJ 2017;356:j84

The PMH represents the very principles that are required for effective integration of care, such as accessible, patient-centered, socially accountable and comprehensive team-based care, with continuity. This means that these medical homes are the entry and return points for patients in the health system, and where their healthcare journey is held. These are integral elements of any initiative that seeks to enhance system integration.



There are numerous compelling examples in Ontario of family physicians and integrated teams of health professionals introducing innovations and delivering the quality of care in keeping with PMH principles. Adhering to these principles not only improves patient experience, health outcomes and provider satisfaction, patient medical home health care also leads to fewer unnecessary hospital admissions and ER visits, system savings and better use of public resources. It creates the conditions for health system reform success.[10,11,12]

[10] Levesque JF, Haggerty JL, Hogg W, Burge F, Wong ST, Katz A, Grimard D, Weenink JW, Pineault R. Barriers and Facilitators for Primary Care Reform in Canada: Results from a Deliberative Synthesis across Five Provinces. Healthc Policy. 2015 Nov;11(2):44-57. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4729282/

[11] https://www.mihia.org/index.php/quad-aim/what-is-the-quad-aim

[12] Starfield, B., Shi, L., Macinko, J. (2005). Contributions of Primary Care to Health Systems and Health. Millbank Quarterly, 83(3): 457-502.

***Recommendation #2*: The Patient's Medical Home should be the framework to support primary care as the anchor in Ontario Health Teams**

3. Enhancing Capacity for Family Doctors, Regardless of Practice Model, to Benefit from Access to Core Team-Based Care

In a PMH practice, family doctors, regardless of practice type, have access to the team members and resources to best care for patients – particularly those with complex medical needs. Currently, about 75 per cent of Ontario's family doctors work without funded multidisciplinary team support – most often offered through Family Health Teams and Community Health Centres – that more easily enables the concept of team-based care within the PMH. This has created 'have and have not' access for patients in primary care. Despite this, there are other innovative ways to create teams in primary care that improve clinical work and make patient lives better in a very tangible way.

Our members cite the most common needs for the core or minimum care team in a PMH to include: a social worker; and care coordination and system navigation provided by either a registered nurse or nurse practitioner. This core team must be supported by integrated EMR, data, and IT support. In response, the OCFP has continued to advocate for more equitable access to these essential team members and resources, thus making it easier for family doctors to provide continuity and comprehensive care for patients.

Continuity is one of the key aspects of primary care. A recent study in the *British Medical Journal* showed that patients who were more closely followed by the same family physician fared better on serious matters, such as having to return to the hospital and the chance of dying altogether.

To fully succeed and best serve the province's patients, Ontario Health Teams must ensure that the majority of family doctors not practicing in interdisciplinary care models, and importantly their patients, are not left behind. A population-based approach to determining access to these resources can enhance provision of services for patients and families across communities. By allowing improved integration through the provision of needed supports, the government can ensure the majority of family doctors, who work outside of interdisciplinary practices, have the capacity needed to fully implement the government's vision of integrated care.

Indeed, research from the U.S. shows interdisciplinary teams were associated with improved mediation reconciliation, reduced service utilization, stronger provider buy-in, meeting the needs of the most vulnerable populations from rural locations, and reduced workplace stress. The deliberate inclusion of and supports for interdisciplinary teams were valued by providers and impacted their decision to join an ACO.[13]

***Recommendation #3*: Support the inclusion of family physicians and their patients, regardless of their practice model, to benefit from access to core team-based care.**

[13] Peckham A, Rudoler D, Allin S, Bhatia D, Abdelhalim R, Kavelaars RA, Marchildon, G. Rapid review 12 - Accountable care organizations: Success factors, provider perspectives and an appraisal of the evidence. North American Observatory [Internet]. 2019 March [cited 2019 March 21] Available from: https://ihpme.utoronto.ca/wp-content/uploads/2019/03/NAO-Rapid-Review-12_EN_1.pdf

4. The Importance of Family Physician Engagement in System Co-Design and Implementation

With the significant transformation outlined in Bill 74, the government should ensure formal structures are established to allow family doctors to provide input in system design and ongoing decision-making. Family doctors must play a meaningful role in shaping the changes ahead, given they are at the heart of the system that the government seeks to improve and are ultimately central to success.

Clinical leadership needs to include decision-making authority through collaborative governance and not simply be a consultative role. Indeed, research shows that initiatives that effectively engage physicians in health system design, change processes, and leadership development opportunities are more likely to experience improved outcomes.[14] And, as noted, learnings from the U.S. show that the most successful integrated care organizations are led in primary care through Patient-Centred Medical Home practices, and with family physician leadership.[15,16] In the UK, GPs were engaged to lead more fundamental reform of the public healthcare system.[17] This followed lessons learned from previous unsuccessful reform attempts that failed to meaningfully engage GPs in decision-making.[18]

The importance of supporting clinical leaders with tools, time and resources in order to optimize transformation effort success cannot be underestimated. The government needs to consider the cost-benefit of a physician's time in administration and planning including leadership time, supporting change management in their own practices and/or with peers, and other administrative tasks – these activities take time away from the physician's important clinical work with patients and teaching role with medical students, and it is time that must be valued. Family physician leadership cannot happen off the side of a desk.

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 our collaborative mentoring networks, particularly our Leadership in Primary Care network. A cadre of leaders is already engaged and connected as mentors and could serve to augment capacity in regional structures.

Ontario already has a strong network of family doctors to draw upon who are on both the frontlines of care and in clinical leadership roles. We need to keep these leaders engaged because they have expertise in local community needs and understand how to support capacity in family practices.

Recommendation #4: Ensure family physician leadership and co-design in planning and implementation of Ontario Health Teams

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[14] Denis J-L, Baker GR, Black C, et al. Exploring the Dynamics of Physician Engagement and Leadership for Health System Improvement. *Saskatchewan Ministry of Health*. 2013. https://www.cfhi-fcass.ca/sf-docs/default-source/reports/Exploring-Dynamics-Physician-Engagement-Denis-E.pdf?sfvrsn=0.

[15] Peckham A, Rudoler D, Allin S, Bhatia D, Abdelhalim R, Kavelaars RA, Marchildon, G. Rapid review 12 - Accountable care organizations: Success factors, provider perspectives and an appraisal of the evidence. North American Observatory [Internet]. 2019 March [cited 2019 March 21] Available from: https://ihpme.utoronto.ca/wp-content/uploads/2019/03/NAO-Rapid-Review-12_EN_1.pdf

[16] https://www.milbank.org/wp-content/uploads/2018/08/advanced_primary_care_report_080118.pdf

[17] https://www.ijic.org/articles/10.5334/ijic.3044/

[18] https://ocfp.on.ca/docs/default-source/default-document-library/pbfm_evidence_brief_oct2015.pdf?sfvrsn=f075f689_2

5. Excluding Family Physicians as Health Service Providers

The definition of a Health Service Provider in Bill 74 is open ended, allowing additional entities to be prescribed by future regulations. Entities defined as a Health Service Provider have significant requirements placed on them including possible directives issued by the Minister of Health and Long-Term Care or Ontario Health on operational priorities. Similar definitions of Health Service Provider in previous legislation, such as the Local Health System Integration Act, contained specific exemptions from this definition for physicians as well as for health professional corporations.

The OCFP supports the exemption of physicians and health professional corporations as a Health Service Provider and believes such an exemption should be carried forward to Bill 74 as well.

Recommendation #5: Amend the wording in Bill 74 to exclude family physicians as Health Service Providers.

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