Ontario College of Family Physicians
Leaders for a healthy Ontario

Ontario College of Family Physicians' Input to the OMA Negotiations Task Force
JULY 31, 2020

Begin with a vision for primary care

Our priorities below are anchored in the evidence-based principles of the Patient's Medical Home (PMH) and Patient's Medical Neighbourhood (PMN) vision: team-based care, timely access, comprehensive and community adaptive care, continuity, EMR and Quality Improvement, with better integration across other parts of the health system.

The PMH and PMN recognize that family physicians, as the most responsible provider (MRP), care for their patients and support them throughout all interactions with the health system. Success of the PMH/N depends on family physicians being connected with each other, to their community, and to the broader health system.

While facilitating family physician connections is essential, ultimately achieving a better care experience for patients and clinicians, as well as health system sustainability, depends on collaboration and teamwork – from the patient's participation in their care, to interprofessional care providers working together, to policymakers who offer needed supports.

Considerations guiding our input

Our input is guided by these imperatives:

- **Focusing on population health planning at the local/community level:**
    - Local-level planning is universally recognized as a pre-requisite for improvements in population health because it better reflects and enables regional/community health needs and local connections.
- **Supporting a commitment to comprehensive/generalist practice, as defined by the CFPC Family Medicine Professional Profile:**
    - The PMH and the PMN are enabled by the responsibilities defined in the CFPC Family Medicine Professional Profile:

      "Working together, family physicians provide a system of front-line health care that is **accessible, high-quality, comprehensive, and continuous**. Individually they take responsibility for the overarching and proactive medical care of patients, ensuring follow-up and facilitating transitions of care and/or referrals when required. More than a series of tasks, **it is through relational continuity and a commitment to a broad scope of practice that the complexity of care is meaningfully addressed**. The care family physicians provide improves the overall health of the population" (CFPC, 2018).
- **Ensuring no practice or patient left behind:**
    - Greater equity among the various primary care models is urgently needed in order to support more equitable comprehensive and patient-centred care, practice viability, and healthy work environments for family physicians. The current maldistribution of team resources must be examined so that all family physicians, in any practice model, can access funded team resources for their patients.
- **Supporting continuity of care with the patient's family physician as MRP:**
    - When assessing provincial scalability of new innovative models (i.e. SCOPE, Team Care (formerly known as PINOT), Care Point), ensure that the model is not referral-based, but rather, is relationship-based. As evidence shows, family physicians are essential to maintaining continuity for their patients, which results in reduced hospital admissions, better patient satisfaction and reduced system costs[i].

Q1. What are the top three negotiation priorities of your organization?

Summary:

1. Ensure family physician access to funded team-based resources and payment supports to enable care for complex patients through:
    a. Access to a "core minimum team" of a social worker/nurse dyad for all family practices; and
    b. Complexity modifiers for all payment models.
2. Open access to blended capitation models for all family physicians, and address inequities resulting from COVID-19 on FFS and FHG practice models.
3. Ensure three-way accountability (i.e. family physicians, government, and patients), and include a modernized definition of "access."

Negotiation Priority #1:

Ensure family physician access to funded team-based resources and payment supports to enable care for complex patients through:

- **Access to core minimum team (i.e. social worker and nurse) for all family practices; and**
- **Complexity modifiers for all payment models.**

- **The core minimum team:**

  - Increase access to team-based resources across the province for the 75% of family physicians who practice without funded teams (i.e. FHTs and CHCs), especially for their patients with complex/co-morbid conditions, including mental health and addictions, chronic and co-morbid illness and social determinants of health (SDOH) needs.
  - This can be accomplished through access to a "core minimum team" for each family physician:
    - A social worker to provide mental health and addictions (MHA) counselling and psychotherapy *in addition to* navigation support for complex patients (i.e. when "stepping up" care for MHA – see alignment priority re: MHA below) and/or to support SDOH needs (i.e. sustainable housing, income assistance, employment challenges etc.); and
    - A nurse for care coordination, clinical support and wrap-around care.
  - Teams must be coherent and identifiable to the patients and the providers, whether co-located, intermittently co-located or virtual.

- **Complexity modifiers:**

  - Establish a *permanent* payment methodology acuity modifier for all practice models.
    - Look at latest US evidence about Patient-Centered Medical Home models that integrate social determinants of health (SDOH) in addition to number of chronic illnesses.
    - Ensure SDOH reflected in complexity premiums, including across all practice models, not just capitated models.
  - In the interim, restore the previously established *interim* payment methodology acuity modifier and apply across all models.
  - Align the above with efforts to sustain enhanced virtual care, including:
    - Virtual codes that enable more nuanced visits (see PEI schedule of benefits).
    - Better integrated EMRs that also encompass SDOH and other complex measures; work toward EHRs accessible by clinicians and patients.

Negotiation Priority #2:

Open access to blended capitation models (specifically FHOs) for all family physicians. Given the impact of COVID-19, address inequities experienced by FFS and FHG family physicians.

- The COVID-19 pandemic exacerbated pre-existing inequities across Ontario's diverse primary care models – FFS /FHG practices have experienced significant income instability, and continue to struggle, while FHO/FHNs have not to the same extent.
- Equity among payment models is now needed more than ever to support comprehensive and patient-centred care, practice viability and healthy work environments for family physicians across the profession. This can be achieved through:
    - Opening access to a blended capitation models (i.e. FHO) for all family physicians.
    - Applying sustainable income stabilization measures—i.e. beyond "loans"—to protect the viability of FFS/FHG practices through the COVID-19 impact.

Negotiation Priority #3:

Ensure three-way accountability (i.e. family physicians, government, and patients), and include a modernized definition/measure of "access."

- **Three-way accountability:**
    - Modifying existing, or creating any new practice model should aim to roster all patients and should ensure access is supported through three-way improved accountability whereby:
        i. MOH ensures that necessary supports are in place (EHR, minimum team access), contract obligations are met and fair measures are applied (see modernized definition of access below).
        ii. FP provide care as contracted.
            - Patient access is variable in some FHO practices, which requires solutions around adherence to the FHO contract expectations.
        iii. Patients understand their rights and responsibilities with respect to accessing their MRP.
            - A communications strategy should be developed to educate patients on their rights and responsibilities with their respect to accessing their MRP. This could include user-friendly information on who to call, availability of after-hours access to avoid ER use, and a simplified form from the Ministry of Health (e.g., "what did you just sign up for?") etc.
    .
- **Modernized access definition and related measures:**
    - Develop and apply a more appropriate, fair and nuanced definition and related measures of "access."
        - New measure of access should differentiate those patients prioritizing convenience over the continuous relationship with their MRP.
        - For example, as per the CFPC Best Advice Guide on Timely Access to Appointment in Family Practice, "advanced/same-day" access can be combined with a "carve-out" model.
        - Use the Eight Priorities for Improving Primary Care Access Management in Health Care Organizations—a set of definitions and recommendations to optimize primary care access—to redefine access measures, including access in the home.[ii]
        - Use primary care maturity model and key enablers, a road map developed by a group of family physician leaders and patients, under the leadership of Dr. Jocelyn Charles.

Q2. Are there Ministry priorities you are aware of that align with your organizations' interests and if so please explain?

Summary of Ministry-OCFP alignment priorities:

1. Sustain and optimize **virtual care** for primary care, anchored by the FP as the MRP.
2. Enable enhanced shared care and stronger connections between primary care and **mental health and addictions**.
3. Modernize **home and community care**, including stronger and more seamless connection with the patient's MRP – most often the family physician.
4. Integrate **palliative care** in the community.
5. Support **clinical leadership** and organizing primary care.
6. For **reforms in Long Term Care**, consider the type of care required and not just the building.

Alignment Priority #1:

Sustain and optimize virtual care for primary care, anchored by the family physician as MRP, to maintain continuity.

- Recent OMA-MOH efforts to address virtual care billing code issues arising from COVID-19 response are appreciated, and should be sustained, as this form of access is vital to patient care and physicians deserve to be remunerated for adapting their practice and providing this service.
- Virtual care should be inclusive of video, telephone, email and secure messaging.
- Leverage the gains identified during COVID-19; address non-remuneration issues that may have emerged (e.g., connectivity, platforms available).
- Improve access to cell and high-speed internet in rural, remote, and indigenous communities (note: video conferencing more challenging for more vulnerable/older patients).
- Improve ability of virtual platforms to integrate with office workflows and booking systems.
- Improve virtual codes that include more nuanced visits (see PEI schedule of benefits, which includes multi-issue office visits, complex chronic disease management, addictions care, among others).
- Expand access to approved platforms, beyond OTN:
    - Choice of platform that is affordable and user-friendly– Note recent recommendation of the Ministry's Digital Health Information Exchange (DHIEX) policy that suggests targeted funding might be available to relevant stakeholders is encouraging.
- When expanding virtual access to walk-in clinics, maintain continuity of care.
- Connect walk-in clinics to family doctors in their communities through technology/integrated EHRs.

Alignment Priority #2:

Enable enhanced shared care and strong connections between primary care and mental health and addictions.

- Mental health and addictions/substance use disorders are among the most challenging clinical areas for family physicians. This is because they are difficult conditions to treat/manage, there is a lack of resources/supports available, and they are the most prevalent and time-consuming issues they face] [source: OCFP member research, 2019].
    - Family physicians list solutions for better mental health/addictions care as follows:
        1. Affordable and accessible counselling (including longitudinal counselling i.e. for those who need support beyond the time limited CBT/psychotherapy sessions), through a healthcare professional who is tied to the FP's practice and who can provide psychotherapy
        2. Timely access to psychiatrists – see Health System Priority #1
        3. Knowledge of, and access to, available community-based resources.
- As noted in Negotiation Priority #1 above, a social worker is an integral value-add member of a core minimum team in family practices, particularly for the MHA population.
    - Social workers provide mental health and addictions counselling *as well as* navigation support for complex patients and/or social determinants of health (SDOH) needs.
    - There is strong evidence to support that effectively enabling shared care through inter-professional collaboration is an effective means of improving patient outcomes for the MHA population, whether coordinated or co-located. Positive outcomes were observed among diverse MHA needs including anxiety, depression and substance use.[iii]
- While some family physicians seek training/education for complex mental health and addictions issues, OCFP member research reveals that, what is most need are additional supports as noted above to effectively care for their patients, particularly for those:
    - with bipolar disorder, schizophrenia, or schizoaffective disorders,
    - with severe substance use and addictions challenges,
    - with concurrent disorders of the above, and
    - who require psychotherapy and counselling beyond online/structured CBT.
- The government's Roadmap to Wellness introduced measures to improve quality through a core services framework and better data, to scale new innovations, to expand services for marginalized/high needs

populations and to develop access/wait times indicators. These are a good step in the right direction; however, significant gaps remain as expressed by our FP members.
    - The focus on mental health supports should begin in primary care, not from the acute system out, given most people are more likely to consult a family doctor than any other health practitioner for mental health needs.[iv]
    - Innovations such as Mindability etc. work best for patients with mild/moderate anxiety and depression and those who are relatively self-driven and technologically literate. [Source: OCFP member research, 2019].
    - Patients with more moderate, complex and severe mental health and addictions needs continue to be areas of tremendous concern and challenges for FPs in their practice.
- As stated above, enabling shared and funded collaborative inter-professional care—whether coordinated or co-located—is proven to improve outcomes for MHA patients. Furthermore, in the Roadmap, primary care is mentioned only within the context of Ontario Health Teams, but no further details, pathways, or examples were provided.
    - As referenced above, given that patients with mental health and addictions illnesses often first present themselves in family doctors' offices, this is a significant omission.
    - The strategy lacks a co-design methodology– experts, including family physicians, need to be engaged throughout the implementation of the strategy.

Alignment Priority #3

Modernize home and community care, including stronger and more seamless connection with the patient's MRP – most often the family physician.

- Remove barriers and "red tape" that hinder FPs from obtaining information in a timely manner about their patient receiving home care.
    - In addition, Bill 175 should enable timely communication between patients receiving care at home and their family physician (i.e. assessment, care plan etc.).
- Enable shared care between primary care and home care by anchoring care coordination in primary care and with the community they serve (i.e. leveraging the vital role of the 4000+ care coordinators funded through the LHINs).
- Expand equitable access to comprehensive team-based care in primary care, that is also connected to home and community care, to address patients' complex, social and mental health needs.
    - See core minimum team in Negotiation Priority #1.
- Enhance access to virtual care – see Alignment Priority #1.
- Enhance FP access to home care services for their vulnerable patients, such as the frail elderly, so that they can continue to stay in their homes for as long as possible.
- Explore models and incentives to encourage home visits by FPs in a community-based setting – see Dutch home care solution as one example of an innovative model.

A Buurtzorg: An Innovative and Modern Dutch Solution for Comprehensive Home Care

In the Netherlands, up to two hours of scheduled house calls are a part of the daily work of family physicians. Patients need to live within a reasonable distance of their physician so when they move, the family doctor community of their new neighbourhood organizes a system to enroll them. To enable this time commitment, medical assistants perform other tasks like PAP tests, suture removal, wound checks, and well-baby checks/immunizations are looked after by a public health system.

A newer Dutch development called "Buurtzorg" is based on an RN taking on a home care patient and looking after all their needs – medical, logistical, social. They have a lower case load, but early data from the King's Fund suggests that this broad scope care is cost effective.

[Source: https://www.kingsfund.org.uk/blog/2019/09/buurtzorg-model-of-care].

Alignment Priority #4:

Integrate palliative care in the community.

- The principles outlined in Alignment Priority #3 (home and community care) also support more integrated palliative care in the community.
- Ensure supports are provided in primary care, including after hours access to home care nurses for patients who want to die at home.
    - COVID-19 has created a burning platform to ensure better support for people to remain at home until death, however family physicians and caregivers require better and more consistent support as further detailed below.
- Remove barriers and "red tape" that hinder FPs from obtaining information in a timely manner about their patient receiving palliative and end-of-life care.
- Expand equitable access to comprehensive team-based care in primary care to address palliative patients' complex, social and mental health needs (see core minimum team in Negotiation Priority #1).

Alignment Priority #5:

Support clinical leadership and organizing primary care.

- Extensive evidence from other jurisdictions shows support is required for clinical leadership and for organizing primary care in OH regions.[v,vi,vii] Current inconsistencies in funding for primary care leadership must be addressed.
    - Family doctors must play a meaningful role in shaping reforms and providing input in system design and ongoing decision-making. Continue to encourage primary care networks of connected FPs.
    - Recognize this work requires funded leadership roles *as well as* some administrative support to connect family physicians to each other to develop a shared vision for providing care for patients in a community.
    - Connecting regional networks province-wide will foster greater shared learnings and consistency in best practice adoption; again, some administrative support would enable this to occur.
- Proposed approach to enable more connected and modernized primary care:
    - Each OHT to have an Integrated Primary Care Centre (IPCC), which acts as an organizing body for family physicians in the community and be a hub of collaborative planning within its OHT. Key Components of IPCCs:
        i. Network of and for family physicians.
        ii. Support for change management and ongoing Quality Improvement (e.g., through a practice facilitator).
        iii. Support for IT and digital health solutions.
        iv. Horizontal and Vertical integration through care coordination and connection with specialists, such as the Care Point model where specialists come to the 'hub' to support primary care.
- Leverage the co-designed **Made in Ontario 10 High Impact Actions** developed through the Primary Care Virtual Community (see appendix A).
- Adopt and enable the Primary Care Maturity Model and Key Enablers for Ontario Health Teams: recommendations of the Ontario Primary Care Council, led by Dr. Jocelyn Charles.
    - This is a Maturity Model that aims to provide a road map for OHT primary care leaders to work together to ensure that a patient medical home/neighbourhood is accessible to all residents of Ontario.
    - This model was developed collaboratively with patients and families, primary care leads, local primary care support teams, hospital leadership, home and community care leadership and key data and analytics supports.

Alignment Priority #6:

For reforms in long-term care, consider the type of care required and not just the building.

- Long term care is a verb, not a building.
- There are barriers to house calls, particularly in urban settings – time to get to patient (traffic, parking, already busy clinic) and payment does not reflect the time commitment to provide house calls.
- Difficulty communicating in a timely fashion with one caregiver (family and/or professional) who is familiar with all the issues. This requires integrated EMRs, better still, EHRs accessible by the care team and the family.

Q3. What are the health care system/policy priorities that should be addressed in these negotiations?

Summary of health system priorities:

1. Develop a central referral process that maintains choice for FPs
2. Unattached patients – understand barriers to attachment and connect to a MRP
3. Promotion of good healthcare stewardship by 'practicing wisely'

Health System Priority #1:

Develop a central referral process that maintains choice for FPs.

- Develop a central referral process.
    - Major bottleneck in achieving coordinated and integrated care for the patient is the inability of family physicians to access timely diagnostics, specialists, and other services.
    - Family physicians in early stage of practice may not have the established referral patterns cultivated by mid--to-late stage practicing family physicians.
    - These have been high on the list of priorities within OHTs, and 'accessing specialists/patient referrals' are among the top practice level pain point for family doctors [source: OCFP member survey, September 2019].
    - At minimum, reduce and streamline the number of referral forms in EMRs.
- Maintain choice within a centralized referral process.
    - While centralized referral platforms can significantly increase efficiency, pre-existing relationships and referral patterns between FPs and specialists/others should be maintained.
- Ensure access to team-based care (see core minimum team in Negotiation Priority #1) for models without access to funded interprofessional healthcare teams.
- When assessing provincial scalability of new innovative models (i.e. SCOPE, Team Care (formerly known as PINOT), Care Point), ensure that the model is not referral-based; rather, is relationship-based; that is, it maintains continuity between the patient and their MRP and enables ongoing relationships between the FP and the team members. This way, continuity of care is protected and enhanced, communication across the interdisciplinary health team is strengthened, and the capacity of healthcare providers to work to their full scope of practice is activated.

Health System Priority #2:

Unattached patients – understand barriers to attachment with MRP.

- "Unattached" could refer to many different segments of the patient population—including but not limited to: vulnerable populations, such as low-income patients, Indigenous populations, new immigrants and refugees.
- Connect walk-in clinics to family doctors in their communities through technology/integrated EMRs (ultimately EHRs).
- Strike a multi-stakeholder working group to explore the unattached populations, including the rationale behind walk-in clinic usage and ensure appropriate representation of FFS/FHG physicians.

- **Further areas for exploration:**
    - How can walk-in clinics be better connected to their colleagues and within emerging OHTs?
    - How can we best scale innovations (i.e. RAAM clinics or teams in FHTs and CHCs), in which attachment to an MRP is the ultimate goal of the model?

Health System Priority #3

Promotion of good healthcare stewardship.

- Leverage Practising Wisely to reduce over-prescribing, over-imaging, over-screening and over-monitoring using the latest evidence and tools and to align with the Choosing Wisely Canada campaign to implement good healthcare stewardship and avoid over-medicalization.

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[i] 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

[ii] Rubenstein, L., Hempel, S., Danz, M. et al. Eight Priorities for Improving Primary Care Access Management in Healthcare Organizations: Results of a Modified Delphi Stakeholder Panel. J GEN INTERN MED 35, 523–530 (2020). https://doi.org/10.1007/s11606-019-05541-2

[iii] Mental Health Commission of Canada. Collaborative Care for Mental Health and Substance Use Issues in Primary Health Care: Overview of Reviews and Narrative Summaries. Ottawa, ON: Mental Health Commission of Canada; 2018. Retrieved from: https://www.mentalhealthcommission.ca/sites/default/files/PrimaryCare_Overview_Reviews_Narrative_Summaries_ENG_0.pdf

[iv] 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).

[v] 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/wpcontent/uploads/2019/03/NAO-Rapid-Review-12_EN_1.pdf

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

[vii] https://content.oma.org/wp-content/uploads/pbfm_evidence_brief_oct2015.pdf

Appendix A: 10 Made-in-Ontario High Impact Actions developed by the Primary Care Virtual Community.