Ontario College of Family Physicians

Leaders for a healthy Ontario

July 15, 2020

Dr. David Price, MOH Co-Chair
Dr. Nadia Alam, OMA Co-Chair
Primary Care Working Group

Re: Request for Advice to the Primary Care Working Group

Dear members of the Primary Care Working Group,

On behalf of the Ontario College of Family Physicians (OCFP), we are grateful for the opportunity to provide input on the four key topics outlined in your letter of June 10, 2020. To provide feedback, the OCFP struck a small working group of Directors from the Board. The group consisted of a mix of practice models, including academic FHO/FHT, community FHO/FHT, and two FFS family physicians.

As context for the feedback provided, we are guided by the Patient's Medical Home (PMH) and Patient's Medical Neighbourhood, an evidence-based vision for family practices and for a connected health system across Canada, as well as by the insights provided in the OCFP's member research in November 2019. We are also incorporating themes from our ongoing communication with members, especially those who are FFS and FHG, in the last number of weeks and months through COVID-19. The OCFP asserts that being a medical home for patients should not depend on the model in which a family physician chooses to practice. However, we are aware that some practice models benefit from teams and infrastructure supports that make being a PMH more achievable.

These inequities within the profession must be addressed for the benefit of Ontarians. We are increasingly concerned about the experiences that our FFS and FHG colleagues are sharing with us. COVID-19 exposed existing gaps among practice models and created wider chasms that will be difficult to close without focused policy direction and funding supports. The lack of income stability for FFS and FHG practices is unacceptable when access to family doctors is considered an essential service. We can no longer fix the healthcare system with incremental tweaks. A concerted effort to transform primary care and family medicine, led by family physicians, must be a priority for policymakers and the profession. This makes the recommendations of the Primary Care Working Group (PCWG) and ensuing negotiations all the more critical.

phone: 416.867.9646 toll-free (Ontario): 1.800.670.6237
fax: 416.867.9990 email: ocfp@ocfp.on.ca
400 University Ave., Suite 2100, Toronto ON M5G 1S5 ontariofamilyphysicians.ca

An important opportunity exists to continue the work that began with the evolution to OHTs by supporting family physicians to be connected to each other and to their communities. The objectives of accessible, coordinated, comprehensive and high quality primary care can be achieved if we actively connect family practices (PMHs) within a Patient's Medical Neighbourhood. While the input requested in your letter does not specifically relate to a vision for primary care, our recommendations are aligned with the evidence associated with all high-performing health systems and, as such, are anchored in a vision for the health system based on a strong primary care foundation. We hope that the PCWG will keep the vision for population health, equitable access and social accountability in mind as it develops its recommendations.

Finally, the OCFP also drew on the College of Family Physicians of Canada Family Medicine Professional Profile. This profile represents the value of family physicians to the health system, and when members practice to their full scope, many of the issues being discussed by the PCWG can be addressed. As stated in the profile, "Individually [family physicians] 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." The profile is practice model agnostic.

We have framed each of the topics with a summary of the issues to be addressed, followed by the OCFP's recommendations and relevant evidence. We would welcome an opportunity to further discuss our feedback with the PCWG or answer any questions that may arise. Furthermore, we would appreciate the opportunity to provide additional information, as warranted, following the OMA/SGFP July 23rd Town Hall given the critical issues that will be discussed among family physicians.

Sincerely,

Dr. Jennifer Young, President
Dr. Elizabeth Muggah, President-Elect
Dr. Sundeep Banwatt, Director
Dr. Abhishek Raut, Director

cc. OCFP Board of Directors
Leanne Clarke, Chief Executive Officer, OCFP
Leslie Greenberg, Director, Member Engagement and Public Affairs, OCFP

OCFP Submission to the Primary Care Working Group
July 15, 2020

Statement of Principles – the context against which the OCFP is providing input to the PCWG:

1. **Evidence-based vision for primary care:**
   - Our recommendations are anchored in the core principles of the Patient's Medical Home (PMH) and Patient's Medical Neighbourhood (PMN): team-based care, timely access, comprehensive care, continuity of care, EMR and evaluation & Quality Improvement.

2. **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).

   - As such, when making decisions about funding and health care, we urge the bilateral Primary Care Working Group to keep the collective contributions and capabilities of the profession in mind because this is the fundamental value of family medicine.

3. **No practice or patient left behind:**
   - The OCFP strongly supports achieving equity and inclusivity among the various primary care practice models, including consideration for a separate consultation, or working group, with FFS and FHG colleagues.

The following chart presents OCFP's understanding of the issue behind each of the four topics requested by PCWG, our proposed recommendations, and where available, underlying evidence. We have also included further areas for exploration.

**Of note, given the broad scope of 'Access and Quality,' this topic has been segmented into seven underlying themes, many of which are interconnected with other issues (i.e. sub-themes of "Access and Quality" are interlinked with "Walk-in Clinics").

Topic	**OCFP's Recommendations** (NB: Themes are numbered for differentiation only; they are not ranked in priority order.)
Access and Quality Issues	**THEME #1: Increasing Access to Team-Based Care to Manage Increasing Patient Complexity** **Issue:** • Patients are getting more complex and the effective management of their needs is challenging, especially for the 75% of family physicians who practice without teams. • Teams, with family physicians as the anchor, are increasingly necessary to ensure patients get the care they need and deserve when they need it. • There is currently a maldistribution of funded team resources in the province, and while efforts have been made to expand access, there are still significant gaps. **OCFP's Recommendations:** • Surround the patient with a team to help family physicians manage their complex patients – **see "core minimum team" below.**

	• Increase equitable access to team-based resources for family physicians' complex patients, particularly for those not practicing in models with funded interprofessional team members (e.g., FHTs, CHCs).
	  ○ **"Core minimum team"** =
	  ○ social worker for mental health and addictions counselling *as well as* navigation support for complex patients and/or social determinants of health (SDOH) needs; and
	  ○ nurse for care coordination, clinical support and to provide wrap-around care.
	  ○ Teams must be coherent and identifiable to the patients, and the providers, whether co-located, intermittently co-located or virtual. Referral-based models to teams that erode continuity should be avoided. This is consistent with the principles of the Patient's Medical Home.
	
	Proof/Support Points:
	• FPs with access to interprofessional healthcare providers for complex patients (i.e., as part of the care team) were associated with: improved medication reconciliation; better patient outcomes for complex issues; reduced service and ED utilization; stronger provider buy-in, and reduced workplace stress[i].
	• Care coordination (transitions) and patient navigation support lead to better outcomes for patients, especially those with complex illnesses and is associated with reduced costs and better system integration[ii]. Members of this provider team must communicate skillfully with one another, known as team coherence. This group of providers is also identifiable as a team; it looks and feels to patients within the practice like a well-functioning unit working collaboratively to meet their health care needs.[iii]

	THEME #2: Sustain and Enhance Virtual Care **Issue:** • Access issues (availability including after-hours; home-bound patients; rural and northern factors, etc.) have underscored the need to enable additional modes of physician-patient interaction beyond in-person visits. This was a major impetus behind recent OMA-MOH efforts to develop a tiered approach with respect to virtual care. • COVID-19 has accelerated the introduction, and highlighted the importance, of offering patients a range of virtual care options to ensure their care needs can continue to be met during and beyond the pandemic. **OCFP's Recommendations:** • Concerted effort to sustain virtual care is needed, 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. • 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 the functionality of OTN: access to it can be difficult and implementation of it is costly. • 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: ○ Choice of platform that is affordable – 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 (**see walk-in clinics section below**).

Proof / Support Points:

- Canadians have embraced virtual healthcare options (e.g. phone or video appointments) during the pandemic, according to a CMA poll.[iv]
  - About half (47%) of Canadians have used "virtual care" such as calls, email, texts, or video during the pandemic. Of these, 91% said they were very satisfied with the experience.
  - This is generally consistent with Canada Health Infoway data, showing more than half of patient visits with health care providers are now virtual. Before the pandemic was declared, about four per cent of primary care visits in Canada were done virtually (by phone, video, text or app), according to CHI.
- Doctors want to see virtual care expand.
  - With improved access to cellphone and high-speed internet service in rural, remote, and Indigenous communities — while addressing issues including quality of care and privacy [source: CMA interview].
  - A survey (Apr 26 to May 6) of 126 physicians and six nurse practitioners and physician assistants in Hamilton revealed almost nine-in-10 (87%) like virtual visits and want to keep digital alternatives after COVID-19.
  - Among the challenges: lack of integration into the normal workflow and technology issues; need to optimize video calls.

THEME #3: Practice Models and Accountability

Issue:

- The COVID-19 pandemic has exacerbated pre-existing inequities across Ontario's diverse primary care payment models; equity between payment models is now needed more than ever.
- Specific equity-related challenges include, but are not limited to:
  - Currently FHO access is restricted to only regions government deems to be underserved; as a result, many new grads are unable to practise in the models in which they have been trained.
  - Patient access is variable in some FHO practices, which requires solutions around adherence to the FHO contract expectations.
  - The pandemic has impacted FFS and FHG practices more than FHO and FHN practices; significant income instability has been experienced disproportionately by FFS/FHGs and student health physicians. Of note, other provinces have mitigated this issue through income stabilization measures for FFS family physicians; in Ontario, "loans" provided some temporary relief although this measure ultimately will not support the viability of many FFS family practices further struggling as a result of the pandemic.
- Addressing the tension between accountability to the population with autonomy in the practice.

OCFP's Recommendations:

- Open access to blended capitation models (specifically FHOs) for all family physicians.
- Harmonize practice models to foster greater equity in providing comprehensive and patient-centred care, practice viability, and in creating healthy work environments for family physicians.
- Whatever is developed as a practice model should aim to roster all patients and ensure access is supported through three-way improved accountability where:
  - FP to provide care as contracted.
  - MOH to ensure necessary supports are in place (EHR, minimum team access), and that contract obligations are met.
  - Patients are educated about their rights and responsibilities with respect to accessing their MRP, including providing them with simple information about who to call, availability of after-hours access to avoid ER use, etc.
- **Of note, accountability/access issues are interconnected with walk-in clinics issues – see below for recommendations that are relevant to this theme.**

	Proof/Support Points: • An Alberta study[v] suggests that with respect to the promotion of three-way accountability, the evidence shows that funding model is part of a broader picture of interdependent factors that leads to success. Government needs to provide fair payment, EHR, etc.; FPs provide access; patients must also be accountable to their MRP.
	THEME #4: A modernized definition of "access" **Issue:** • The "same day/next day" concept is a limited understanding of access and needs to be expanded and updated to reflect other considerations identified in the literature and by family physicians (i.e. continuity of care, access to the right team member, and priority access for vulnerable / complex patients). • How to define "appropriate access" versus "care when I want it". ○ We need to re-think how we define appropriate access to account for the fact that in today's "busy" culture, many patients, who are offered timely appointments, choose convenience outside the MRP relationship instead. • Some practices, particularly larger practices with many chronically ill and elderly patients requiring regularly scheduled follow-ups, have found the introduction of pure advanced access or same-day scheduling to be challenging and have preferred modifications of the ''carve-out'' model[vi]. In a carve-out model, appointment slots are either booked in advance or held for same-day urgent care; same-day non-urgent requests are deflected into the future. **OCFP's Recommendations:** • Develop a more appropriate, fair and nuanced definition of "access" and ways to measure it. 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.[vii] **Proof/Support Points:** • Dr. Kamila Premji's work on patient access (Healthy Debate, 2015) is well-known and widely recognized. • In 2018, in a *Canadian Family Physician* journal article called "Patients' perceptions of access to primary care", Dr. Premji and others conducted a quantitative survey to gain a more comprehensive understanding of Ontario patients' perceptions of access to their primary care practice and how these relate to patient characteristics. • The authors used a more comprehensive definition of "access" than the "same-day/next-day" concept, which considers additional things such as ease of appointment, how other healthcare resources were leveraged, location, etc. • **Key finding: most patients had favorable impressions of their access, and there was no difference among characteristics (i.e. language, sex, income, education, ED use, chronic disease status),** suggesting that it's important to consider other dimensions of primary care quality when assessing access, or when implementing reforms/policies aimed at improving access. • A group of family physician leaders, led by Dr. Jocelyn Charles, developed a primary care maturity model and key enablers that should be used as a road map.
	THEME #5: Population-Based System Integration, through: **A) Integrated EHRs;** **B) Better Access to, and Interaction with Home and Community Care;** **C) Streamlined Referral Processes**

A) Integrated Health Record

Issue:

- Administrative burden/paperwork is the biggest practice level pain point by far for Ontario family doctors, contributing to inefficient practice and physician burnout.
- Not being able to access and share patient data in real time creates barriers for coordination and integration of patient care
- More broadly, population needs assessment and the development of system integration solutions designed to address those needs are dependent upon robust data access, collation and analysis.

OCFP's Recommendations:

- EHRs need to be designed to talk to each other intuitively: either single or intra-operable systems that can both push and pull required information. Start with integrated EMRs but plan for EHRs.
- Current Ministry consultation on its proposed DHIEX policy and regulation is a step in the right direction.
- Family physicians need to be supported to facilitate this integration; that is, FPs need to be better connected *to each other* and *to the system* and supported to do this work.

Proof/Support Point:

- Administrative burden/paperwork is the biggest practice level pain point by far for Ontario family doctors [source: OCFP member survey, September 2019]

B) Better Family Physician Access and Integration with Home and Community Care

Issue:

- Ontarians want to age in place; even more so given the learnings arising from COVID-19.
- For complex patients, this means the ability to stay at home and live as independently for as long as possible, through increased in-home visits by their family doctors (or at a minimum, family physician two-way link to care provided at the home), and better and more consistent access to home care services, directly with the home care provider.
- Current family physician / home care coordination and interaction are variable across the province.

OCFP's Recommendations:

- Enable better and more direct family physician access to, and integration with, home and community care; more specifically:
    - Remove barriers and "red tape" that hinder FPs from obtaining information in a timely manner about their patient receiving home care.
    - Enable shared care between primary care and home care by anchoring care coordination in primary care and also 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.
    - Enhance access to virtual care – see above.
    - 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.

Proof/Support Point:

- According to a 2016 HQO report, among the provinces and countries surveyed, Ontario has one of the lowest reported percentages of family doctor communication with home care services. Family doctors also report challenges coordinating care with social services and other community providers.

C) Streamlined Referral Processes

Issue:

- Major bottleneck in achieving coordinated and integrated care for the patient is the inability for family physicians to access timely diagnostics, specialist 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.

OCFP's Recommendations:

- Develop a central referral process. 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]
- Easier access to team-based care (see above Theme#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, but, 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.

THEME #6: Clinical Leadership

Issue:

- Ontario is short-changing itself by not investing in and supporting family physician leadership.
  - This is a proven enabler of high-quality health systems and transformation efforts.[viii]
- Research (see proof points below) shows that transformation initiatives that effectively engage physicians in health system design, change processes, and leadership development opportunities are more likely to experience improved outcomes.

OCFP's Recommendations:

- Support is required for clinical leadership and organizing primary care
  - Extensive evidence supports the importance of clinical leadership and organizing primary care – need mechanisms to allow family doctors to provide input in system design and ongoing decision-making. Family doctors must play a meaningful role in shaping reforms, given they are at the heart of the system and ultimately central to success.
  - 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.
- 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.
	
	Proof/Support Points:
	• 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.[ix]
	• 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.[x] [xi]
	• In the UK, GPs were engaged to lead more fundamental reform of the public healthcare system.[xii] This followed lessons learned from previous unsuccessful reform attempts that failed to meaningfully engage GPs in decision-making.[xiii]

	THEME #7: Quality / Practice Improvement
	
	Issue:
	• Good data drives good decisions in the practice and larger healthcare environment.
	• Presently, there is limited uptake by family physicians to engage in quality / practice improvement.
	• Approximately 75% of family physicians do not practice within a team-based model (e.g., FHTs, CHCs) where administrative support/QI staff are available. This limits their ability to engage in practice / quality improvement.
	• This speaks to the larger issue where primary care sector has limited infrastructure to support much beyond direct provision of patient care. As such there is:
	  ○ Limited human resource expertise and support,
	  ○ Lack of ability to facilitate change management or adopt new practices,
	  ○ Lost opportunities to leverage economies of scale, house common infrastructure, or back office support, and
	  ○ Limited forums for collaboration in care planning or system design.
	
	OCFP's Recommendations:
	• QI support (including practice facilitation) – sustained support (i.e. funding) is needed for practice improvement efforts given they have been shown to work and support access/quality.
	• Improve primary care data, so that it becomes consolidated, integrated, actionable (tells you which patients need what), and timely.
	• Provide administrative support / QI staff resources to those family physicians who do not practice within a team-based model (e.g., FHTs, CHCs)
	• Encourage uptake of MyPractice Report by all physicians; potential ways of enhancing uptake include but are not limited to:
	  ○ Send to all family practices
	  ○ Enhance timeliness of data
	  ○ Enable online registration and phase out of paper/mail registration
	  ○ Continue to improve relevance and use of report and ability for FPs to use it at the practice level
	  ○ Better align the report with Quality Improvement and change management principles; currently report is more focussed on Quality Assurance rather than Quality Improvement

	○ Enable family practice groups to delegate the data access to a physician lead/administrator so that the data can be looked at across a family practice • As noted above under "Clinical Leadership," a connected and modernized primary care infrastructure for Ontario is needed. Proposed approach is for each OHT to have an Integrated Primary Care Centre 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: ○ Network for family physicians. ○ Support for change management and ongoing Quality Improvement & Performance Management. ○ Support for IT and digital health solutions; and ○ Horizontal and Vertical integration. • Opportunity to lever the introduction of CFPC's Personal Learning Plans to identify practice improvements, supported by facilitation. **Proof/Support Points:** • Ontario data indicate QI /PI opportunities to improve screening, chronic care, and prescribing patterns, as well as to reduce less-urgent emergency department visits (Cape triage score, CTS 4–5), avoidable hospital admissions, hospital re-admissions and specialist visits[xiv]. • Practice improvement programs have been shown to increase patient and provider satisfaction AND improve processes and health outcomes. Systematic reviews have shown improvements in wait times, continuity of care, screening, patient self-management, care processes, chronic disease management and health outcomes when compared with no intervention [same source as above].
Complexity Modifiers	**Issue:** • Acuity modifiers for family medicine were introduced in 2012 and later suspended in 2015 as part of the MOHLTC-OMA negotiation challenges. • That notwithstanding, the need for fair compensation for physicians working with patients requiring complex care in a capitated model remains. • Complexity premiums already exist for specialties other than family medicine (E078). • Current complexity premiums and acuity modifiers do not reflect social determinants of health (SDOH) needs, which are often associated with complex patients. **OCFP's Recommendations:** • Restore the previously established *interim* payment methodology acuity modifier and apply across all models. • Establish a *permanent* payment methodology acuity modifier for all practice models. ○ Look at latest US evidence and payment models that integrate SDOH in addition to number of chronic illnesses. • Ensure SDOH reflected in complexity premiums, including across all practice models, not just capitated models. • Improve virtual codes that include more nuanced visits (see PEI schedule of benefits). • Support enabling technologies to help care for complex patients (i.e. integrated EHRs that also encompass SDOH and other complex measures)
Walk-in clinics	**Issue:** • Walk-in clinics are filling a gap, as there will always be orphan patients or those who need acute/out of hours care – but linking with MRP, where possible / identifiable is important. • For those patients who seek care from walk-in clinics, how can we maintain continuity of care regardless of practice setting? • How can we ultimately connect frequent walk-in users with an MRP? • Patients value a doctor they trust and who they know will be there in the long term for them. This is a central tenet of the Patient's Medical Home.

	OCFP's Recommendations:
	• Connect walk-in clinics to family doctors in their communities through technology/integrated EHRs.
	• Virtual care through OHIP should be for those FPs with an existing patient relationship/ in the setting of a patient's group/family doctor
	  ○ OCFP supports what the worldwide evidence has shown: that the cornerstone of excellent primary care is the care provided by a comprehensive family physician to his / her patient.
	  ○ This essential relationship needs to be recognized in any effort to address the walk-in clinic issue as continuity of care allows for the best outcomes: enables the quadruple aim and is a key line of defense against hallway medicine (reduced hospital admissions; better patient satisfaction; reduced system costs). A study in the British Medical Journal showed that patients who were more closely followed by the same primary care provider fared better on serious matters, such as having to return to the hospital and the chance of dying[xv].
	  ○ Explore whether walk-in clinics could serve as mobile/in-person assessment for high use/complex patients that should have access to a broader team with their MRP.
	• Strike a multi-stakeholder working group to explore the rationale behind walk-in clinic usage (**see below areas for exploration**) and ensure appropriate representation of FFS/FHG physicians.
	  ○ Based on feedback from our members, the inclusion of the FFS/FHG perspective is currently missing from this discussion. As reinforced in the principles at the outset of this document, equity among the various primary care practice models will require equity in representation of those models.
	
	Proof / Support:
	• BMJ article: in patients with high healthcare utilization, who seek care from multiple providers, the quality of care is poor – need to wrap teams around these patients.[xvi]
	
	Further areas for exploration:
	• Currently walk-in clinics are filling a critical care gap; thus, it is important to understand the main users of walk-in clinics and what is driving their usage?
	• How can walk-in clinics be better connected to their colleagues and within emerging OHTs?
	• What are some of the barriers in attaching them to MRPs? Are there patients who do not want to be rostered?

GP focused practice designation	**Issue*:***
	• FPs in a focused practice can play a significant role in fulfilling a community need. It is important to ensure this valuable work is supported in a way that does not ultimately serve to undermine comprehensive care.
	• How to ensure family physicians are choosing to practice in the way in which they are trained, as expert generalists, and providing comprehensive care as defined in the primary responsibilities of the CFPC professional profile:
	  ○ Comprehensive medical care for all people, ages, life stages, and presentations. This care includes all clinical domains, both acute and chronic, and all stages, from preventive to palliative care. Family physicians work across care settings and regulatory environments, including: Primary care; Emergency care; Home and long-term care; Hospital care; Maternal and newborn care.
	
	OCFP's Recommendations:
	• Maintain current application process and recommend inclusion of:
	  ○ Demonstration of competency in focused practice area.
	  ○ Individual professional development goals should be balanced with community/population needs – the latter a key factor, i.e., demonstrate the gap the GP focused practice is filling.

	• Ensure that the application process, required training, and other policies uphold the principles of the PMH/PMN and emphasize the CFPC professional profile (community adaptive with augmented skills). • Apply the CFPC's Best Practice Guide on Communities of Practice in the PMH, which contains guiding principles on integrating GP focused practices so that family practices continue to provide the full suite of comprehensive care (i.e. connecting FPs together, seamless information exchange, co-location if possible etc.). • Leverage the move to regionally based planning to make it easier for FPs to determine community need for a particular focused practice area, thereby making the process fairer, more transparent and less onerous for the individual applicant. • Ensure GP focused practices are seamlessly connected to, and integrated with, the rest of the health care system i.e. ensuring connections with other family physicians/rest of primary care, as well as other health providers in their communities. ○ GP-focused practices should be easily accessible, and available to all within an OHT • Continue to provide funding that rewards family physicians who provide comprehensive care. Billing codes should not inadvertently incentivize individuals to move away from comprehensive family medicine. **Further areas for exploration:** • What is the gap in the system that GP focused practices are filling? • What is the driving the perceived decrease in interest of comprehensive family medicine?

[i] 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-RapidReview-12_EN_1.pdf

[ii] Craig C, Eby D, Whittington J. Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2011. (Available on www.IHI.org)

[iii] https://pcmh.ahrq.gov/sites/default/files/attachments/creating-patient-centered-team-based-primary-care-white-paper.pdf

[iv] Abacus Data conducted the national poll of 1,800 Canadians for the CMA between May 14 to 17.

[v] https://hqca.ca/wp-content/uploads/2019/12/HQCA-Crowfoot_Taber-Case-Study-Evaluation-2019.pdf

[vi] CFPC Best Advice Guide on Timely Access to Appointment in Family Practice, 2012

[vii] 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

[viii] Evidence Brief: Preparing for a Devolved, Population-Based Approach to Primary Care. OCFP. October 2015.

[ix] 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/ExploringDynamics-Physician-Engagement-Denis-E.pdf?sfvrsn=0.

[x] 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-RapidReview-12_EN_1.pdf

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

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

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

[xiv] Advancing Practice Improvement in Primary Care Final Report, OCFP, May 2015

[xv] 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. Available from: BMJ 2017;356:j84

[xvi] 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. Available from: BMJ 2017;356:j84

Appendix A: 10 Made-in-Ontario High Impact Actions developed by [the Primary Care Virtual Community](#).