# Primary Care Maturity Model and Key Enablers for Ontario Health Teams:

Recommendations of the Ontario Primary Care Council

*July 10, 2020*

**Introduction**

Currently in Ontario, primary care is provided in some neighbourhoods by highly integrated, population focused primary care providers (FHTs, CHCs). However many Ontario citizens continue to receive primary care from unconnected and often solo primary care providers without access to interprofessional teams and who often have inconsistent access to specialists, and community care resources. Therefore, building a more uniform, high quality primary care system across the province is urgently needed as we transition to Ontario Health Teams (OHTs) as the success of the OHT model depends on a strong foundation of primary care.

The first step to a more uniform primary care system is a shared ideal state for fully integrated primary care with the key enablers required for diverse primary care practices in variable settings to be able to function in a fully integrated model. This maturity model 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. While there is a need for strong coherence, flexibility is also required to tailor the model in local contexts using available resources. By working together, local innovation can be identified, harnessed and shared across OHT regions.

This Maturity 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.

| Element | Ideal State Description | Key Enablers | Ontario Examples |
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| Primary Care Leadership and Engagement<br><br>**GOVERNANCE** | • Primary care providers are full partners in planning and system change together with patients and system partners<br>• PCPs regularly collaborate on improvement initiatives with system partners<br>• There is a strong coalition of PCPs, PC organizations, community partners and HRPs who have entered into accountability agreements to steward population | 1. Funded Primary Care leadership roles with a core minimum set of deliverables across OHTs; 2. Funded primary care support structure to enable front line providers to inform system planning and implementation in each OHT (e.g. association or network) with the flexibility and authority to organize and act quickly to emergent issues that may be local in nature or more provincial as with CoVid; 3. Primary care leadership or co-leadership of OHT initiatives to address population health needs. 4. Clinical advisory councils with similar mandates that are led by PC and include NPs, midwives, specialists, home care, public health, paramedics and other clinical | 1. Markham/Stouffville; North Toronto; East Toronto; Mid-West Toronto; London-Middlesex (Covid related only), Mid-East Toronto, Muskoka and Area; Southlake Community OHT<br>2. East Toronto, Mississauga Halton, Southlake Community OHT, Couchiching, Brampton-Etobicoke, All Nations Health |

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| | health initiatives | leaders where appropriate | Partners, Mid-West Toronto 3. above + North York;<br><br>*1.&2.Many international examples (e.g. UK, Switzerland, Sweden, Germany, Australia) |
| Cross Sectoral Governance & Shared Accountability<br><br>**GOVERNANCE** | • Relationships between PC organizations and providers provide for an organized, accountable network of care<br>• Relationships and clear governance structures between PC, patients and local health and community providers<br>• All organizations have access to the same data to plan and monitor service provision | 1. Primary care leadership is supported and enabled to have a prominent role at the OHT leadership level; 2. There is primary care representation in all aspects of OHT planning and governance; 3. Data on primary care practices (including CHCs and NPLCs) such as patient enrolment, provider FTEs, and health care utilization are available to primary care providers and regional primary care leadership; 4. Shared accountability* of all organizations of each OHT to support primary care delivery aligned with population needs; 6. Key data for planning and research is available centrally and integrated across providers at a patient level.<br>*Accountability is defined as shared vision/purpose to create a coalition of the willing. | 1. & 2. Couchiching; All Nations; Guelph; East Toronto; Mississauga Halton; Brampton-Etobicoke; Muskoka and Area; London-Middlesex; North Toronto; Hamilton. |
| Primary Care Attachment<br><br>**OPERATIONS** | • All patients who want or need a primary care provider are attached<br>• There is an easily accessible database that enables full health system awareness of PC attachment<br>• PCPs consistently report their intentions to change practice to their local system partners (e.g. retire, take extended leave, change focus) | 1. Processes in place in all organizations to identify patients' primary care provider, level of attachment and patients without a primary care provider; 2. Single access point for patients looking for a PCP in each OHT with facilitated attachment through connectors when needed; 3. Easily accessible database enables full health care system awareness of the rates of PCP attachment in a neighborhood and OHT; 4. A common agreement on how to prioritize and distribute patients between PC providers for attachment, including managed entry of FHO positions; 5. Virtual care solutions are equitably available, integrated with EMR systems and enabled across Ontario (with reliable internet access) together with standards on appropriate use of virtual care; 6. Primary care provider human resource management planning process in all OHTs ensure primary care is matched to population needs and succession planning addresses the issue of physician retirement/leaves to ensure patients have continuity of | 2. Health Care Connectors in OHT regions; 6. HHR Model developed by University of Ottawa with the TC –LHIN. |

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| | | primary care. | |
| Primary Care and Specialist Access<br><br>**OPERATIONS** | • Centralized intake and e-referral processes are in place and easily accessed for specialists and specialized clinics<br>• A coordinated integrated access point for a suite of services (SCOPE) is implemented in all geographies<br>• All patients have timely access to PC including in the home when required | 1. All primary care physicians/NPs have timely and easily facilitated access to specialists, diagnostic, hospital and community resources to meet patient needs (e.g. SCOPE platform) in all OHTs for real-time and virtual resources as well as an organized scaffold to nimbly respond to urgent and ongoing primary care needs; This includes rural access to specialty care in urban centres. 2. Centralized intake and referral processes for all specialties and sub-specialties are in place and easily accessed by all PC providers; 3. Specialist directory that is up to date and easily accessible by all PCPs. 4. Comprehensive primary care outreach is available for vulnerable populations who have difficulty accessing office-based and/or virtual care - eg. homebound patients, those residing in shelters and supportive housing. | 1. Mid-West Toronto is the lead for SCOPE, now available in Mid-East Toronto, West Toronto, East Toronto, North Toronto, London, Scarborough, Brampton-Etobicoke; 2. Centralized intake for selected specialties in central Toronto (Addiction medicine, low back pain, others in progress)<br>4. North Toronto, Mid-East Toronto, East Toronto (Hubsn'n MUMs model). |
| Continuity of Care<br><br>**OPERATIONS** | • Home care coordinators are fully aligned and integrated with PC<br>• Community and hospital providers routinely connect with PC to meet patient needs in a timely manner<br>• Appropriate post discharge appointments are booked at discharge and information is shared with PCPs<br>• Warm handovers facilitate continuity of care for patients with complex needs at all transition points<br>• PCPs have one number to call to access community care resources and services | 1. Care coordinators are aligned and attached to primary care practices; 2. There is one portal to access all health care records for both patients and their providers. 3. Patients have access to information about providers electronically for communication and self-booking needs; 4. After hours primary care is coordinated across all PC providers regardless of their model of care, and 24/7 care is available for vulnerable homebound patients and people living in congregate spaces, long term care and palliative care; 5. Walk-in clinics/virtual walk-in clinics are part of the OHT and have organized and integrated linkages with PCPs including access to relevant PCP records and timely reporting back to the responsible PCP ; 6. CCPs are available electronically by all providers in the circle of care through a dynamic platform that can both be updated and communicated within and across providers; 7. Hospital discharge summaries are received within 48 hours of discharge with a contact number for clarification if required: 8. PODS are expanded for all discharged patients; 9. HRM is full implemented by all facilities and primary care providers with e-Notification; 10.There is one number to call for patients to provide timely linkages back to care providers and one number to call for warm hand offs between providers. | 1. FHTs/CHCs in central Toronto regions 10. Hypercare in East Toronto facilitates post discharge communication between PC and specialists. |

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| High Performing Interprofessional Teams<br><br>**OPERATIONS** | • All people in all geographic areas who need interprofessional care have an identifiable, cohesive interprofessional team aligned to their needs<br>• Core team compositions are aligned with health and social needs of populations being served<br>• Interprofessional team resources are equitably allocated and prioritized by population need and available resources<br>• Chronic disease management and prevention is organized and easily accessed locally<br>• Decisions about how care is delivered are made using ethical principles and values<br>• Virtual team consultations are accessible for patients with multimorbidity and their family physicians | 1. Establish & implement shared health and social needs based criteria for access to interprofessional team care for all Ontario residents; 2. Establish a minimal interprofessional team standard tailored to the patient roster needs for all practices (teams could be co-located, intermittently co-located or virtual aligned with patient needs and contexts) and includes public health and home care; 3. Establish a set of standardized performance measurements (common key performance measures - KPMs) to track access to interprofessional care, efficient use of IP team resources and patient experience measures (such as patient activation in self-management and Patient Reported Experience Measures -PREMs) within and across OHTs; 4. Establish a provincial community of practice for interprofessional team-based primary care to identify and spread best practices of efficient models and contribute to evidence-base in IPC team care. | 1.and 2. Guelph; 2. North Toronto mobile IP Teams; North York mobile IP Team; West SR IPC Team; SCOPE Platform as a scaffold for accessing chronic disease management and community resources and interprofessional teams. 3. Central Toronto (West, Mid-West, Mid-East, East , North) established common IP team performance metrics and initiated a community of practice for IP teams. |
| Primary Care Information Management and Communication<br><br>**DIGITAL** | • All PCPs have access to and use clinical information through central repositories (that include laboratory, hospital, home care and diagnostic information) for optimal patient outcomes with efficient use of health care resources<br>• EMR systems are interoperable with all health care information platforms with a common log in<br>• All PCPs use secure provider to provider and provider to patient communications<br>• Practice and geographic population health data is available and used regularly for service delivery planning and evaluation<br>• Practice and geographic population | 1. Primary Care providers have EMR systems that provide consistent and efficient access to patient information and there are clear expectations for EMR vendors to respond to identified deficiencies in timely and efficient access to available patient information; 2. Access to a shared patient record that is common and available as clinically appropriate between the hospital, PC providers, home care, paramedics, public health, community care providers, and includes laboratory and diagnostic imaging/test results; 3. EMR systems are interoperable with all health care information platforms with a common single log in; 4. All EMR systems, communications and repositories, and integrated virtual care solutions are available to all PCPs with no financial burden. 5. Hospital EHR systems across an OHT and within an OHT referral network are on a common platform to enable easier access by PCPs; 6. All PCPs have access to a Secure Provider-Patient communications platform allowing | 3. and 5. South Georgian Bay;<br>4. Partial example: ONE ID Bundle roll-out central Toronto; 6. MyChart expansion; 7. Hypercare in East Toronto |

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| | health data is available and used regularly for service delivery planning and evaluation (including registries of vulnerable populations) | efficient two-way communication where appropriate. 7. All PCP and specialists use a secure platform that allows secure and in-time communication about patient care. | |
| Patient Experience<br><br>**COMMUNITY ENGAGEMENT** | • Patients contribute their knowledge and experience to co-design how care is delivered and evaluated at the organizational level<br>• Patients inform their own care and are able to be a full member of their care team.<br>• Patients experience care that is connected and coherent over time | 1. Patient & family advisory groups co-design how care is delivered within primary care and between primary care and other sector; 2. Patients actively participate in care planning in primary care and with other members of their health care team; | 1. North Toronto PFAC; SCOPE Patient Advisory group; Mid-West Toronto - OHT co-design with patients with lived experience; Mid-West SCOPE Patient Advisory Committee; Brampton-Etobicoke; 2.Telemedicine IMPACT Plus for virtual patient-present interprofessional care planning;- West Toronto, Mid-West Toronto, Mid-East Toronto, East Toronto, North Toronto. |
| Provider Experience<br><br>**OPERATIONS** | • All PCPs are part of identifiable, cohesive interprofessional teams and are able to easily access the resources required to meet the needs of their patients<br>• PCPs have the supports required to care for their patients and manage their practices efficiently | 1. PPE procurement is organized across the OHT and involves the hospital, PCPs, community providers, long term care, congregate care settings, paramedics as well as dental and optometry with shared procurement solutions; This should be expanded to include other needed supplies. 2. Primary care is supported by local Infection Prevention & Control teams to operate safely during the Covid pandemic and on an ongoing basis; 3. Coordinated primary care led assessment centres are available for symptomatic patients to reduce the burden on individual practices and preserve PPE 4. Existing interprofessional teams are expanded and new teams created with existing organizations to ensure each PCP has interprofessional providers to meet the needs of their patients; 5. Primary care Primary care providers have a provincial council to bring forward challenges and inform viable solutions to ensure primary care is well supported across the province. | 3. Guelph OHT (functions based approach); Couchiching;<br><br>4. Ontario Primary Care Council |

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