afhto association of family health teams of ontario

Submission to

The Commission on the Reform of Ontario's Public Services

For discussion

Thursday, November 10, 2011

Contents

1 Introduction

The Association of Family Health Teams of Ontario (AFHTO) welcomes the invitation to present to the Commission on the Reform of Ontario's Public Services our thoughts on how to deliver the most efficient and effective public services possible for Ontarians. The central points in our submission, which looks at Ontario's health system from the perspective of primary care, are as follows:

- Illness prevention and effective management of chronic conditions – the outcomes of a strong primary care infrastructure – are the keys to health and health system sustainability;
- Clear goals for our health system and sound information to track health outcomes, costs and public satisfaction, are the keys to driving and managing improvement;
- This must be coupled with leadership capacity and other mechanisms to bring organizations together to facilitate the flow of patients, information and the workforce, in order to improve health outcomes, system efficiency and public satisfaction;
- With further evolution and support, Family Health Teams could act as "Primary Care Hubs" to provide primary care leadership and support for population-based planning, service integration and improvement.

2 Family Health Teams (FHTs) and the Association of Family Health Teams of Ontario (AFHTO)

Over 20% of Ontarians are enrolled with the 2000+ physicians working in Ontario's 186 Family Health Teams (FHTs). FHTs are health care organizations that include a team of family physicians, nurse practitioners, registered nurses, social workers, dietitians, and other professionals who work together to provide health care for their community. They focus on chronic disease management, disease prevention and health promotion, and work with other health care organizations, such as public health units and Community Care Access Centres.

The FHT model for delivering primary care was first announced in 2004. They were introduced in five "waves", the first ones being announced in 2005. The fifth "wave" of 30 FHTs became fully operational over the summer months of 2011.

With 92% of these teams as members, AFHTO is the voice for FHTs. Our vision is that Family Health Teams will be recognized by patients, FHT boards and staff, other health organizations, the public at large and their government as an innovative and efficient model for delivering accessible, comprehensive, high-quality, patient-centred primary health care. To achieve this vision, AFHTO works with and on behalf of its members as the advocate, champion, network, and resource center for family health teams, to support them in improving and delivering optimal interprofessional care.

AFHTO strives to represent individuals and organizations committed to the following principles of Comprehensive Primary Care:

1. The basis of Comprehensive Primary Care is the existence of a trusting accessible relationship between patients and their primary care providers.
2. Comprehensive Primary Care is accountable to the population it serves.
3. Comprehensive Primary Care needs to represent the expectations and needs of the population it serves.

4. Comprehensive Primary Care embraces the opportunity for group (team) objectives, dynamics and outcomes.
5. Comprehensive Primary Care embraces the opportunity for the innovative use of all service provider skills in the achievement of group (team) objectives, dynamics and outcomes.
6. Comprehensive Primary Care embraces the responsibility of health system stewardship, conservation and sustainability.
7. Comprehensive Primary Care incorporates all the PCCCAR Functions[1], namely:
    1. Health assessment
    2. Clinical evidence-based illness prevention and health promotion
    3. Appropriate interventions for episodic illness and injury
    4. Primary reproductive care
    5. Early detection, initial and ongoing treatment of chronic illnesses
    6. Care for the majority of illnesses (with specialists as needed)
    7. Education and supports for self-care
    8. Support for hospital care and care provided in-home and in long term care facilities
    9. Arrangements for 24 hours/ 7 day a week response
    10. Service co-ordination and referral
    11. Maintenance of a comprehensive client health record
    12. Advocacy
    13. Primary mental health care including psycho-social counseling.
    14. Co-ordination and access to rehabilitation
    15. Support for people with terminal illnesses

3 Observations on primary care delivery in Ontario

3.1 Primary health care is the key to system sustainability

Primary care is the "front door" to the health system, where comprehensive care takes place over a person's lifetime. This is where the vast majority of all interactions with the health system occur. Overall, health care systems with strong primary care infrastructures have been found to enjoy:

- healthier populations
- fewer health-related disparities
- lower overall costs for health care.[2]

Primary care practices have significant influence on the demand for other health services and health system costs. This can stem from use of evidence-based practice that avoids the use of unnecessary drugs and tests.[3] It also includes the ability to keep people healthy through health promotion and

[1] From the Subcommittee on Primary Care of the Provincial Co-ordinating Committee on Community and Academic Health Science Centre Relations (1996) *New Directions in Primary Health Care*. PCCCAR report to the Minister of Health Ontario,

[2] *Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Millbank Q 2005:83:457-502*

[3] For example, the Ontario Health Quality Council's 2011 Report on Ontario's Health System reports that only 17% of elderly patients with uncomplicated hypertension are treated with a low cost but equally effective drug as the first line of treatment (p.82).

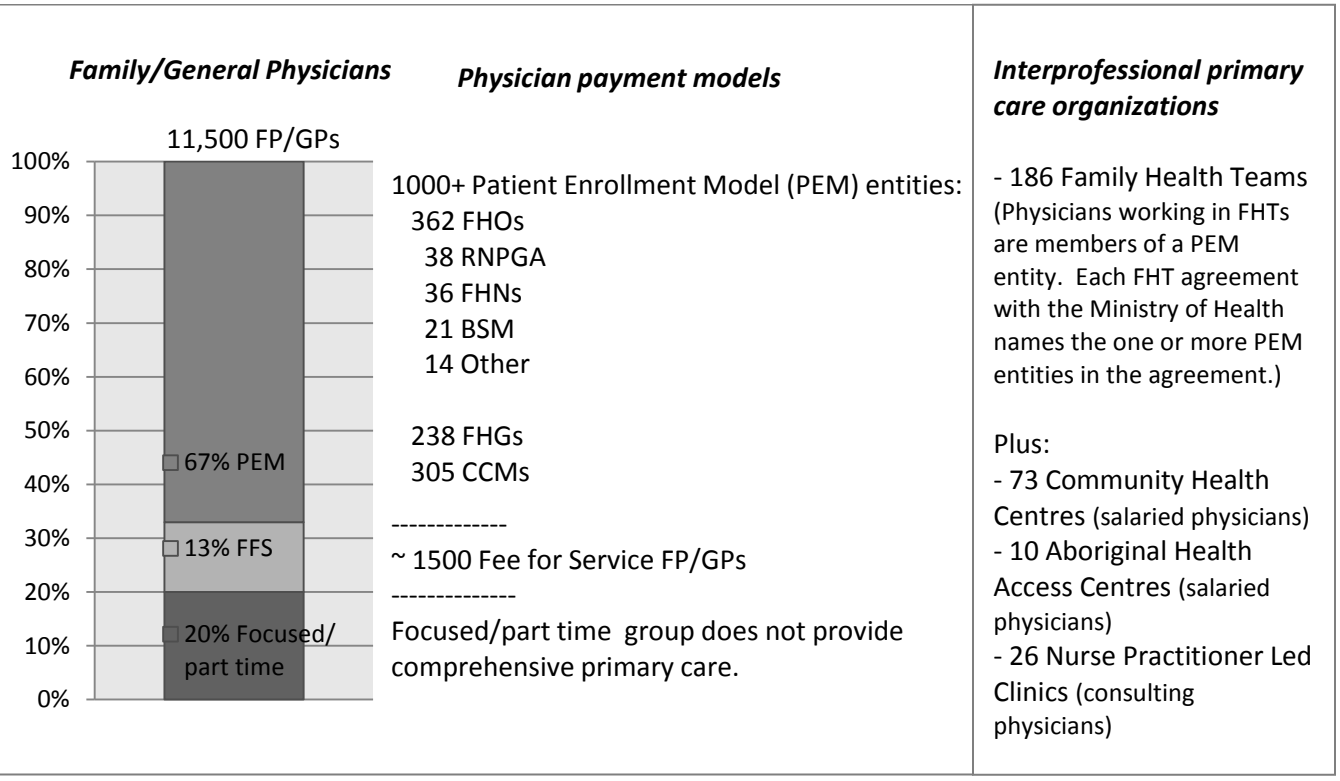
effective management of chronic disease. For example, a 2008 report estimated that if the optimal number of Ontario patients with diabetes or coronary artery disease were on the right drugs and had blood sugar, blood pressure in control, there was potential for:

- 8,000 lives saved
- 8,000 heart attacks prevented
- 4,000 fewer strokes
- 1,200 fewer cardiac surgeries or procedures.[4]

Primary care is the foundation for developing a high-quality, sustainable health system.

3.2 Primary care in Ontario is fragmented

Ontario has a proliferation of entities delivering primary care, ranging from solo family physicians to interprofessional teams consisting of from 4 to 300 physicians, nurse practitioners, dietitians, pharmacists and other health professionals. There are also many different ways in which physicians are paid, each of which relates to an organizational entity. The landscape can be summarized as follows:



From "Quality in Primary Care" Working Group report submitted to MOHLTC, August 2011 (derived from the authors' communication with ICES and OMA)

As mentioned above, just over 20% of Ontarians are enrolled in FHTs, and another 3-4% are enrolled in the other interprofessional primary care organizations. Roughly three-quarters of Ontarians receive their care in more traditional physician-based settings, or are not enrolled with a provider.

[4] Ontario Health Quality Council, Council's 2008 Report on Ontario's Health System (pp.90-102)

3.3 Primary care lacks formal connections to the rest of the health system

While individual primary care organizations have collaborated with other entities to coordinate care in their own communities, this has been due to individual leadership and relationships, and sometimes in spite of the organizational and funding barriers that stand in the way. Local Health Integration Networks (LHINs) are the entities established to build greater integration and efficiency into the health system, based on population health needs, however almost all of primary care (all but the 73 Community Health Centres) and public health are outside of the formal LHIN mandate. While some FHTs or other primary care representatives are at LHIN planning tables when discussing integration and coordination of care, this is often the exception rather than the norm.

3.4 Traditional primary care models have insufficient capacity and support to improve quality and health system efficiency

An Ontario Ministry of Health and Long-Term Care-funded investigation into successful health system improvement around the world found the following attributes to be common among all:

- Leadership: both administrative and clinical, supported by the board's expectations for improvement
- Strategy and policies: clear priorities and plans, supported by policies and incentives that are aligned
- Structure: teams and team work
- Resources: staff time and support from quality improvement expertise
- Information: clinical and administrative data that is readily available
- Communication channels: regarding priorities, initiatives, results and learning
- Skills training: in improvement methodology, team work, project management and epidemiology
- Physician/clinician involvement: opportunity for physician/clinical leadership and ownership.[5]

Ontario has provided quality improvement support for primary care through the Quality Improvement and Innovation Partnership (now part of Health Quality Ontario); however traditional family practices have been hampered by the lack of administrative, team and information infrastructure needed for successful participation. Doctors who are busy providing care lack the time and face financial disincentives to participate in the relationship-building, planning and coordination required to develop programs to integrate care across multiple providers. To date the only clear priority for primary care in Ontario has been to enroll "unattached" patients, and with 1,000,000 more Ontarians attached since 2005, good progress has been made as a result.

3.5 The Family Health Team model offers a solution

The design of FHTs includes a number of features to enable improvement in quality and efficiency:

- Physician engagement in leadership and, in most cases, governance of the FHT
- Interprofessional team
- Organizational infrastructure

[5] G.Ross Baker et al, High Performing Healthcare Systems: Delivering Quality by Design, Toronto: Longwoods Publishing, 2008.

- Informational infrastructure (EMR) for patient care
- Patient-centred / population-focused approach
- Some capacity to use data to improve planning, performance and outcomes
- Some ability to develop comprehensive community-based programs[6] in:
  - health promotion and illness prevention
  - early detection/diagnosis
  - chronic disease management
  - self-care programs
- Developing links with other health care organizations at the community level

These enablers have been key to the innovations and improvements FHTs have been able to accomplish so far.[7] Taken as a whole package, this is what makes them unique as a model of primary care delivery in Canada.

4 Recommendations from a primary care perspective for improving quality, efficiency and sustainability of Ontario's health care system

4.1 Set and communicate health system goals, based on the "Triple Aim" with specific, quantifiable performance targets

The people of Ontario, through its government, give direction and shape to our publicly-funded health care system. System improvement has been greatly hampered by lack of focus. With lack of focus there are many good intentions going in multiple, disjointed directions, as well as high vulnerability to the predictable resistance to change.

Clear goals are essential so that:

- The public can understand where our health system is headed and why
- Public discourse can be shifted from "we can't do this" to "how can we make this happen"
- "Silos" of funding, policy making, and organizational boundaries can be crossed and innovations introduced toward achieving these goals
- Health care providers and communities can be engaged and effectively contribute to their achievement.

As a public good, health care requires the balance of the "Triple Aim" approach[8] in goal-setting. Developed by the Institute for Health Care Improvement, this requires goals that simultaneously:

- Improve health of population
- Enhance the patient experience of care (including access, quality and reliability)
- Reduce, or at least control, the per capita cost of care.

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[6] Ministry funding for FHTs is based on "enrolled" population, not population served. While many FHTs offer community-based programs, they face resource limitations.

[7] The Ontario Health Quality Council's 2011 Report on Ontario's Health System profiled three FHTs for the progress they've made in improving the quality of diabetes care — New Vision FHT, Petawawa Centennial FHT and Timmins FHT. HQO also noted Peterborough Networked FHTs success in bringing together partners to achieve a 50% reduction in patients' risk of having a cardiac event risk in the next 10 years. (pp.46, 143)

[8] For more information go to http://www.ihi.org/offerings/Initiatives/TripleAim/Documents/ConceptDesign.pdf

4.2 Ministry of Health and Long-Term Care must renew and accelerate its shift to a stewardship role (and stop the "busywork")

FHTs were set up to innovate and improve primary care delivery. To date the funding and accountability relationship with the Ministry has focused on number of patients enrolled, collection of reams of activity data, and micromanagement of budget lines. This type of relationship – based upon perceived accountability requirements – is misdirecting attention, stifling useful innovation, and wasting many person-hours of Ministry and FHT staff time in activity that is showing little or no value to patient care and wellness.

Together with recommendation 4.1, the Ministry could fulfill its rightful role in establishing priorities, policies that ensure a reasonable level of consistency for what Ontarians can expect from their health system, outcome targets and funding envelopes, then monitoring performance in achieving these.

4.3 Support the critical enablers required for primary care to play its role: leadership, teams, information, physician/clinician involvement

The findings referenced in section 3.4 indicate that FHTs are well-positioned to help advance health system transformation and to improve primary care. With 20% of Ontarians as patients, existing FHTs have created a critical mass of leadership and organization for health system transformation and primary care improvement.

With some evolution and support, FHTs serving as "Primary Care Hubs" for the rest of the primary care system would be able to support population-based planning, service integration and improvement for more traditional physician-based practices.

4.4 More work is needed to support health and health system sustainability through population-based funding

Ministry policy at present is to fund for "enrolled" population, not population served. This creates a number of inefficiencies, e.g.:

- For cultural or other reasons, some people will not enroll. This has been particularly true among first nations or homeless populations. These populations also tend to have poorer health status; outreach and community-based programs can play a significant role in avoiding downstream health costs. (For a handful of FHTs that serve a particularly high proportion of non-enrolled patients, the Ministry has made some allowance for this.)
- It creates a resource limitation for community-based programs to promote healthy living, vaccinate people and screen for conditions such as hypertension.

Added to this is the Ministry requirement for physicians to "shadow bill", i.e. to submit data as though they were billing fee-for-service. This information has been identified as very limited in usefulness for outcomes. Not only does this create extra work for data collection and management, it also sends a conflicted message for managing the health of the practice population (i.e. quantity rather than quality). It would be more useful to have meaningful information shared rather than just historically-based accountability methodology.

4.5 Primary care organizations need (better) information systems, including data on health system costs, and support to use this information

Sound information on health outcomes, organization performance and system costs are absolutely fundamental to improving quality, efficiency and sustainability in health care. Although FHTs do have electronic medical records (EMRs), and due to legacy reasons some have multiple EMRs, most are not anywhere near being able to aggregate and report data. Problems are due to lack of functionality, lack of consistency in data structures and data entry (e.g. too many free text fields), making it difficult or impossible to pull data for analysis. Systemically, there is lack of direction on which indicators need to be tracked (understandable given the absence of health system goals and targets discussed in section 4.1) and therefore the data components that need to be collected and the information to be managed. The current discussion of establishing a standard of "meaningful use" in the further development of the EMR implementation is commendable.

To contribute to health system sustainability primary care organizations such as FHTs also require feedback on the health system costs attributable to their practice population. This data resides with other entities in the health system, such as hospitals and CCACs. Primary care organizations have significant influence on the demand for health services – based on health promotion activity, quality of care, and choices made by physician and patient. Because of the long-term comprehensive approach with patients, it builds an environment of trust in which patients and physicians/clinicians can consider a conservation orientation to patient health needs. Shifting patient expectations to a safe and conservation oriented approach to problems would result in significant reduction in patient demand as has already been demonstrated in some FHTs.

Underpinning all this is the need for sufficient support for FHTs to manage and analyze their data and act on the results. A handful of FHTs are fortunate to have physician leaders who also have deeper expertise in information management. Coupled with their passion for quality improvement, they have found ways to improve data quality, pull the data, create work-arounds where needed, and track some aspects of performance for their FHT.

4.6 "Value for information" could fund investment in EMRs and better use of data

Primary care practices such as FHTs are a high quality source of information and data to assure the maintenance of quality and to monitor population health. In 2009, however, it was estimated that 43% of family physicians in Ontario used electronic medical records (EMRs).[9] As stated above, those that do have EMRs struggle to get the data and information they need.

The regular reporting of population health status, quality outcomes and quality processes has genuine value to the system. This creates an opportunity to fund primary care practices to regularly report this information in an accurate and verifiable manner. If the value for information is sufficient, it creates the sustainable case for the adoption of EMRs which can record, aggregate and report the valued data. If the value is sufficient, the payment would result in a change in physician compensation to include payment for information reporting and could also fund the use of allied health professionals to achieve the reported outcomes and processes.

Funding a "value for information" solution could come from the shifting of existing funds, new funding, or from revenue freed by reduced health system costs.

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[9] Ontario Health Quality Council, *2010 Report on Ontario's Health System*, p.74

4.7 Need for mechanisms to facilitate flow of patients and information between organizations and improve efficiency

FHTs have taken a giant leap forward with the introduction of interprofessional teams but it is still centered mainly on the primary care office setting. Strong linkages with our other partners, e.g. specialists, labs, hospitals, and CCACs, would be for ideal for delivering the best care by the most appropriate individual, in the best location and at the most beneficial time interval. Until we can connect the pieces of this puzzle and support it with efficient information flows, we won't have the true picture of what primary care can deliver to our communities.

The local/regional level is also the best place to identify and eliminate duplication or inefficiency, and address barriers in the way. One simple example comes from Prince Edward County, where the FHT's lower limb and wound assessment clinic was found to be significantly more cost effective than wound care provided through home care or more serious care in hospital, with potential savings of $85,000 per year, but the FHT lacked the $15,000 needed to pay for medical supplies. After a combined submission by the three organizations, the Ministry flowed the additional funds to the FHT. While such examples may be small individually, they certainly add up!

Ontario's current system of LHINs provides one mechanism[10] for various health organizations in a region to come together to assess and address population needs from a system level. Although the role and mandate of LHINs continues to evolve, they have provided some means for these organizations to identify and take action to improve flow of information and patients across organizations, improve coordination and integration of care, and tackle efficiency. The challenge is, as mentioned in section 3.3, primary care and public health fall outside the LHIN mandate, leading to spotty involvement of these sectors that are fundamental building blocks for a sustainable health system.

4.8 Need for more opportunities to provide team-based care

Health system efficiency calls for the right provider at the right time in the right setting; team-based primary care is built on this concept. New health professionals are being trained to work in teams to take the full advantage of this model. Unfortunately we currently have a mismatch between training and work opportunities – with less than one-quarter of primary care delivery being provided through teams, many new graduates will likely end up working in traditional practices. The concept of FHTs as Primary Care Hubs could potentially offer an opportunity to leverage and expand team based services.

4.9 Need to support mobility of health workforce among various settings

Improving quality and efficiency means system change. Change brings the inevitable need to shift resources, including our system's scarce health human resources, among different organizations.

At the moment Ministry policy and funding for health human resources has created some barriers to the movement of staff from one part of the health system to another. Data collected through a collaboration with the associations representing Ontario's four models of interprofessional primary care

[10] Specialized regional networks also exist, such as those for stroke, cancer and child health.

(i.e. the Association of Ontario Health Centres and the Nurse Practitioners Association of Ontario) has found significant inequity in compensation for interprofessional (i.e. non-physician) health providers and administrators compared to other health sectors, in particular, hospitals, public health and CCACs. One of the significant barriers to mobility is the lack of pension plans in primary care. Health care workers in many other parts of the health care system are members of the Healthcare of Ontario Pension Plan (HOOPP), but they would have to leave the plan to move to primary care positions since very few primary care providers are able to afford this. Furthermore, salary ranges are currently 5 – 30% below what a Hay analysis recommended in 2009 for health professionals in primary care.

5 Conclusion

Reiterating our opening statement, AFHTO's advice can be summarized as follows:

- Illness prevention and effective management of chronic conditions – the outcomes of a strong primary care infrastructure – are the keys to health and health system sustainability;
- Clear goals for our health system and sound information to track health outcomes, costs and public satisfaction, are the keys to driving and managing improvement;
- This must be coupled with leadership capacity and other mechanisms to bring organizations together to facilitate the flow of patients, information and the workforce, in order to improve health outcomes, system efficiency and public satisfaction;
- With further evolution and support, Family Health Teams could act as "Primary Care Hubs" to provide primary care leadership and support for population-based planning, service integration and improvement.