afhto association of family health teams of ontario
400 University Avenue, Suite 2100, Toronto ON M5G 1S5

July 15, 2020

Dear Drs. Alam and Price,

We would like to thank you for inviting the Association of Family Health Teams of Ontario (AFHTO) to provide recommendations to the Primary Care Working Group (PCWG) as you continue your mandate in ensuring primary care in Ontario is sustainable, driven by high quality, and evidence informed. Physicians working with family health teams (FHTs) are essential in ensuring patients receive high-quality and timely access to care, so we share the PCWG's vision of a robust and sustainable primary healthcare system. We agree with the OMA in ensuring family physicians receive fair compensation for the care they provide their patients, which relies on strong collaboration with team members in FHTs and other models of team-based care. Collectively, we also support Dr. Barbara Starfield's observation that comprehensive, relationship-based, patient-centered care is the foundation of a sustainable healthcare system. And that relationship is strong in primary care.

AFHTO also strongly endorses the 4Cs of primary care that were coined by Dr. Starfield and believes that most of primary care embody these elements:

- **Continuity** through better relationships,
- **Coordination** of better transitions,
- First point of **Contact** into the healthcare system, and
- **Comprehensiveness** by providing a wide range of programs and services that deal with a broad range of patient issues through their lifespan.

We have consulted some of our physician leaders and would like to provide their feedback for consideration in the development of recommendations to the Physician Services Committee. These recommendations are applicable to physicians affiliated with FHTs but many could apply to any physician that works in a patient enrolment model (PEM) in Ontario.

1. Access and Quality Issues

i. Increase Access to Interprofessional Team-Based Care

Access is a very broad area and encapsulates many elements of care delivery, but foundationally we believe more Ontarians deserve access to comprehensive team-based care. There has been a strict limitation over the last few years of having more physicians join team-based models of care like FHTs, which has meant more Ontarians have not been able to access interprofessional care. This is coupled with the fact that the number of physicians allowed to join comprehensive, organized payment models like FHOs has led to physicians being forced into non-team, transactional models of care like solo practices. Research shows that patients not attached to organized primary care practices in Ontario receive lower quality care, which has widened over time[i].

Over the last few decades, family medicine residents have been trained by exceptional family physician teachers in the team-based models of care, but upon completing residency, they are finding it difficult to practice in the model in which they have been taught. Patients receiving care that is centered on their needs from a team that knows their story is a major tenet of the Patient Medical Home, allowing for continuity of care, higher patient satisfaction, and increased provider satisfaction[ii]. This is a principle AFHTO strongly agrees with.

Although this was known prior to the pandemic, the inequity in how physicians are remunerated was brought to light during COVID-19. Physicians that are paid fee for service saw their compensation decrease substantially as they struggled to maintain patient volumes, while worrying about their overhead and paying their staff. The ability to move physicians to capitated models of payment has been restricted over the years to underserviced areas. This two-tiered payment approach has destabilized the family physician work force and created an even further fragmented, unsustainable primary healthcare system.

Physicians working in community sponsored FHTs have also experienced stalled growth in this model of care delivery. Physicians with this blended salary model (BSM) of payment are often overlooked when there is an opportunity to look at expansion in team-based care. These physicians have worked hard over the years with their communities to develop programs and services that best serve the population, often with the lens of health equity and social determinants of health. As complexity in our province continues to grow, we need more physicians working in these types of models to help address the community needs and to provide high-quality care.

Recommendation #1: Increase access to team-based care for more patients by adopting the Patient Medical Home vision within the Patient Medical Neighbourhood. Advocate for increased access for physicians who wish to join team-based models of care and ensure funding is available to increase the number of interprofessional health care providers (IHPs) to support the expansion of team-based models, like FHTs, to ensure more patients are receiving interprofessional care. Alongside increasing access to team-based care, stabilizing the family physician workforce should be a priority and there needs to be an increase in the number of physicians being able to practice in capitated models like the FHO. And there needs to be an increase in the number of affiliated physician practices, including BSM physicians, who are working alongside IHPs in delivering comprehensive team-based care for their patients.

ii. Billing for Digital Access to Care and Investments in Electronic Medical Records Integration

Family physicians and primary care teams pivoted quickly to provide care for their patients by moving to virtual care to ensure seamless and continued care, while also protecting the acute care system should there have been an influx of people diagnosed with COVID-19. Within 48 hours, the primary care sector went virtual despite no additional funding or change management support. Previous virtual care billing codes were resurrected to allow physicians to bill for virtual visits. Something that has taken years to implement happened very quickly, which highlighted that you can make a quick policy implementation when needed.

While the sector pivoted quickly to virtual care, there are still changes that need to be made as the move is not just a response to the pandemic but a catalyst on how care can be delivered in the future. Not only should the virtual care billing codes become permanent, there should be inclusion of the secure messaging modality along with already existing phone and video. Additionally, the platforms should be integrated within the electronic medical record (EMR) and not standalone to ensure

continuity of care. Virtual care should also only be enabled if there is a relationship with the patient; otherwise, we will have issues of pop-up virtual walk-in clinics that erode continuity and the trusted relationships that patients have with their family physicians.

AFHTO strongly believes in the importance of continuity and the need to ensure that there is a trusting relationship between the family physician and the patient. These relationships are built over time and should not be based on convenience, but rather on trust as it enables the providers to work more effectively and, most importantly, results in improved clinical outcomes[iii]. A move towards 'convenience' medicine erodes the importance of continuity and will lead to further fragmentation in care.

As we become more digital, our patients are asking for alternative ways to communicate with their healthcare teams, often looking for immediate access to their providers. Whether it is email, text messaging, or web inquiries, these methods of communications are being demanded by patients. The lack of economic incentives to encourage physicians to consider this mode of communication is a huge barrier to its uptake.

Ontario Telemedicine Network (OTN) was the platform of choice for the Ministry, mainly because it is an existing provincial asset that falls under the purview of Ontario Health (OH). However, the OTN platform is cumbersome and, given it does not integrate well with the primary care EMR, it is difficult to use. Outside the Greater Toronto Area, many teams also said that the platform was challenging to rely on because of dropped calls during video visits. As a result, many primary care providers moved towards integrated EMR solutions (e.g. Telus' Akira, Accuro's Medeo) that are more seamless for patient care and are much more reliable. But this came at a cost.

The pause of OntarioMD subsidies to enhance and optimize the use of EMRs has meant that integration with these modes of communication and better integration of patient information with the other forms of EMRs in other healthcare sectors has come to a standstill. Patients deserve to know that their information is being shared with their circle of care, and teams deserve to know that the primary care EMR is the source of truth for most patient information. More attention needs to be paid on building a sustainable, integrated, and interoperable electronic health record that includes the primary care EMR.

Recommendation #2: We recommend permanent billing codes be built into the Schedule of Benefits that addresses all digital modes of communication, including secure messaging. Billing for virtual visits should only be done if there is a trusted relationship between the patient and family physician based on the principle of continuity and a relationship that has existed for at least two years. Additionally, to encourage digital tools uptake, policy development work should be done by the Office of the Privacy Commissioner to address any privacy concerns the patient and/or the family physician may have.

Recommendation #3: We recommend that OntarioMD subsidies be brought back so that primary care EMRs can continue to be optimized and utilized to their full extent. This includes online booking and the ability to integrate with digital modes of communication, such as email and video visits.

Recommendation #4: As digital communications become part of the 'new normal' in the delivery of care, we recommend that all patient health information, regardless of where care was delivered, be part of an integrated electronic health care record that is housed in the Patient Medical Home (i.e. primary care). This record should be accessible to both the patient and their primary care provider.

iii. Funding Support for Quality Improvement

Engaging primary care practices in quality improvement (QI) activities is essential to achieving Bodenheimer's quadruple aim of improving the health of the population, enhancing patient experiences and outcomes, reducing the cost of care, and improving the provider experience[iv]. In the last few years, primary care has seen an explosion in the number of quality improvement activities and reports, including HQO's Primary Care Practice Reports, CCO's Cancer Screening Activity Report, AFHTO's D2D Report, and the mandated HQO Quality Improvement Plans for FHTs and other team-based models of care. While it is great to see so much data, it can also be overwhelming about what to do with it all.

Through AFHTO's focus on quality improvement, we have seen firsthand that a 'ground up', member-driven quality improvement initiative changes the conversation because providers want to participate in measuring indicators that are measurable and meaningful to them and their patients. And only through this measurement can we affect change by implementing improvement activities that lead to better outcomes.

However, for even the most determined practice, meeting its improvement goals can be daunting as it requires identifying areas for improvement, understanding and using data, planning, making changes, and tracking performance over time[v]. But above all, this work requires dedicated time – time to review reports, time to verify patient panels, time to develop improvement strategies, time to implement, and time to evaluate.

The Saskatchewan Medical Association (SMA) and the Ministry of Health provide funding from monies that were agreed to as part of the quality and access funding within their current SMA-Ministry agreement[vi]. That province's Physician Compensation Quality Improvement Program (PCQIP) compensates physicians for time they spend on approved QI training and projects that support provincial health system priorities and are based on an application process with rates that were agreed upon by both parties.

Recommendation #5: To encourage more physicians and physician practices to participate in quality improvement, we recommend that there be a QI billing code or additional, new monies set aside to support QI activities. Lessons learned in Saskatchewan and other provinces would help build a robust program for an Ontario Physician Compensation Quality Improvement Program. Additional resources should include practice facilitation and change management support, which needs to include quality improvement decision support specialists (QIDSS) who can support physician groups with their QI work. And for physicians who already work in team-based care and have ready access to QIDSS, they should be required to participate in initiatives like the QIPs.

Recommendation #6: The College of Family Physicians of Canada will be implementing personal learning plans next calendar year, and this is a good opportunity to tie financial incentives to quality. There should be a focus on the move towards integrated care quality measures and encouragement to implement team-based quality initiatives to incent physicians to work in teams.

Recommendation #7: We recommend there be a mechanism to track and capture the work that is being done during clinic visits as you cannot measure what you do not know. One billing code does not accurately capture the breadth of a patient visit as patients often come in with multiple issues requiring multiple interventions. A move towards tracking visits by utilization of ICD 9 or 10 codes or

even through shadow billing will better capture of the complexity of each visit and will allow for targeted QI initiatives to support the patient roster.

iv. Elimination of Negation for Outside Use – Moving to a truly population health approach to care

As Ontario moves towards further integrated care, there are barriers that do not allow for a population health approach to care. For example, at the team-based level, we know that there are multiple FHOs/FHNs that are affiliated with one FHT. In the interest of efficiency and to meet after hours requirements, and understanding that the family health team is a 'one team' model of care delivery, there can be consolidation of these FHOs/FHNs to offer care after hours to all patients affiliated with the FHT. However, this currently leads to outside usage reports and negation if the patient does not go to their rostering FHO/FHN. This applies even if that practice group is a member of the one FHT. This breaks down the concept of the 'one team' model. As we look to 'joining up' primary care by encouraging family physicians to work more closely with their colleagues and partners in Ontario Health Teams (OHTs), the concept of negation discourages a collaborative and organized primary care system in communities.

Recommendation #8: All affiliated physician groups with one FHT should be treated as a collective and not be subjected to negation in the spirt of greater office efficiencies and collaborative care. Family physicians working towards integrated care by participating in the OHT concept of care delivery should not be subjected to negation, especially if they are working collaboratively with their colleagues to provide accessible and ongoing care for their patients and the population in their community.

2. Complexity Modifiers

Patients with complexity often have multiple chronic conditions, which require ongoing management by a family physician and, often, a range of other healthcare providers. A move towards recognizing complexity is welcome and will be a great planning tool to identify what additional supports are needed in a patient population. Through analysis of the first cohort of OHTs, communities have already identified that the populations that require the most integrated care (thus, potentially the most complex) are frail seniors, individuals with multiple chronic diseases, and people dealing with mental health and addiction issues.

As complexity increases, so does the need for things like social connectedness. Social isolation was highlighted during this pandemic as a factor that increased feelings of loneliness, anxiety, and depression. One way to address this is through social prescribing. Social prescribing is an integrated and streamlined way to support patients' health and wellbeing by addressing the social determinants of health, particularly the need for social connectedness[vii]. It is a structured pathway for referring people to a range of non-clinical services, and it seeks to address people's needs in a holistic way. The pathway involves a social prescription from a primary care provider, like a family physician, who refers patients to a navigator that connects them to a suite of social community development supports drawn from the assets of the community[viii].

Recommendation #9: The move towards recognizing complexity is welcome and supported, especially as patient visits become more multifaceted in primary care. To collect the non-medical information, it is recommended that social determinants of health (SDOH) data, including race, be voluntarily collected by turning on the SDOH toolbar that can be found in many EMRs (for example).

Recommendation #10: As complexity increases, so does the need for better integration with other parts of the health and social systems. With the passage of Bill 175, Connecting People to Home and Community Care Act, 2020, there is leverage to modernize home and community care by ensuring these supports are embedded in primary care. It is highly recommended that there be advocacy done to support further alignment between primary care and home care.

Recommendation #11: We know that 80-90% of our health and wellbeing is determined by factors outside the mainstream health system. The pandemic exposed that the most vulnerable are at the highest risk for exposure and most of their needs are based in SDOH. It is recommended that social prescribing be ramped up and spread so that individuals who are highest risk get access to much needed support. Family physicians can take comfort in knowing that the holistic health and well-being of their patient is being taken care of.

3. Walk-In Clinics

AFHTO strongly believes in the importance of continuity and the need to ensure that there is a trusting relationship between the family physician and their patient. However, we also recognize that walk-in clinics fill in a gap and they need to be included and incorporated into an integrated health system solution.

Recommendation #12: Walk-in clinics need to be incorporated as part of an integrated health care system as they fill in a gap. However, to encourage continuity of care, we recommend that any walk-in clinic that sees a rostered patient must produce a note to the family physician to provide feedback on the visit (in absence of an integrated EMR).

Recommendation #13: Virtual walk-in clinics, however, do not adhere to the principles of continuity and are built on convenience, without any feedback loop or a patient-provider relationship. With an in-person walk-in visit, you can pick up visual cues with the patient, which you cannot do with a virtual visit. As a result, we recommend that if virtual care be part of the new normal, care should only be provided virtually if the family physician has had at least two years of in-person contact with the patient.

4. GP Focused Practice Designation

The Family Medicine Professional Profile from the College of Family Physicians of Canada communicates the collective contributions, capabilities, and commitments of family physicians[ix] to their patients. In their profile, they indicate that one of the primary responsibilities is the provision of comprehensive medical care for all people, ages, life stages, and presentations, in domains that are both acute and chronic, and in all stages from preventive to palliative care[x]. To be community adaptive and respond to where there are gaps in care, many physicians have added on certificates of added competencies to meet those gaps, but the intention was to enhance general comprehensive family medicine, not necessarily to move into a sole GP focused practice, away from comprehensiveness.

While we do believe in the importance of a comprehensive family medicine practice, we also know that there are a lot of challenges in accessing speciality care. Family physicians who have done this added training should be incorporated into the integrated health care system and be part of teams of care.

Recommendation #14: Team-based care, like FHTs, have speciality sessional dollars to encourage speciality colleagues to provide case conferencing and capacity building with the primary care team, including the family physicians. Family physicians with a GP focused practice designation (especially in the high-need areas of psychotherapy, addictions, dermatology, oncology, palliative, sports medicine) should be able to access these speciality sessional dollars and be integrated as part of the team. As we move towards even further integrated care with OHTs, family physicians who have the GP focus practice designation will fill in a much needed gap of speciality care in the community and must be funded to be part of the integrated model of care.

5. Other Important Considerations

i. Support for Clinical Leadership

Primary care is foundational to the successful transformation of Ontario health care. The province is moving towards more integrated care with the development of Ontario Health Teams, but "integrated care" isn't integrated unless it's built around primary care.[xi] Primary care providers know patients and their families best. It is critical that primary care be key in the formation of OHTs and be empowered to lead their development. "*If we fail to include clinicians, particularly physicians, in the design, implementation and leadership of integrated care, we increase the likelihood of failure"*[xii]

With the transformation efforts currently underway, more physicians must be involved in leadership roles at the beginning and throughout the process of change.[xiii] Successfully building integrated care in OHTs, led by primary care, will require funding support for current and future family physician leadership. These clinical leaders are the best resource we have for shifting the profession and the health system towards a shared vision and purpose. But the scope of work facing them is significant: it cannot be managed by one or two individuals alone.

Ontario needs to develop a team of leaders at practice, organization, and community levels to drive change on the ground and across all practice models. Developing family physician leadership capacity is critical as many physician leaders approach retirement. Succession planning will be important; more family doctors are needed to broaden the physician pool, so leadership capacity is not compromised. And we need to support frontline providers by freeing up time from their unrelenting workload.

Recommendation #15: In the recognition that physician leadership is integral in implementing the province's priorities, we recommend that there be provision of financial support for physician leadership development and remuneration for physicians in leadership roles, including when being asked to consult on an ad hoc basis. There must be funding available to support clinical leadership.

ii. Organized Primary Care

Accountability is about being responsible and in health care that is being responsible for care being delivered to the patients, while also recognizing that we are working in very constrained financial environments. Indeed, the pandemic is leading the country into considerable debt that will take decades to clear. Therefore, it is important that elements of accountability be built into the recommendations to the Physician Services Committee and those elements be in three areas: *provider, patient, and funder*. With the rhetoric that the FHO model may not be living up to what the model was intended to do, there has never been any recourse of action given the failure of government in addressing the issues. Why was that able to happen?

We have allowed the status quo to be good enough in primary care and have not engaged in more innovative and joined up approaches to care. As we move towards better connected care, there is an opportunity to organize primary care as the foundation of the health system at the local level. But this will require a change in some of the ways the sector is organized and a willingness to do things differently. The move towards integrated care through OHTs will necessitate elements of accountability as community expectations will affect how each partner will be expected to adhere to principles of partnerships between their community partners and the patients in the population.

Recommendation #16: We recommend that the MOH and OMA start considering what accountability elements to implement in a tri-party approach: physician accountability (to self, to their profession, to their colleagues, to their funder, to their patients), patient accountability (to their physician, to the system), and government accountability (to the patient, to the physician, to the system).

Recommendation #17: Family physicians are innovating across the province in how they are structured and how they are organized. We recommend that as OHTs continue to develop, each region be able to organize primary care (through sustainable funding) and take lessons learned from existing family practice networks like in East Toronto (which has formally incorporated as the East Toronto Family Practice Network) or Mississauga Halton (which has a volunteer Mississauga-Halton Primary Care Network). An organized primary care system will be the driver that is needed to create the integrated care that patients, families, and caregivers need, and it will ensure that family physician clinical leadership is recognized as an important element to building that foundation of the health care system.

AFHTO, the Ontario College of Family Physicians, the Nurse Practitioners' Association of Ontario, and the OMA Section of General and Family Practice have worked collaboratively over the last few years to create a cohesive and collective voice for primary care. As part of that work, we are proud to have co-founded the Primary Care Virtual Collaborative (PCVC), an initiative that was facilitated through The Change Foundation. As part of the PCVC, we have engaged with hundreds of primary care providers, including family physicians, to develop the Made in Ontario 10 High Impact Action Items (HIA) that primary care providers need to free up time to participate in more 'joined up care', a term that was coined by Dr. Robert Varnam from the NHS in the UK who supported this work. Appended to this letter you will find a schematic of the 10 HIAs that the community has said is important to them. As part of your recommendations to the Physician Services Committee, we encourage you to reference this document that was codesigned by the primary care community. More information about the PCVC is here: https://changefoundation.ca/project/primary-care-virtual-community/.

We thank the Primary Care Working Group for permitting AFHTO to provide recommendations to the Physician Services Committee. We look forward to continuing to work with the PCWG in this very important work and would be pleased to meet with you to expand on our recommendations. We consider the OMA and the MOH to be some of our most important partners, and we look forward to our ongoing partnerships.

Yours Sincerely,

Dr. Tom Richard
President and Board Chair

Kavita Mehta
Chief Executive Officer

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[viii] ibid

[ix] Family Medicine Professional Profile. *College of Family Physicians of Canada*. Available at: https://portal.cfpc.ca/resourcesdocs/uploadedFiles/About_Us/FM-Professional-Profile.pdf. Accessed July 10, 2020.

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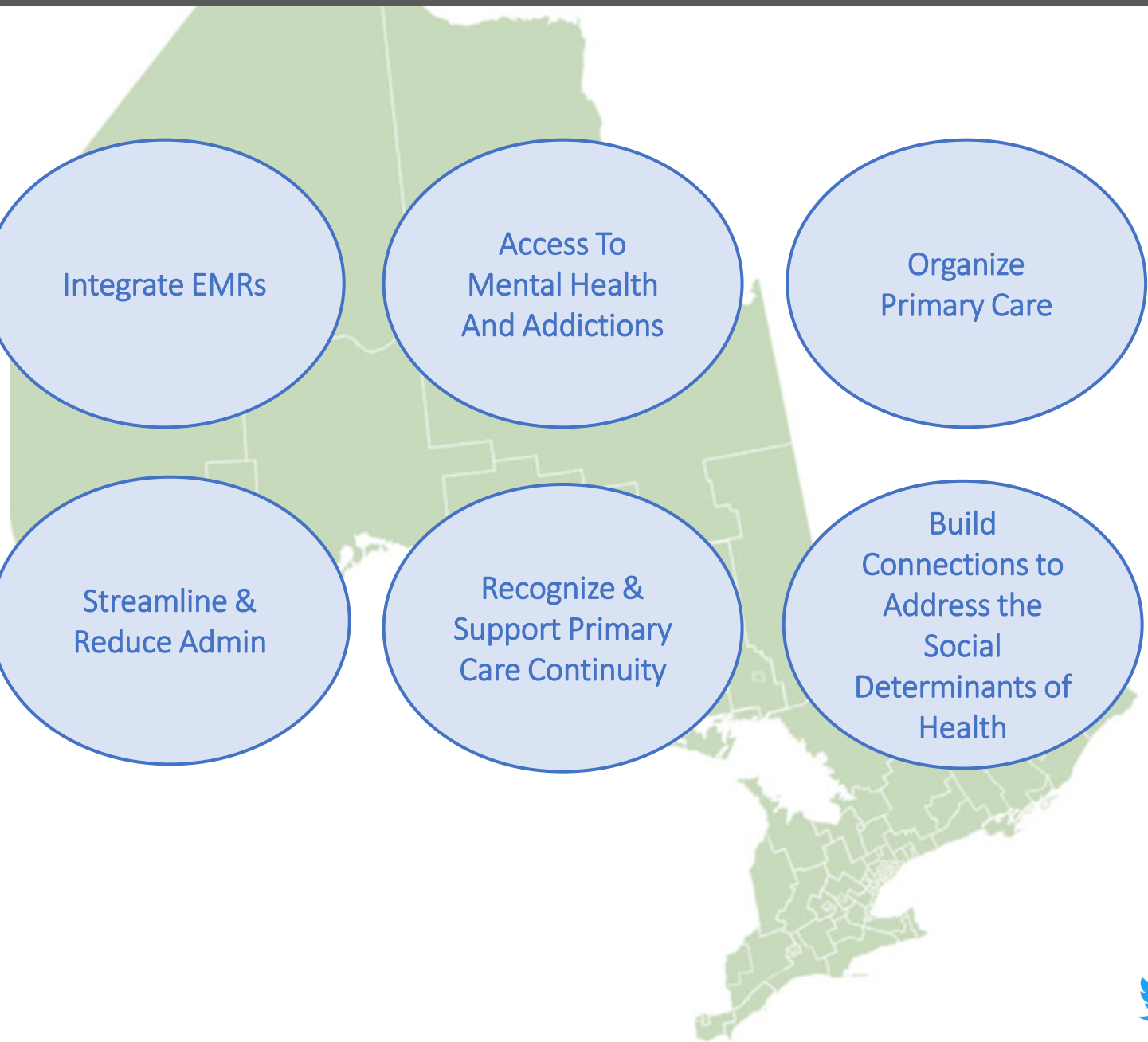
Made-in-Ontario 10 High Impact Actions



- Navigate & Coordinate
- Integrate EMRs
- Access To Mental Health And Addictions
- Organize Primary Care
- Practice Facilitation & Change Management
- Build the Extended Team
- Streamline & Reduce Admin
- Recognize & Support Primary Care Continuity
- Build Connections to Address the Social Determinants of Health
- Patients & Caregivers as Partners

#ONPrimaryCareLeads