Strengthening Primary Care Access

Report of the Working Group to the Primary Healthcare Planning Group

August 2011

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Working Group Membership

The membership of the working group was diverse and reflective of the many stakeholders and jurisdictions involved in primary care access in Ontario. Experts from across the province including healthcare practitioners, Aboriginal health experts, researchers, administrators and policymakers participated in the *Improving Access in Primary Care Working Group*.

Please Note: Membership in the Improving Access in Primary Care Working Group does not indicate full endorsement of every recommendation in this report.

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Glossary of Acronyms

AHAC – Aboriginal Health Access Centre
AHQR – Agency for Health Quality and Research
ALC – Alternate Level of Care
AOHC – Association of Ontario Health Centres
CHC – Community Health Centre
ECFAA – Excellent Care for All Act
ED – Emergency Department
EHR – Electronic Health Record
EMR – Electronic Medical Record
FHG – Family Health Group
FHO – Family Health Organization
FHT – Family Health Team
GIS – Geographic Information System
GP – General Practitioner
HCC – Health Care Connect
HHR – Health Human Resources
HR – Human Resources
HQO – Health Quality Ontario
HSP – Health Service Provider
ICES – Institute for Clinical Evaluative Sciences
IP – Interprofessional
LAO – Legislative Assembly of Ontario
LHIN – Local Health Integration Network
MOHLTC – Ontario Ministry of Health and Long-Term Care
NACRS – National Ambulatory Care Reporting System
NP – Nurse Practitioner
NPLC – Nurse Practitioner-Led Clinic
OCFP – Ontario College of Family Physicians
OECD – Organisation for Economic Cooperation and Development
OHA – Ontario Hospital Association
OHQC – Ontario Health Quality Council
OMA – Ontario Medical Association
OTN – Ontario Telemedicine Network
PCAS – Primary Care Access Survey
PCCCAR – Provincial Coordinating Committee on Community and Academic Health Science
　　　　　　Centre Relations
PHC – Primary Healthcare
PHIPA – Personal Health Information Protection Act
PHPG – Primary Healthcare Planning Group
QIIP – Quality Improvement and Innovation Partnership
RNAO – Registered Nurses' Association of Ontario
WHO – World Health Organization

Executive Summary

Primary care is a central component of health care and an important element of primary health care. It is the entry point for patients and a key determinant of that patient's journey along the continuum of care. Access to primary care is a critical element for the health of patients as well as the ultimate sustainability of Ontario's health system. Primary care providers must see themselves as having a responsibility to best ensure patient access to appropriate services along the continuum of care.

Yet according to the Commonwealth Fund's *International Health Policy Survey in Eleven Countries*, Canada was ranked 10th out of 11 countries in accessing after hours care without going to the emergency department (ED), 9th in getting same day or next day appointment when sick or in need of care, and 10th for patients having to wait six days or more when sick or when care is needed.[1]

Ontario also falls behind the curve compared to international jurisdictions in terms of urgent visits. Data from them Primary Care Access Survey (PCAS), presented by the Institute for Clinical Evaluative Sciences (ICES) shows that fewer than half of Ontario's residents can see their provider when sick or when care is needed. After hours primary care coverage and advanced access options are far from reaching the level of availability which would be beneficial to the public and meet evidence-based standards of access to primary care.[2]

Although most Ontarians have primary care providers located within 60 minute travel times of their homes[3] timely and continuous access remain key issues, with patients turning to walk-in clinics and EDs much more than is optimal. ICES figures show that each year one quarter of people with a family doctor will still opt to go to a walk-in clinic to receive primary care. ED usage rates remain stubbornly high, including treatments which could be provided to the patient via more suitable sources of primary care.[4]

Underutilization of needs-based and population-based analyses as well as insufficient incorporation of equity and socio-economic indicators hinder the identification of barriers and delay the adoption of a more patient-focused approach to primary care.

In Ontario, as in most of Canada, primary care services work mostly in isolation from one another, experiencing structural and funding barriers which detriment cross-service collaboration and limit the effective pooling of resources. Informational barriers between primary care providers reduce information sharing, presenting coordination obstacles and diminishing the breadth of available primary care services.

One dimension of access is the *attachment rate* – the proportion of Ontario's population connected to a primary care provider. In Q2 2010/11 there were 10.1 million Ontarians (age 16+) who had a family doctor, which represents an increase of 150,000 (1.5%) compared to Q2 2009/10.[5] A high attachment rate is a positive first step; however as other findings indicate, attachment does not mean patients have access to timely or continuous care. Also, exempt from the above attachment rate are patients attached to primary care professionals other than physicians and nurse practitioners (NPs).

Ontario's current primary care system remains a predominantly physician-focused system. Interprofessional (IP) collaboration has been found to provide positive outcomes for patients, providers and the health care system.[6] Positive steps have been taken with the Government of Ontario's expansion of Community Health Centres (CHCs), Family Health Teams (FHTs), and Nurse-Practitioner Led Clinics

[1] The Commonwealth Fund. *International Health Policy Survey.* 2010.
[2] Glazier, R. "Primary Care Access." *ICES*. Presentation delivered to Access Working Group on April 19, 2011.
[3] Glazier, R. et al. *Geographic Access to Primary Care*. ICES. January 2011.
[4] Glazier, R. "Primary Care Access."
[5] Health Analytics Branch. MOHLTC. *Health Care System Quarterly*. Spring 2011.
[6] Barrett, J. et al. *CHSRF Synthesis: Interprofessional Collaboration and Quality Primary Healthcare*. Canadian Health Services Research Foundation. December 2007.

(NPLCs). The access working group strongly endorses the transition taking place in Ontario towards a greater prevalence of IP teams.

Primary care access is further inhibited by a lack of pertinent information, where data seems to be insufficiently collected or unavailable to providers and the public. The absence of interoperable Electronic Health Records (EHRs) limits the sharing of medical information among stakeholders, impeding patient access to information and hindering freer transitioning through the various modalities of care. Moreover, lack of an openly-accessible central repository of pertinent primary care data is detrimental to conducting robust analyses and hinders the incorporation of evidence-based decision-making into policy development and planning.

Working Group's Vision for Strengthening Primary Care Access:

*Primary care access where patients have **equitable, timely,** and **continuous** access to primary care that is **comprehensive**, **evidence-informed** and **culturally safe** while being acceptable to patients across all regions of the province and according to the local needs of diverse populations.*[*]

High Level Summary of Recommendations for MOHLTC:

More Equitable Access
1. MOHLTC in partnership with LHINs and primary care organizations adopt a population needs-based, equity-oriented planning approach to primary care for all Ontarians with unique strategies for five sub-populations: Aboriginal; Francophone; Northern and Remote; Southern Rural; and Urban populations with a focus on racialized communities, new immigrants, lesbian, gay, bisexual, transgendered and queer (LGBTQ), as well as the disabled
2. Complex vulnerable populations to receive acceptable care that results in equitable health outcomes and reduced usage of ED and Alternate Level of Care (ALC)
3. A patient-focused approach be embraced in all primary care policy and planning
4. Mechanisms be established to enable the tracking of all patient's addresses for planning purposes
5. A central repository for primary care data be created with mandatory requirements for primary care services to provide data as appropriate and in line with relevant privacy legislation, and ability to update patient information
6. Develop a strategy to identify and focus on patients with complex co-morbidities and to determine appropriate resource level for optimal return on investment

More Timely Access
1. All primary care models be required and supported to:
    a. Immediately provide 3 hours of after hours care per physician and NP per week
    b. Work in collaboration with other providers in the community to provide 24/7 coverage to meet primary care needs by March 2015
2. "Access bonus" be reviewed to better enable collaboration across primary care models and to reduce barriers to patient usage of other primary care models
3. All patients have access to their primary care provider within 48 hours through advanced access

More Continuous Access
1. Mechanisms be established to foster increased after hours care options across primary care services and models
2. Leveraging of system navigators and case managers[*] to help better coordinate patient care
3. Walk-in clinics[α] be phased out and replaced by planned after hours care provided by all models of primary care to ensure continuous care to patients

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[*] For definitions please refer to section 1.2 "Definitions" on page 9.
[*] For definitions please refer to http://www.ontla.on.ca/library/repository/mon/24002/299238.pdf.

More Comprehensive Primary Care
1. All Ontarians who want to be attached to IP primary care models are able to do so. A long-term strategy be developed to enable this transition, taking into account current assets of the primary care system
2. All IP teams are fully functional, with appropriate mix of professionals working to full scope of practice
3. All IP teams provide a full basket of services including at a minimum the PCCCAR basket of services$^{\delta}$
4. Northern and remote primary care models be assisted to recruit and retain optimal level of IP teams
5. *OntarioMD* specification for future Electronic Medical Record (EMR) certification standards improved continuously to enable all IP team members access to patient records as per security profiles
6. Innovative methods of primary care be leveraged such as mobile clinics, telemedicine, virtual ward
7. Information database(s) be developed for community and social services to facilitate patient referral

More Evidence-informed Primary Care
1. All aspects of primary care access to be guided by sound research and evidence, where available
2. Evidenced-informed primary care to incorporate input from patients, families and communities
3. Implement practice-level patient access and satisfaction surveys as soon as possible

More Culturally Safe Primary Care
1. All Ontarians to have access to culturally safe care that is culturally competent and addresses the inequities to health care, with a focus on Aboriginal Ontarians, Francophones, new immigrants and racialized communities, LGBTQ and those with disabilities
2. All health care educational institutions be supported to provide education on cultural safety
3. Primary care models resourced to have IP teams including cultural workers, translators, community workers and primary care providers from the cultural communities being served
4. A human resources (HR) plan be developed which includes primary care training for members from these communities
5. Indicators be developed to depict provision of culturally safe care (e.g. Pap rates for racialized women, colorectal and breast cancer screening for Aboriginal populations, etc.)

Recommendations pertaining to foci of other Working Groups
1. Primary care secretariat be established with the responsibility to oversee the strategic planning and transitioning to a more robust primary care system in Ontario, including but not limited to developing a comprehensive HR strategy for culturally safe, comprehensive IP teams, and strengthening patient and community-focused care and engagement
2. Primary care to be the next priority for implementation under the *Excellent Care for All Act (*ECFAA)
3. All primary care models to have accountability agreements with their funding bodies which incorporate performance indicators
4. LHINs to be formally linked to the planning of primary care to enable accountability and linkages
5. Primary care models in communities assisted to collaborate within and outside of the health sector to provide comprehensive services
6. Timely implementation of advanced access in all primary care settings be made available as soon as possible
7. All primary care models be required and supported to implement certified EMRs as soon as possible

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[α] The working group's definition of "walk-in clinic" pertains to stand-alone clinics which are not connected to any primary care model.

[δ] The Provincial Co-ordinating Committee on Community and Academic Health Science Centre Relations (PCCCAR) Basket of Services includes: (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 24/7 response; (10) Service coordination and referral; (11) Maintenance of comprehensive patient health record; (12) Advocacy; (13) Primary mental health care including psycho-social counselling; (14) Coordination and access to rehabilitation; (15) Support for the terminally ill.

Chapter 1: Introduction to Primary Healthcare Access

1.1 Definition of Primary Healthcare

Primary healthcare (PHC) is often defined as the first point of contact for patients into the health care system. At the McMaster Health Forum "Strengthening Primary Healthcare in Canada" (2009) it was determined that *primary healthcare*:

> *…includes first-contact services delivered by a range of providers. Most commonly in Canada these providers are general practitioners and family physicians. However, increasingly these providers can also include nurse practitioners, pharmacists, and telephone advice lines, among others. Primary healthcare also serves a coordination function to ensure continuity of care as patients seek more specialized services within the health system.*
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> *Health Canada defines the list of primary healthcare services as potentially including: 1) prevention and treatment of common diseases and injuries; 2) basic emergency services; 3) referrals to/coordination with other levels of care (such as hospitals and specialist care); 4) primary mental healthcare; 5) palliative and end-of-life care; 6) health promotion; 7) healthy child development; 8) primary maternity care; and 9) rehabilitation services.*
>
> *However, whether any given service is defined as a primary healthcare service per se, or as a service "coordinated" by primary healthcare providers, can vary by jurisdiction and even by organization within a jurisdiction.[7]*

A highly related but unique term, the Johns Hopkins Primary Care Policy Centre states that *primary care:*

> *…is that level of a health services system that provides entry into the system for all new needs and problems, provides person-focused (not disease-oriented) care over time, provides care for all but very uncommon or unusual conditions, and coordinates or integrates care, regardless of where the care is delivered and who provides it.[8]*

PHC is most appropriately traced to the jointly-sponsored World Health Organization and United Nations Children's Fund International Conference on Primary Health Care that took place in Alma-Ata, USSR, in September 1978.[9] The *World Health Report 2008* credits Alma-Ata as shifting the paradigm in thinking about health, stating: "the Alma-Ata Conference mobilized a 'Primary Health Care movement' of professionals and institutions, governments and civil society organizations, researchers and grassroots organizations that undertook to tackle the 'politically, socially and economically unacceptable' health inequalities in all countries."[10]

Key hallmarks of PHC are universal access; multi-disciplinary teams; maximum participation of the community in planning, organizing, operation, and control; and the clear responsibility of governments to implement PHC by building and exercising political will to mobilize resources.[11] Of course, access to

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[7] Lavis JN and Boyko JA. *Evidence Brief: Strengthening Primary Healthcare in Canada*. Hamilton, Canada: McMaster Health Forum. May 2009.

[8] Johns Hopkins Primary Care Policy Centre. *Definitions*. Baltimore: John Hopkins Bloomberg School of Public Health.

[9] World Health Organization. *Primary Health Care: Report of the International Conference on Primary Health Care, Alma-Ata, USSR,* 6-12 September 1978.

[10] World Health Organization. *The World Health Report 2008: Primary Health Care--Now More Than Ever.* 2008.

[11] World Health Organization. *Primary Health Care: Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978*. Geneva: Author, 2-6. 1978.

primary care is necessary but not sufficient to address the multiple, intersecting factors that determine why some people are healthy and others are not.[12] The World Health Organization's *Commission on the Social Determinants of Health* is unequivocal that access to health and health care are functions of how we organize our societies:

> *The health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods and services, globally and internationally, the consequent unfairness in the immediate, visible circumstances of people's lives—their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities—and their chances of leading a flourishing life. This unequal distribution of health-damaging experiences is not in any sense a "natural" phenomenon but is the result of a toxic combination of poor social policies and programs, unfair economic arrangements, and bad politics.*[13]

With the aim of focusing on primary care while remaining attentive to the important broader concept of primary healthcare, the working group found it most appropriate to approach the initiative by embracing the concept of *primary care informed by a primary healthcare framework*.

1.2 Definitions

The working group determined that patients should have *equitable*, *timely*, and *continuous* access to primary care which is *comprehensive*, *evidence-informed* and *culturally safe* while being acceptable to patients across all regions of the province and according to the local needs of diverse populations. Below are definitions which elucidate how the working group understands these six key concepts:

Equitable: Addresses unfair differences in health status, access to healthcare and health-enhancing environments, and treatment within the health and social service system.[14]

Timely: Patient ability to access their primary care provider within 48 hours.

Continuous: Care is connected and coherent, and the management of a patient's care over time is coordinated amongst providers.[15]

Comprehensive: The provision, either directly or indirectly, of a full range of services to meet patient's health care needs. This includes health promotion, prevention, diagnosis and treatment of common conditions, referral to other clinicians, management of chronic conditions, rehabilitation, palliative care and, in some models, social services.[16]

Evidence-informed: An approach to policy decisions that is intended to ensure that decision making is well-informed by the best available research evidence.[17]

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[12] Raphael, D. (2009). <u>Social Determinants of Health: Canadian Perspectives</u>. Toronto: Canadian Scholars' Press, Inc.

[13] Commission on Social Determinants of Health. (2008). *Closing the gap in a Generation*: *Final Report on the Commission on Social Determinants of Health*. Geneva: World Health Organization, 1.

[14] Pan American Health Organization. *Renewing Primary Health Care in the Americas*: *A Position Paper of the Pan American Health Organization/World Health Organization*. World Health Organization (WHO). Washington, D.C: PAHO, 2007.

[15] Pineault R. et al. *Accessibility and Continuity of Care: A study of Primary Health Care in Quebec*. Research report presented to the Canadian Institutes of Health Research and the Canadian Health Services Research Foundation; March 2009.

[16] Haggerty, J. et al. "Operational Definitions of Attributes of Primary Health Care: Consensus among Canadian Experts." *Annals of Family Medicine*. July/August 2007.

[17] Oxman, A. D. et al. "Support Tools for evidence-informed health policymaking (STP) I: What is evidence-informed policymaking?" *Health Research Policy and Systems.* December 2009.

Culturally Safe: Pertains to being respected and having cultural location, values and preferences taken into account, as well as explicitly linking service delivery to cultural respect and awareness. The concept includes cultural sensitivity, cultural competence and involves the recognition of unequal power relations.[18]

Chapter 2: Current State Analysis

2.1 Key Literature

The working group agreed that at present there is a considerable amount of evidence-based literature on the topic of primary care access. It was noted, however, that there seems to be a lack of literature specifically pertaining to policy recommendations for strengthening primary care access.

Co-chairs and participants were encouraged to propose documents which would be pertinent to the initiative. The access working group identified numerous reports worth leveraging, from sources which include: ICES, Ontario Health Quality Council (OHQC), MOHLTC, ECHO, Ontario College of Family Physicians (OCFP), Association of Ontario Health Centres (AOHC), Women's Health in Women's Hands (WHIWH), Legislative Assembly of Ontario (LAO), and others which are included in *Appendix B – References.* The main findings of key documents have been included below.

Institute for Clinical Evaluative Sciences (ICES)

A recent ICES report[19] on primary care access (January 2011) focused on geographical access to care via car in Ontario's rural and northern areas. The study identified primary care providers, EDs, hospitals providing obstetrical delivery care, and hospitals with highly-specialized services.

The study used travel times of 30, 60 and 240 minutes at posted speed limits to reach care facilities by residents of Ontario communities with 30,000 or fewer residents. The study concluded that primary care and urgent care sites are *highly accessible geographically* to members of Ontario communities of this size. Other key findings include:

- 99.6% had geographic access to a primary care provider (family physician or nurse in an independent remote nursing station) within 30 minutes, increasing to 99.9% within 60 minutes
- All Ontario communities with a population of at least 1,000 people had geographic access within 60 minutes to a location where primary care is provided
- EDs were geographically accessible within 30 minutes for 97.8% of the population in communities of 30,000 or fewer people and within 60 minutes for 99.0% of that population
- All Ontario communities with a population of at least 5,000 people had geographic access to an ED within 30 minutes

ECHO: Improving Women's Health in Ontario

The ECHO *Power Study*[20] (March 2010) includes a specific section which examines the issue of access to primary care. The study notes that while the Ontario health care system is premised on the concept of

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[18] Registered Nurses' Association of Ontario. *Embracing Cultural Diversity in Health Care: Developing Cultural Competence.* Toronto, Canada: Registered Nurses' Association of Ontario.

[19] Glazier Richard H, Peter Gozdyra and Naira Yeritsyan. Geographic Access to Primary Care and Hospital Services for Rural and Northern Communities. Institute for Clinical Evaluative Sciences (ICES). January 2011.

equal healthcare access for all, there are numerous constraining, enabling, and need-related factors which can detriment access to care. ECHO asserts that these factors can include socioeconomic position, gender, citizenship or immigration, geographic location and health status.

The *Power Study* notes that timeliness is an important dimension of access to care, affirming that *Ontario's Wait Time Strategy* has had success in reducing wait times in some areas. However, ECHO cautions that access involves much more than simply wait times. The study acknowledges that gender influences level of access to care with women particularly at risk of coming across certain barriers to care.

Ontario Health Quality Council (OHQC)

The Ontario Health Quality Council's *2010 Quality Monitor Report on Ontario's Health System*[21] centered its examination of primary healthcare accessibility upon wait times in EDs. The OHQC noted that approximately 20% of the Ontario population visited an ED at least once in 2009, which accounted for 5.4 million ED visits. Other key findings include:

- About one-quarter of people spend more time in the ED than is desirable. This has not improved significantly in the last year
- In 2007, Ontario and Canada had the worst ED wait times compared to several other countries
- Six out of every 100 Ontarians who visit the ED leave without being seen by a physician, likely because they were tired of waiting. This problem has worsened over the past five years
- People are waiting too long to see a doctor in the ED, and this problem has gotten worse in the past five years
- Half of Ontarians waited more than three hours for a bed after being admitted to hospital from ED

Ministry of Health and Long-Term Care (MOHLTC)

In the *Rural and Northern Health Care Framework/Plan*[22] (January 2010) it is noted that quality health care in rural, remote and northern communities is a long standing issue in Ontario. The challenges of providing appropriate access to health care in these communities stem from multiple factors, including: geographic remoteness, low population densities, less availability of other providers, inclement weather conditions and other variables.

Association of Ontario's Community Health Centres (AOHC)

The AOHC, which represents Ontario's Community Health Centres (CHCs) and Aboriginal Health Access Centres (AHACs) commissioned a study[23] to identify the areas where the need for access to CHC programs is high and to plan expanded access to CHCs and AHACs. The study looked at the 141 subLHINs and used Statistics Canada data from the 2006 census to map the province according to the highest rates of: poverty, rurality, racialized communities, disability, new immigrants, Francophones and Aboriginals. The findings revealed that:

- There are 413,450 Aboriginal peoples in Ontario but only 52,638 have access to an Aboriginal-focused CHC or AHAC
- In the Mississauga Halton LHIN and the Central West LHIN the total number of Francophones is in excess of 32,000 but there are no CHC or satellites serving these populations

[20] Bierman A.S. et al. *Ontario Women's Health Equity Report: Access to Health Care Services Chapter 7*. ECHO: Improving Women's Health in Ontario. March 2010.
[21] Ontario Health Quality Council (OHQC). *Quality Monitor 2010: Report on Ontario's Health System*. 2010.
[22] Fjeldsted, H. *Rural and Northern Health Care Framework/Plan: Final Report*. Ministry of Health and Long-Term Care (MOHLTC). January 2010.
[23] Association of Ontario Health Centres. *Addressing Ontario's Great Health Divide*. 2010.

- In the rapidly growing 905 urban belt surrounding Toronto, there are 503,800 people living in poverty, but only 36,582 have access to a CHC or satellite
- In Toronto Central there are 217,690 people living in poverty, but only 93,480 have access to a CHC

Women's Health in Women's Hands

In 2004 – 2005, Women's Health in Women's Hands Community Health Centre which provides primary health care for Black Women and Women of Color was funded by the Ontario MOHLTC's Primary Health Care Transition Fund to examine access to primary health care for Black Women and Women of Colour in Ontario.[24] The report's findings include:

- 29.3% of the women did not have a doctor
- 24.1% women did not have enough travel money to access health care services
- 18.4% women cited lengthy wait times as a major barrier for them
- 20.4% reported long distances to health care
- 23.6% cited work demands as a barrier
- 29.3% identified other obligations that prevented accessing services when they were available

2.2 Original Analysis

The working group determined that an effective way to examine primary care access would be to map out the province of Ontario. With the central objective of identifying *gaps* to access, it was agreed that relevant data would be gathered to depict (1) *need* for primary care access by individuals, families, populations, etc; and (2) *supply* of primary healthcare access, as provided to the public via the range of models of care available at present.

This approach is in step with a population needs-based planning approach as outlined in the Health System Intelligence Project's Health Planners Tool Kit. Health planning is a process of creating "an actionable link between needs and resources."[25] While utilization data may describe "met" need, it is not a good indicator of "unmet" need. This is because utilization of health care is affected by: provider practice patterns and referral mechanisms; patient variations in help-seeking; and availability of providers and services that vary "according to physical, psychological and ethno-cultural barriers to access."[26]

Health systems face the challenge of allocating limited health resources to close the gap between need and supply. Underlying most approaches to allocation of resources in public health systems is the idea that health care should be allocated equitably based on the needs of the population. Furthermore, planning and resource allocation that is based on the existing distribution of providers and utilization data risks perpetuating inequalities and inefficiencies in the health care system.[27] [28] [29]

Needs-based planning and resources allocation has been used in Ontario to varying degrees for several decades although it is used more frequently in other jurisdictions (United Kingdom, Australia, New

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[24] Women's Health in Women's Hands Community Health Centre. *Every Woman Matters: A Report on Accessing Primary Health Care for Black Women and Women of Colour in Ontario.* April 2011.

[25] Health System Intelligence Project. MOHLTC. *The Health Planners Toolkit. Module 1, The Planning Process.* 2006. p.1.

[26] Health System Intelligence Project. MOHLTC. *The Health Planners Tool Kit Module 2. Assessing Need*, 2005. p.22.

[27] Newbold KB in HSIP. *Module 2*. 2006.

[28] Eyles J & Birch S. *A population-needs-based approach to health care resource allocation and planning in Ontario: A Link between Policy Goals and Practice?* Canadian Journal of Public Health. 84(20:112-117). 2010.

[29] Mustard C & Derksen. *A Needs-based Funding Methodology for Regional Health Authorities.* Manitoba Centre for Health Policy and Evaluation. 1997.

Zealand, Finland, Quebec, Manitoba, Saskatchewan, Alberta).[30] In many existing models, an index of needs is applied to a portion of the population or budget to provide a partial weighting for needs. A share remains unweighted in recognition of base costs of providing services and the need for common, universal services for all (regardless of level of need).[31] Experience in other jurisdictions in most cases uses a combination of demographic, socio-economic status (SES) and health indicators as measures of need in a population.

Need-Side Data

The working group determined that to help complete the *need* data, it would be useful to leverage concurrent research being conducted under the auspices of the AOHC. The AOHC research encompasses Statistics Canada Census Data, the Community Social Data Strategy, Francophone- and Aboriginal-specific data, as well as data on complex patients, including geographic location. AOHC's research is population-based and examines health indicators at the sub-LHIN level using composite indices. This research overlays a supply footprint and utilizes demographic data, such as age and gender, while using Geographic Information System (GIS) software to map the footprint and determine where gaps exist.

Supply-Side Data

The Health Analytics Branch (HAB) at MOHLTC completed the supply-side analyses and mapping for the working group. HAB utilized data from the Health Data Branch (HDB) to populate a map of Ontario so as to locate all models of primary care in the province. This final product, when juxtaposed against AOHC's needs analysis, was used to produce a preliminary image of potential gaps to primary care access and to elicit constructive working group discussion.

Limitations and Cautions

A population needs-based planning process that meets recommended practice is beyond the scope and timeframe of the working group. Given the complexities in the concept of health, there is no overriding "objective" definition of health need, so needs-based planning is an ethical and policy activity over and above the technical tools it uses. This would include stakeholder discussion towards consensus on criteria for decision-making, equity and other objectives, distribution of benefits and other issues.

Some data sources such as Health Care Connect (HCC) would be helpful in determining need data for those actively seeking care; however its use is limited as it is estimated that over 100,000 paediatric patients are inadequately captured by HCC. Additionally, information gathered by telephone (such as the Primary Care Access Survey – PCAS) excludes those without a telephone such as people who are homeless, and cannot be analysed at the subLHIN level.

The working group agreed that individual-level information can prove very difficult to acquire. It was also determined that although postal code information linked to census data can be a useful metric, it can be a rather crude implement.

The concept of the "prevention paradox" was raised in the discussion of data analysis and mapping. Although it was agreed that vulnerable populations must be afforded unique consideration in primary care policy and planning, the assertion of Rose (1981) should be recalled that "a measure that brings large

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[30] Birch S & Eyles. *Needs-based planning of health care: A critical appraisal of the literature*. CHEPA Working Paper Series 91-5. May 1991.

[31] Basrur S. et al. *Towards Equitable Funding for Public Health*. Final Report.1996.

benefits to the community offers little to each participating individual."[32] Therefore, it was recommended that the need-based population planning approach be applied to all Ontarians with separate strategies to focus specifically on more vulnerable populations.

Analysis and Discussion

The group agreed that there is utility in combining population needs-based planning and supply (including assets or strengths in Ontario's health care system) in access to primary care planning. Naturally, a key consideration lies in determining which data would be incorporated into the mapping. Overcrowding and overlapping of information was found to be a recurring challenge in mapping many points on a single two dimensional map. It was suggested that in future work this challenge could be addressed via the utilization of interactive virtual maps. This approach would allow for multiple data sets to be incorporated into a single map, allowing the user to select specific data overlays to examine and compare in tandem.

Chapter 3: Business Case for Change

Canada and Ontario do not rank well in international comparisons of access to primary care. In 2010 the Commonwealth Fund's *International Health Policy Survey in Eleven Countries*[33] found that:
- Only 42% of Canadians could see a doctor or nurse the same day or next day when they were sick or needed care (rank 10/11 countries) and 29% waited six days or more for care (rank 10/11)
- 63% of Canadians had difficulty getting after hours care without going to the ED (rank 9/11 countries) and 44% had used the ED in the past two years (rank 11/11 countries)
- Compared with six other Canadian provinces/regions Ontario ranks 2nd or 3rd on these measures

The Primary Care Access Survey (PCAS)[34] is conducted quarterly in Ontario and recently reported that:
- While the number of Ontarians with a family doctor has increased since the PCAS started in 2006, the proportion has stayed relatively constant at 93-94%
- Fewer than half of Ontarians could see their doctor or nurse the same day or next day when sick, a proportion that has not significantly improved over time
- Close to a quarter of Ontarians with a family doctor had been to a walk-in clinic in the previous year, a proportion that also has not significantly changed over time

Additional primary care data[35] depicts that:
- There were close to 450,000 orphan patients enrolled in 2010, a number that is more than 50% of those felt to be unattached at any one time (PCAS)
- The number of ED visits rose over time but the rate remained relatively constant (National Ambulatory Care Reporting System – NACRS)

Timely access to primary health care is a key feature of a high-functioning health care system. Lack of timely access can lead to over-use of alternate sources of care such as EDs and walk-in clinics, both of which create discontinuities in care and provide challenges for the flow of information back to the primary health care provider. Lack of timely access can also cause quality of care to suffer, for example as patients delay or avoid chronic disease prevention and management. Waiting times for minor problems

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[32] Rose, G. "Strategy of Prevention: Lessons from Cardiovascular Disease." *British Medical Journal (Clinical Research Edition)*. 282:6279, June 1981, pp 1847-1851.

[33] Commonwealth Fund. *International Health Policy Survey*. 2010.

[34] Ontario Ministry of Health and Long-Term Care. *Primary Care Access Survey*. 2011.

[35] Glazier, R. "Primary Care Access." *ICES*. Presentation delivered to Access Working Group on April 19, 2011.

are often as long as four hours in Ontario's EDs, creating major inconveniences for patients and their families.

With respect to urgent visits and the provision of same-day/next-day services Ontario falls behind the curve when compared to international jurisdictions. ICES data[36] shows that after hours primary care coverage and advanced access options are far from reaching the level of availability which would be beneficial to the public and meet evidenced- based standards of access to primary care.

Although most Ontarians have primary care providers within 60 minutes of their homes[37] patients still excessively turn to walk-in clinics and EDs for care. Recent figures from ICES[38] demonstrate that each year one quarter of people with a family doctor will still opt to go to a walk-in clinic to receive primary care. ED usage rates also remain stubbornly high, which includes visits for non-emergencies which could alternatively be provided to the patient via a more optimal model of primary care.

In Ontario the focus of access has been on the *attachment rate* – the proportion of Ontario's population who report having a family doctor. In Q2 2010/11 there were 10.1 million Ontarians (age 16+) who had a family doctor, which represents an increase of 150,000 (1.5%) compared to Q2 2009/10.[39] However, the attachment rate as a proportion of Ontario's population has not significantly improved in recent years.

Additionally, it was noted that exempt from the above data are attachment figures pertaining to primary care providers other than physicians and NPs, which *are* captured in the attachment rate. The relatively high attachment rate indicated above is a positive first step; however as the findings indicates, attachment does not mean that patients have access to timely or continuous care.

Taken together, these findings demonstrate that Canada ranks near the bottom in international comparisons of access to primary health care and that other major regions in Canada perform better than Ontario on these measures. Trends over time in access to primary health care in Ontario are relatively static and do not show substantial improvement. These findings are surprising in light of the efforts that have been made to establish patient enrolment models, change physician reimbursement, provide incentives for patient retention, develop IP teams, and require provision of after hours care. All of these steps were taken with the intention of improving access to primary health care. Re-examination of policies designed to improve access to primary health care seems to be needed.

It appears that primary care planning in Ontario has been based predominantly on supply (physician availability and choice) rather than on a population needs-based approach. The exception has been the recent expansion of the CHCs and Wave 4 and 5 of the FHTs where the working group understands that some needs-based approach was utilized. However, this process was not transparent to the communities and most primary care providers.

Furthermore, many studies show that new immigrants and racialized communities are not receiving the preventive health care services they need. The two to three times greater risk of diabetes among several new immigrant groups (South Asian, Caribbean, Sub-Saharan African) compared to other immigrant populations puts a spotlight on the need to ensure newcomer access to appropriate primary health care services.[40]

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[36] Glazier, R. "Primary Care Access." *ICES*. Presentation delivered to Access Working Group on April 19, 2011.

[37] Glazier, R. et al. *Geographic Access to Primary Care and Hospital Services for Rural and Northern Communities*. Institute for Clinical Evaluative Sciences (ICES). January 2011.

[38] Glazier, R. "Primary Care Access." *ICES*.

[39] Health Analytics Branch. MOHLTC. *Health Care System Quarterly*, Spring 2011.

[40] Creatore et al. "Age- and sex-related prevalence of diabetes mellitus among immigrants to Ontario, Canada." *Canadian Medical Association Journal*. 182.8. May 2010.

Underutilization of needs-based equity oriented population-based analyses for resource allocations have fostered inequitable health outcomes. As a result, equitable and culturally safe primary care remains inaccessible to many Ontarians. There are key precedents for needs-based/needs adjusted resource allocation that aim to achieve service equity, reduce access barriers and minimize avoidable inequalities in health. The working group feels strongly that resource allocation strategies that do not take difference in need, access barriers, and health status into account, can have the effect of widening inequities and in some case have been shown to increase risk.

Planning and resource allocation that are based on the existing distribution of providers or utilization data (without taking access barriers and the distribution of unmet need into account) perpetuate inequities and inefficiencies in the health care system.[41] [42] [43]

The underlying principle of the allocation of resources is that health care resources should be allocated equitably based on the needs of the populations. The needs-based approach is equity-oriented and is consistent with the patient-centered focus in *Ontario's Excellent Care for All Act* (ECFAA). All health systems face the challenge of allocating health resources to close the gap between need and supply. Population needs-based planning and resource allocation is an approach that has been used in several provinces for allocating resources for community and social services, education, and health care (Quebec, Ontario, Manitoba, Saskatchewan, British Columbia and Alberta).[44] [45]

Primary care access is further inhibited by lack of pertinent information and data tends to be insufficiently collected or unavailable to the public. The absence of interoperable Electronic Health Records (EHRs) limits the sharing of medical information amongst stakeholders, which impedes patient access as their information cannot more freely flow through the various modalities of care. The lack of an openly-accessible central repository of pertinent primary care data hinders robust analysis and works to the detriment of incorporating evidence-informed decision-making into policy development and planning.

The following are the selected attributes of primary care access and the shortcomings in these areas as determined by the findings and the working group:

Equitable
- Lack of needs-based and population-based analysis as well as equity and socio-economic indicators in planning and funding procedures
- Lack of sufficient data from patients and providers to enable planning for primary care access
- Insufficient and/or out-of-date patient address data, hindering analysis and sound policy and planning
- Primary care data analysis based solely on physician OHIP billings data incompletely captures scope of primary care provided under various models (CHCs, non-physician provider, etc.)
- Insufficient incorporation of a patient- and community- focused approach in policy and planning
- Insufficient focus on the challenges of mental health, addictions and complex co-morbidities
- Need to strengthen communication strategy so as to further reduce informational barriers to access, specifically as pertains to lack of info for patients to access different models

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[41] Eyles, J. and Byrch, S. "A population-needs-based approach to health care resource allocation and planning in Ontario: A Link between Policy Goals and Practice?" *Canadian Journal of Public Health*. 84(20:112-117).

[42] Mustard C & Derkesen. *A Needs-based Funding Methodology for Regional Health Authorities.* Manitoba Centre for Health Policy and Evaluation.1997.

[43] Basrur et al,*Towards Equitable Funding for Public Health*. Final Report. 1996.

[44] Birch, S. and Eyles, J, *Needs-based planning of health care: A critical appraisal of the literature*. CHEPA Working Paper Series 91-5. May 1991.

[45] McIntosh, T. et al. "Population health and health system reform: Needs-based funding for health services in five provinces." *Canadian Political Science Review*. 2010. 4(1):42-61.

Timely
- Serious shortage of after hours primary care coverage for patients across the province
- Extreme difficulty for patients to receive care, from their own provider or IP team, within 48 hours
- High usage rates of EDs for basic primary care services

Continuous
- Persistence of barriers to local cross-model collaboration amongst primary care providers
- "Access bonus" creates perverse incentives for providers to avoid referring their patients to other providers
- Absence of inter-operable EMRs within the health care system
- Lack of a robust system for patient navigation across the continuum of care

Comprehensive
- Restricted scope of practice for non-physician primary care providers
- A sub-optimal proportion of patients with access to IP models of primary care
- Lack of inter-sectoral partnerships and collaboration across continuum of health and social services

Evidence-informed
- Primary care providers not fully utilizing evidence-informed guidelines currently available
- Patients, families and communities generally not provided opportunities for input into their care or for planning. Lack of patient perspective and active community engagement in primary care planning, implementation and evaluation
- Providers (with exception of physicians on salary and capitation) funded according to incentives for visits and procedures as opposed to funded according to evidence-based care
- With the exception of CHCs, it is understood that no other primary care models have accountability agreements with their funders which are focused on indicators and targets for evidenced-based care

Culturally Safe
- Continuation of inequitable health outcomes for the Aboriginal population, Francophones, new immigrant and racialized populations, other vulnerable populations including LGBTQ, people with disabilities, and people living in poverty

Other
- Primary care in Ontario lacks a coordinating body, which has fostered a situation characterized by:
  - Lack of vision and systemic approach to primary care
  - Lack of coordination between primary care and other sector services
  - Lack of comprehensive and strategic HHR planning to encompass all primary care providers in Ontario
- Primary care has not yet been prioritized as the next sector to be implemented under the *Excellent Care for All* legislation
- Lack of access-related accountability agreements between providers and appropriate authority/ies

Chapter 4: Vision/Goals/Priorities and Action Plans

VISION: That Ontarians have **equitable, timely,** and **continuous** access to primary care which is **comprehensive**, **evidence-informed** and **culturally safe** while being acceptable to patients across all regions of the province and according to the local needs of diverse populations.

To foster this vision of a future state, the access working group presents the following recommendations for MOHLTC:

Equitable

1. That MOHLTC in partnership with the LHINs adopt a population needs-based, equity-oriented planning approach to primary care under the principles of primary health care for all Ontarians
   a. That MOHLTC and LHINs conduct a needs-based analysis by sub-LHIN or via postal codes in order to capture unique attributes of neighbourhoods and communities
   b. That this data be mapped against current providers and their patients
   c. That the gaps be determined
   d. That any needs-based population planning approach take into consideration existing assets including current HHR

2. That this needs-based planning approach apply to the entire population, but with a focus on strategies pertaining to five sub-populations:
   a. Aboriginal
   b. Francophone
   c. Northern and remote
   d. Southern rural
   e. Urban with a focus on racialized communities and new immigrants

3. That all strategies take into consideration the unique challenges of:
   a. Chronic disease prevention and management
   b. Complex mental health, addictions and co-morbidities
   c. Patients with disabilities
   d. People living in poverty
   e. LGBTQ issues

4. That future resource allocation be informed by the population needs-based, equity-oriented planning approach

5. That a strategy be developed to identify and focus on patients with complex co-morbidities and determine appropriate resource level for optimal return on investment

6. That complex vulnerable populations receive acceptable care that results in equitable health outcomes and reduced usage of ED and ALC
   a. Complete a complexity of care and socio-demographic profile study to determine adjusted panel (physician/NP) size and resource levels for mix of patients served

7. That a patient-focused approach be embodied in all primary care access policy and planning

8. That *OntarioMD* specification for future EMR certification require the mandatory collection of socio-demographic data for planning purposes while respecting patient rights under prevailing privacy legislation

9. That mechanisms be established to enable tracking of all patient's addresses for planning purposes
   a. Immediately make a mandatory requirement in all *OntarioMD* certified EMRs
   b. In medium term reinstate the mandate to ensure all Ontarians have individual OHIP cards which track current addresses

10. That a central repository for primary care data be created with mandatory requirements by primary care models to provide data as appropriate and as abides by relevant privacy legislation currently in effect

Timely

1. That all primary care models be required to:
    a. Immediately provide 3 hours of after hours care per physician and NP per week
    b. Providers assisted to work in collaboration with other providers in the community to furnish 24/7 coverage to meet primary care needs or as appropriate EDs by March 2015. ED use may be appropriate in northern and remote communities when it is agreed to as part of the after hours plan for the community

2. That the "Access bonus" be reviewed to better enable collaboration across primary care models to reduce barriers to patients for using other primary care models, especially for after hours care

3. That all patients have access to their primary care provider within 48 hours through advanced access, assisted by expanding *Quality Improvement and Innovation Partnership* (QIIP) to all relevant providers with a focus on office efficiency

Continuous

1. That the use of walk-in clinics[*] be phased out as soon as is realistic:
    a. Develop common standards, definitions, and codes for walk-in clinics, urgent care and after hours care so that usage rates can be monitored

2. That mechanisms be established to foster shared after hours care across primary care models
    a. Patients to sign an agreement to enable providers in the shared after hours care services to inform their primary care provider of the reason for visits and treatments
    b. Shared after hours care services be required to immediately inform primary care providers if their patient had a visit to an after hours care service, the purpose of visit and treatment received
    c. That the *OntarioMD* specifications include viewing and input by other providers for the purpose of shared after hours care

3. That system navigators and case managers[Φ] be leveraged so that all patients have better access to seamless and coordinated care as they move across the continuum of care
    a. Primary care models with high-utilization patients be required to track and follow these patients as they access care across the health care system
    b. Family practice nurses and other primary care professionals such as mental health workers be used to their full scope of practice, including system navigator and case manager roles
    c. In some settings it may also be appropriate for community members to be trained as case managers and system navigators and be incorporated into health care teams

Comprehensive

1. That all Ontarians are attached to IP primary care models including AHACs, CHCs, FHTs and NPLCs. It is not recommended to develop new delivery models
    a. In the short-term to continue to attach all Ontarians to primary care providers and to immediately expand HCC to include NPs
    b. In the medium term to develop a strategy to transfer patients to IP teams as physicians move, retire, or change their scope of practice

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[*] The access working group's definition of walk-in clinics pertains to stand-alone clinics which are not connected to any primary care model, and does not include after hours urgent care centres.

[Φ] For definitions please refer to http://www.ontla.on.ca/library/repository/mon/24002/299238.pdf.

    c. Formulate a transition strategy which incorporates current assets including human resources, programs and community services

2. That all IP Teams are fully functional
   a. That standards be defined and established for IP teams
   b. That ongoing quality improvement is ensured for IP team work processes
   c. That IP training is provided at all health professional colleges and universities
   d. That research is conducted to examine health outcomes associated with IP models of care

3. That all IP teams provide a full basket of services including at a minimum the Provincial Co-ordinating Committee on Community and Academic Health Science Centre Relations (PCCCAR) Basket of Services, which includes:

   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, as well as 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 24/7 response
   10. Service coordination and referral
   11. Maintenance of comprehensive patient health record
   12. Advocacy
   13. Primary mental health care including psycho-social counselling
   14. Coordination and access to rehabilitation
   15. Support for the terminally ill

4. That each member of the IP team works to their full scope of practice with an initial focus on NPs and family practice nurses.

5. That each IP Team has an appropriate mix of professionals and that a study be conducted to determine an appropriate mix of professionals for IP teams working at full scope based on population needs (e.g. seniors vs. new immigrants vs. complex mental health may need a different mix of providers)

6. That Northern and remote care models be assisted to recruit and retain optimal level of IP Teams
   a. To develop meaningful HHR strategy for the north including:
      i. Review incentive programs (e.g. 1 year of service = 1 year of tuition)
      ii. Review criteria for "Grow your own NP" and expand program to other professionals
   b. To increase the capacity of education facilities in Northern Ontario

7. That *OntarioMD* specification for future EMR certification standards continuously be improved to enable all members of IP team to have access to patient records as per appropriate security profiles

8. That alternative methods of delivery be utilized as appropriate:
   a. Increased use of mobile clinics and telemedicine, especially in northern and rural Ontario
   b. Explore more primary care provision in homes including long term care facilities (e.g. LTC facilities being allowed to provide IV antibiotics, palliative care at home)

8. That an information database about community and social services be developed such as 211 to enable primary care models to better refer patients to appropriate services as required

Evidence-informed

1. That all aspects of primary care access, where available, be guided by sound research and evidence
   a. To foster broad adoption of the RNAO's internationally recognized *Nursing Best Practice Guidelines*[46]
   b. To require all primary care providers with EMRs to use the alerts and other evidenced-based tools (pathways for chronic disease etc.) already incorporated in the software
   c. To continuously review the *OntarioMD* specifications for EMR software development with the view to incorporate evidence-based information in the products
   d. To review relevant literature, including leveraging best practice guidelines from international jurisdictions, to determine the evidenced-based information related to access that is currently available and make recommendations on its implementation
   e. To conduct research where evidence is currently lacking

4. That evidenced-informed primary care requires input from patients, families and communities
   a. To conduct regular quantitative and qualitative research methodologies to identify patient and population needs and assets to guide programs and services planning and evaluation
   b. To strongly encourage participatory evaluation approaches
   c. To ensure active community engagement in the development of programs and services so as to better meet population needs
   d. To leverage the current LHIN engagement processes as one opportunity for input
   e. To ensure all forms of engagement be conducted in a culturally safe environment, with appropriate languages as required by the patient, their family and the community

5. That all primary care models be required to have accountability agreements with their funders and appropriate authorities that link to performance as per evidence-based access guidelines
   a. To immediately develop relevant performance indicators for primary care access
   b. In the mid-term to link funding to process measures with long-term goal of linking funding to outcomes

Culturally Safe

1. That all Ontarians have access to culturally safe care that is culturally competent and addresses the inequities to health care, with a focus on Aboriginal Ontarians, Francophones, new immigrants and racialized communities, as well as LGBTQ Ontarians and Ontarians with disabilities. That culturally safe care also extends to Ontarians living in poverty

2. That all health care providers be required to develop necessary proficiencies and competencies to deliver culturally safe care to accommodate the unique needs of Ontario's diverse populations

3. That health care professional educational institutions be encouraged and supported to provide education on culturally safe primary care integrated throughout the core curriculum

4. That primary care models be resourced to have IP teams including translation services, community workers, primary care providers who are representative of the cultural community being served, and all staff with familiarity with the predominant cultural groups they are serving

5. That an HR plan be developed that includes supporting and training members from these communities to be trained as primary health care providers

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[46] Registered Nurses' Association of Ontario. *Nursing Best Practice Guidelines*. Canada: Registered Nurses' Association of Ontario.

6. That primary care access indicators be developed to depict the provision of culturally safe care (e.g. Pap rates for racialized women, colorectal and breast cancer screening amongst Aboriginal populations, etc.)

Additional Recommendations pertaining to foci of other Working Groups

1. That primary care be the next priority for implementation under the *Excellent Care for All Act* (ECFAA)

2. That all primary care models be required to sign accountability agreements with performance indicators and targets with their funders or appropriate authorities

3. That a primary care secretariat/council be established with the responsibility to oversee the strategic planning and transitioning to a more robust primary care system in Ontario, informed by the principles of primary health care, including but not limited to developing a comprehensive HHR strategy for culturally safe, comprehensive IP teams, and strengthening patient and community-focused care and engagement

4. That the role of the LHINs be integral and formally linked in the planning of primary care to enable accountability and linkages with the continuum of care

5. That primary care models in communities be supported in working together so as to better ensure comprehensive services are available to all patients (e.g. one FHT may specialize in diabetes education while another CHC in the same community may specialize in mental health)

6. That timely implementation of advanced access in all primary care practices be available as soon possible

7. That all primary care models be required to implement certified EMRs as soon as possible

Chapter 5: Monitoring and Evaluation

The availability of pertinent quantitative data – which is both reliable$^{\partial}$ and valid$^{\Phi}$ – is essential to allow for sound monitoring and evaluation. Furthermore, in order to measure trends over time it is imperative that data be collected in the near-term. Without baseline data it is impossible to compare metrics over time and hence very difficult to determine whether a given indicator is improving or worsening.

Similarly, qualitative data used in monitoring and evaluation needs to demonstrate credibility (i.e. internal validity), dependability (i.e. reliability), confirmability (i.e. objectivity) and transferability (i.e. external validity). Transferability requires that research and evaluation includes a rich description of the context where the research was conducted in order to ensure that others can determine the relevance of results for their contexts.

Respecting the individual privacy of Ontarians is of paramount importance. There is much primary care and access data which would be beneficial to policy and planning, but which requires the provision of patient's personal consent. With this responsibility and challenge in mind, appropriate permissions and mechanisms would need to be developed to appropriately facilitate the sharing of personal information.

$^{\partial}$ *reliability* of data pertains to the consistency of a set of measurements or of a measuring instrument
$^{\Phi}$ *validity* of data pertains to the extent to which a concept, conclusion or measurement is well-founded and corresponds accurately to the real world

In order to measure and monitor improvements in continuous access, it is recommended that common standards, definitions, and codes for walk-in clinics, urgent care and after hours care be developed so that usage rates can be better monitored.

Qualitative research is also strongly encouraged to evaluate the quality and acceptability of primary care access. Furthermore, community-based participatory research is required to ensure that the specific needs of the community being served are met.

Recommendation:

1. That a central repository for primary care data be created with mandatory requirements by primary care models to provide data as appropriate and as per current privacy legislation, such as the *Personal Health Information Protection Act* (PHIPA)

2. That specifications for *OntarioMD* certified EMRs be reviewed to ensure they are able to collect the necessary data to plan and monitor access, such as patient addresses and socio-demographic data

3. That MOHLTC develop common standards, definitions and codes for walk-in clinics, urgent care and after hours care

Community/Patient Involvement in Research and Evaluation

The ultimate goal of strengthening primary care access should involve improving the health system in ways which provide positive outcomes that patients can clearly witness for themselves. For this reason the working group urges MOHLTC to ensure the usage of community-based participatory research. In the short-term, this goal could be facilitated by identifying patient access and satisfaction indicators and developing appropriate survey questions for use in practice-based surveys. In the medium- and long-term, MOHTLC is requested to call on all models of care to conduct community-based participatory research.

Primary care could greatly benefit from engaging in community-based participatory research that actively involves community members as equal research partners where the community drives research and evaluation around issues which are most important to them. The U.S.-based Agency for Health Quality and Research (AHRQ) identifies benefits to this approach.♥ By involving members of the community in the research design, the collaboration lends itself to:
- The selection of relevant research questions
- Development of culturally-appropriate measurement instruments
- A deeper understanding of the community's unique circumstances

It was recommended by the working group that the Health Quality Ontario (HQO) access-related indicators be reviewed to determine their applicability to monitoring access to primary care, some of which have been included below:

Timely
- Percentage of adults who were able to see their doctors on the same or next day, the last time they were sick or needed medical attention
- It was further recommended to draw upon international standards for timely access. It was understood that Belgium has a legislated requirement for access to primary care within 48 hours
- Percentage of adults using EDs for primary care

♥ For more information, please refer to http://www.ahrq.gov/research/cbprbrief.htm#benefits and http://www.ahrq.gov/research/cbprbrief.pdf

Continuous:
- Percentage of adults without a regular family doctor (HQO)
- Percentage of adults without a regular family doctor, and seeking one (HQO)
- Percentage of adults without regular doctor/primary care provider to help manage their care (HQO)
- Percentage of adults using walk-in clinics

Comprehensive:
- % of patients attached to IP teams

Culturally Safe:
- % of immigrant, vulnerable women, Aboriginal, etc. receiving Pap test/colorectal and breast cancer screening in a culturally appropriate manner
- Health outcome indicators for marginalized populations

Acceptable to Patients
- Percentage of adults who have a regular doctor or place of care who rate the overall quality of medical care they received in the past 12 month as excellent or very good (HQO)

Chapter 6: Conclusion

With the aim of aligning the Ontarian context with best practices, patients should have *equitable*, *timely*, and *continuous* access to primary care which is *comprehensive*, *evidence-informed* and *culturally safe* and acceptable to patients across all regions of the province and according to the local needs of diverse populations.

The working group identified the presence of numerous areas for improvement in reviewing the current state of access to primary care in Ontario. Although attachment rates have remained high in recent years, there remain many unattached patients and also exist numerous reasons why patients who *are* attached can find themselves "orphaned on the roster" and unable to access the primary care they need when they need it.

As indicated in this report's business case for change, recent ICES data indicates that Ontario has an especially poor track record in terms of (1) same day/next day visits, (2) over-usage of EDs and walk-in clinics, (3) the persistence of long wait times and (4) a general paucity of after hours options. Access to primary care is further impeded by the persistence of barriers which include a lack of pertinent primary care information amongst patients and providers, insufficient comprehension of cultural safety, as well as the persistence of barriers to coordination and collaboration amongst primary care providers.

The working group identified a strong need for the MOHLTC and other primary care planning bodies to embrace a population needs-based approach in determining how best to strengthen access to primary care. This methodology is well-suited to best ensure that efforts to improve access to primary care are most reflective of the distinct needs of Ontario's diverse populations. This approach will assist in addressing the impetus for MOHLTC to ensure the application of a health equity lens in policy, planning and delivery of primary care. Recognizing the diversity of patient populations and needs in Ontario, it was determined that MOHLTC should be sure develop primary care strategies for the general population, while formulating tailored strategies for marginalized populations to meet their distinct primary care needs. Strategic interprofessional HR planning will support the adequate supply and allocation of primary care provision.

A further recommendation is for MOHTLC to continue to support the transformation whereby all Ontarians are attached to an IP team. The working group determined that IP teams are able to effectively provide
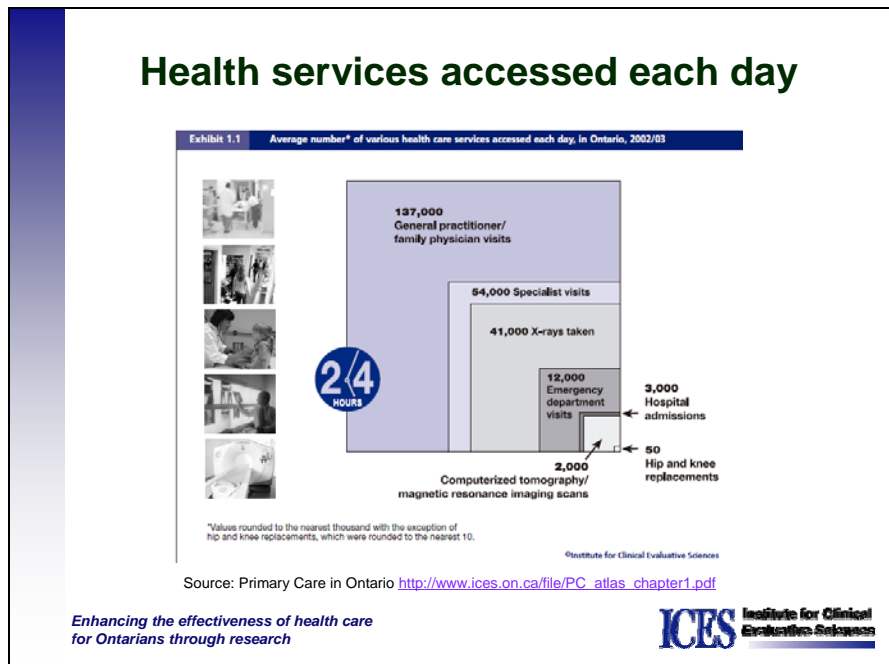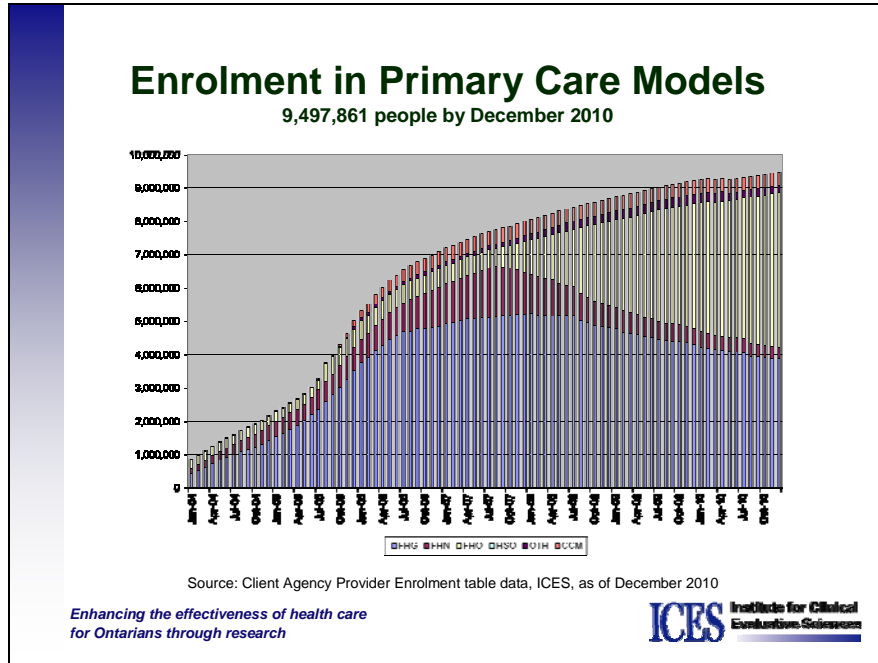
superior outcomes for patient, provider and health care system. Moreover, IP teams are particularly well-positioned to provide continuity and comprehensiveness of care, both of which could be strengthened further by MOHTLC supporting the ability of all IP staff to work to their full scope of practice.
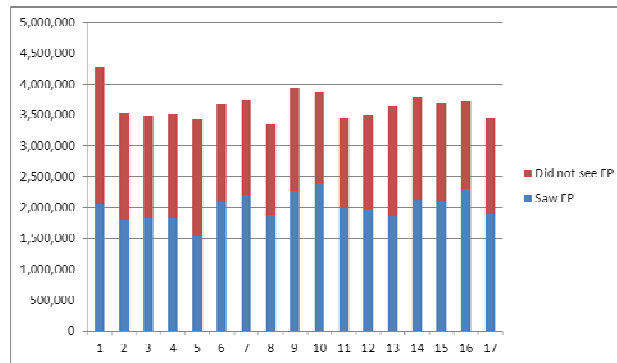
It is vital that MOHLTC continue its communication strategy so as to further reduce informational barriers to access confronted by patients, while working to expand after hours primary care availability and create a situation where patients can see their own primary care provider within 48 hours. Efforts could also be made to help identify and remove barriers to local cross-model collaboration amongst primary care providers. The "Access bonus" should be modified and improved so that providers are less hesitant to refer their patients to other primary care providers.

MOHLTC should continue to support the broad adoption of inter-operable EMRs with the local health care system, to help support both continuity of care and to address the prerogative of providing evidence-informed care. Moving forward, developing policy to strengthen access to primary care should draw upon a range of pertinent data sets and should be reflective of robust monitoring and evaluation. As a starting point, the working group recommends that MOHLTC ensure that walk-in clinics provide their billing codes so as to allow for more accurate and complete analysis.

Appendix A: ICES Graphical Representations

Source: Client Agency Provider Enrolment table data, ICES, as of December 2010

Source: Primary Care in Ontario http://www.ices.on.ca/file/PC_atlas_chapter1.pdf

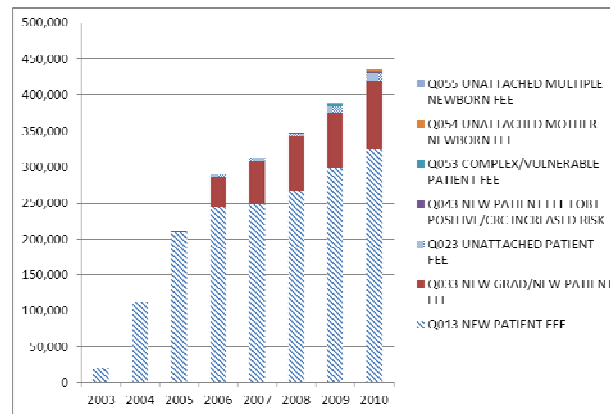## Number of adults who saw their doctor or nurse same/next day when sick, Ontario 2006-2010

Source: PCAS waves 1-17, ICES as of March 2010

Enhancing the effectiveness of health care for Ontarians through research
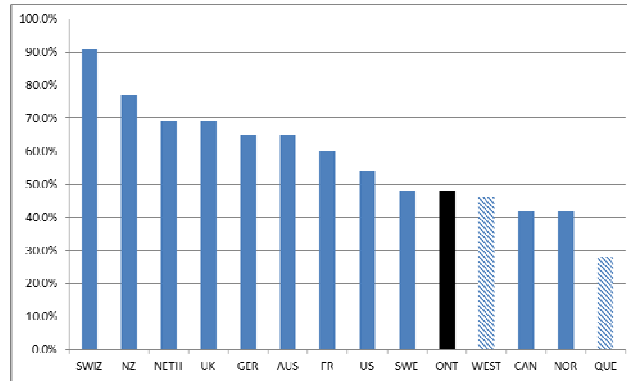
Uptake of Codes for Unattached Patients, OHIP 2005-2010

Source: OHIP billing data, ICES as of December 2010

Enhancing the effectiveness of health care for Ontarians through research
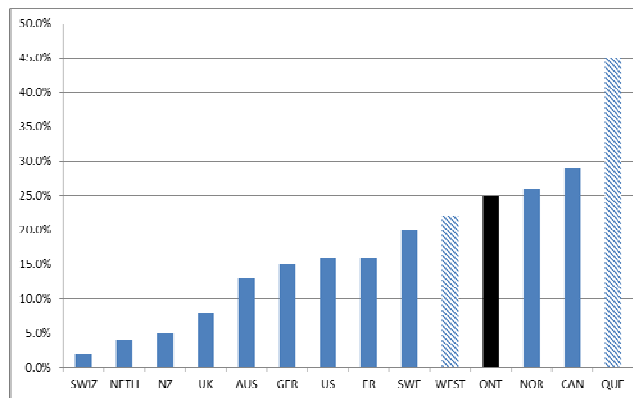
Same day or next day appointment when sick or needed care

Source: 2010 Commonwealth Fund International Health Policy Survey in Eleven Countries

Waited six days or more when sick or needed care

Source: 2010 Commonwealth Fund International Health Policy Survey in Eleven Countries

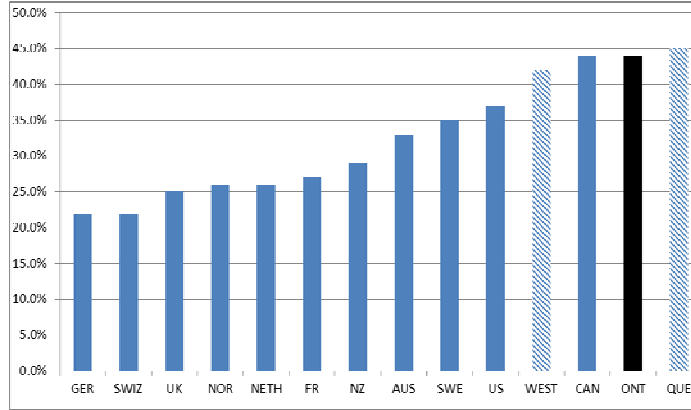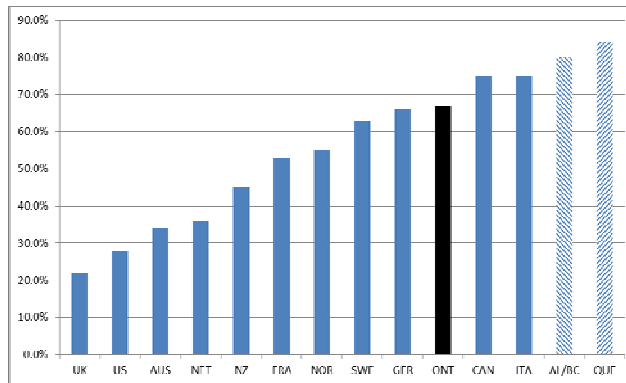**Emergency room use past two years**

Source: 2010 Commonwealth Fund International Health Policy Survey in Eleven Countries

Enhancing the effectiveness of health care
for Ontarians through research

ICES Institute for Clinical Evaluative Sciences

MD report: often long waiting times to see a specialist

Source: Commonwealth Fund International Health Policy Survey of Primary Care Physicians, 2009

Enhancing the effectiveness of health care
for Ontarians through research

ICES Institute for Clinical Evaluative Sciences

Appendix B: References

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Appendix C: Working Group Terms of Reference

Strengthening Primary Care Access

Strengthening Primary Healthcare in Ontario Initiative
Working Group 2

Background
Primary care is the first point of interaction that many Ontarians will have with their healthcare system. Access is therefore an important component of primary healthcare design and service provision. Because the primary healthcare needs of Ontarians and the places they live and work are diverse, so too must be the primary care services they receive. Strengthening access should focus on primary care informed by a primary healthcare framework.

Over the past few years the government has made significant progress in advancing access to primary care such as the addition of Family Health Teams, Nurse Practitioner-Led Clinics, Community Health Centres and increasing the supply of physicians and nurses. A key component of this has also been the creation of Health Care Connect to reduce the number of unattached patients. Since 2003, an additional 1 million Ontarians have gained access to a primary care provider.

Looking ahead, strategies to improve access to primary care require a two-pronged approach: ensuring the demand for timely, comprehensive, continuous and evidence-based health services can be met and that the primary care system has the capacity and capability to address the needs of diverse populations. An access strategy must include how primary care interacts with other health sectors to assist with transitions along the continuum of care.

Objectives
To develop a proposal to ensure that all Ontarians have continuous and timely access to primary care services and that ensures the capacity to meet the needs of a diverse patient population.

Key Areas of Focus
1. Access to inter-professional teams
2. Location and appropriate mix of primary healthcare models
3. Meeting the needs of complex/vulnerable populations
4. Meeting the needs of those living in northern, rural and remote regions
5. Addressing the unique challenges of urban populations
6. Connection with other healthcare providers and services (i.e. public health, acute care, long-term care, mental health and addictions, home care, community support)

Key Principles of Access
Primary care access is characterized by the following two key principles:
1. Provides timely access to primary care across all regions of the province
2. Optimizes continuous access according to diverse populations' needs

Areas of Discussion for All Working Groups
1. Review and validate the current state and business case for change
2. Identify long-term vision and goals for each of the proposed areas
3. Identify short- and medium-term priorities for 2011-2014
4. Develop an action plan for achieving goals and priorities identified above
5. Develop monitoring and evaluation plan to monitor progress against the goals and priorities identified above

Communications
The communication and sharing of any materials developed by the working group will require prior approval by the Primary Healthcare Planning Group.

Reporting and Support
Working group participants will report to the co-chairs. The co-chairs will resolve dispute and disagreement as they arise. The co-chairs are:
- Doris Grinspun – Executive Director, Registered Nurses' Association of Ontario (RNAO)
- Adrianna Tetley – Executive Director, Association of Ontario Health Centres (AOHC)

The working group co-chairs will report to the primary health care planning group, chaired by Susan Fitzpatrick, ADM, Negotiations and Accountability Management Division, Ministry of Health and Long-Term Care (MOHLTC). Support provided by Alex Goddard, Health System Strategy Branch (HSSB), MOHLTC.

1. Meeting Frequency
The first meeting of the working group occurred on March 31 from 11 a.m. – 1 p.m. The second meeting was held at AOHC and via teleconference/OTN on April 19, from 1 – 4 p.m. The day of May 17, 2011 (9 a.m. – 5 p.m.) witnessed a full-day meeting of the working group which took place at the AOHC, located at Suite 500, 970 Lawrence St. W, Toronto ON. A final meeting of the working group took place on June 16, 2011 (9 a.m. – 4 p.m.) at the AOHC.

Participants
- Beth Cowper-Fung, Registered Nurses' Association of Ontario
- Tannice Fletcher-Stackhouse, Registered Nurses' Association of Ontario
- Rick Glazier, Institute for Clinical Evaluative Science
- Joyce Helmer, Indigenous Health Knowledge Centre
- Angie Heydon, Association of Family Health Teams of Ontario
- Paul Huras, South East Local Health Integration Network
- Camille Orridge, Toronto Central Local Health Integration Network
- Roger Strasser, Northern Ontario Medical School
- Wendy Talbot, NorWest Community Health Centres
- Ruta Valaitis, Registered Nurses' Association of Ontario