2017 Ontario Pre-Budget Submission from the Association of Family Health Teams of Ontario

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To: The Standing Committee on Finance and Economic Affairs
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1 Introduction

1.1 Comprehensive primary care is the foundation for a high-quality, sustainable health system

Thank you to the Standing Committee on Finance and Economic Affairs for the opportunity to submit recommendations to the Ontario Government's 2017 Pre-Budget Consultations. AFHTO is a not-for-profit association that provides leadership to promote high-quality, comprehensive, well-integrated interprofessional primary care for the benefit of all Ontarians. It is the advocate and resource to support the spread of knowledge and best practice among 180 Family Health Teams (FHTs) and 5 Nurse Practitioner-Led Clinics (NPLCs) serving over one-quarter of Ontario's population and welcomes all who provide interprofessional comprehensive primary care in Ontario.

Primary care is the foundation of a high performing health system and is fundamental to achieving a health system that truly puts patients first. This is the overarching principle in the Patients First Act which focuses on ensuring patients are at the centre of the health care system, receiving the right care by the right provider at the right time and as close to home as possible. In this upcoming provincial budget, we call on the government to strengthen primary care so that it can deliver on its commitments outlined in the Patients First Act and ensure all Ontarians receive access to high quality, comprehensive, Interprofessional team-based care.

2 Continue on the path to stabilize the primary care workforce

Successful implementation of the Patients First Act requires the energy and commitment of primary care leaders, front-line providers and support staff. After zero increases for the last seven years, the Government of Ontario announced an $85 million investment in the 2016 provincial budget over the next 3 years to assist Primary Care organizations to recruit and retain skilled non-physician staff. This is a welcome start but it is ONLY a start toward levelling the playing field in the competition for health professionals. Primary care teams are launching pads for careers since this is such a rich environment for learning and growing. However, patients lose continuity of care as well-developed, experienced staff feel compelled to move to better-paid jobs outside primary care, despite the fact these roles characteristically have less autonomy and responsibility.

On November 30, 2016, the Liberal Government announced an investment of $125 million in pay raises for managers in the Ontario Public Service. The explanation provided for the increases reflect the long-standing wage freeze and difficulty in recruiting and retaining managers into the public service. This translates to an average salary increase of $6,905 to each of the 8,400 civil service managers. This compensation increase is no doubt very much deserved but it also diminishes the contribution of the work being done on the ground by individuals providing exceptional primary care to patients.

2.1 Invest in the people needed to lead successful change

Salary rates for interprofessional primary care are between the 2006 and 2009 recommended rates. The result: primary care organizations, including Community Health Centres (CHCs), Aboriginal Health Access Centres (AHACs), NPLCs and FHTs, are struggling to retain and recruit qualified healthcare professionals, which impedes their ability to provide primary health care to their patients and communities. In 2014, AFHTO, NPAO and AOHC provided a set of rigorous and methodologically sound recommendations on a Compensation Structure for Interprofessional Teams (based on a market review done by the Hay Group) to the Ministry of Finance in order to address the ongoing revolving door of interprofessional health care providers out of primary care.

The government made some progress on the issue of compensation and while appreciated, this investment is only a 20% down payment towards what is needed***. In the 2017 Budget we want a commitment to $130 M annualized with an implementation plan over 2 years to ensure interprofessional primary care teams can effectively retain and recruit qualified staff.*** These funds will be brought to over 7,500 health care professionals working in over 400 interprofessional primary health care teams to the 2012 recommended rates and help narrow the gap with hospitals, Community Care Access Centres (CCACs) and public health.

3 Broaden access to interprofessional team-based care teams

Primary care – the long-term relationship each person has with their family physician or Nurse Practitioner – is key to keeping people healthy and to keeping health system costs in check. Evidence demonstrates that investment in primary care is associated with improved system quality, equity and efficiency (reduced cost).[1,2,3,4] The ability of primary care providers to access and coordinate care for their patients is vital to ensuring people get the right care at the right time and do not slip through the cracks. Health resources are used more efficiently when people do not have to wind up in the hospital or emergency room unnecessarily.

3.1 Optimize the ability of professions to collaborate

FHTs and NPLCs were introduced over the past decade to improve access, quality and efficiency through team-based primary care. Evaluations and research studies have given evidence of the added value delivered by such teams.[5,6,7] Research evidence also suggests that primary care is most effective when there is a long-term, continuing relationship with a physician or NP who is working as a full collaborator in an interprofessional team.[8,9]

Right now, Ontario has the following mix of primary care providers:

1. Salaried Nurse Practitioners (NPs) employed in teams–FHTs, NPLc, CHCs, AHACs and nursing stations;

2. Salaried family physicians (FPs) employed in teams–AHACs and CHCs and about 10%of FHTs (<5% of all Ontario FPs);
3. Family physicians associated with a team by virtue of being in a group payment model, such as a Family Health Organization or Rural and Northern Physician Group Agreement (about 25% of all Ontario FPs) that is associated with (but not accountable to) a FHT; and
4. Family physicians who have no association with teams (<70% of all Ontario FPs).

Teams in the third group–FHTs with one or more associated physician groups–are living in a three-way relationship:

- Physicians are individually incorporated and loosely associated through a funding contract for their group with the Ministry of Health and Long-Term Care.
- The FHT is a not-for-profit corporation whose Board is accountable to the Ministry for funding it receives to hire interprofessional health providers and associated administrative staff and has no authority over the physician group.
- The FHT and physician group must rely on leadership, trust and their evolving culture to span the organization/funding divide and build the collaboration needed for effective team-based care.

When it comes to the fourth group–family physicians outside teams–the fact that their patients (over 70% of Ontarians) currently have little to no access to teams is neither fair nor equitable. The reach of team-based care must be expanded over time so that all family physicians and primary care Nurse Practitioners are collaborating in teams. ***In the 2017 Budget the government must ensure all Ontarians receive access to comprehensive, collaborative team-based care which will require further investments to be made to expand current teams and facilitate the creation of new teams.***

3.2 Create a culture of trust

Expansion of teams or the creation of new teams will require the Ministry (and the LHINs) to re-allocate funds over time but what is equally important is that family physicians would have to want to change their mode of practice to embrace team-based care. This will not happen where there is no trust.

Unfortunately, physicians are very mistrustful of the Ontario government at present, especially without a Physician Services Agreement in place. In order to ensure that all Ontarians receive access to interprofessional team-based care, we need our physicians engaged and motivated to participate in the conversations and help shape the changes needed in transforming health care. ***In the 2017 Budget there must be commitment that the government will continue to work with our physician colleagues to co-design what will hopefully be a mutually beneficial and accepted Physician Services Agreement.***

4 Ensure Seamless Transition of Care Coordinators into Primary Care

Primary care is an anchor for patients and families, providing comprehensive care throughout their lives. Primary care providers are the first contact or entry into the system for all new needs and problems and they directly influence the responses of people to their health needs by listening to the concerns and preferences and providing clinical evidence-based assessment and treatment recommendations.

Care co-ordination in primary care has the potential to significantly:

- Reduce the duplication and role conflict that currently exists in our health system;
- Improve patient outcomes through much greater continuity and coordination of person-centred care.

In contrast, care coordination provided through CCACs is episodic – about 60% follows from a hospitalization[10] and misses the opportunity to keep people out of hospital in the first place. As experienced by AFHTO members, communication back to primary care providers has been very poor, although the embedding of a CCAC Care Coordinator in some teams has made some improvement.

As the Ministry of Health and Long-Term Care starts implementing its Patients First Act, the Ministry needs to remain committed to the principles, desired outcomes and enablers for effective care coordination, all of which is articulated in the Ontario Primary Care Council's Position Statement: Care Coordination in Primary Care. This is starting now with the dissolving of the CCAC and movement of the employees into the LHIN but we need to ensure that primary care continues to lead care coordination and which will be supported by the transition of care coordinators into primary care.

In the 2017 Budget the Ministry must immediately work with primary care teams and LHINs so that, over the next few years, all functions performed by CCACs, together with the associated resources, can be transitioned into primary care to bring greater efficiency and patient-centredness to care delivery.

5 Invest in Meaningful and Measurable Measurement

Performance measurement is absolutely essential to assessing and improving quality of care. Performance measures must be consistent and comparable across the province, while allowing adaptability for the local context. By identifying those who excel at care delivery, we can learn from one another and scale up improvements to providers in a positive and not punitive way.

There is much to learn from the hands-on experience of AFHTO member organizations caring for nearly 2 million Ontarians, through our Data to Decisions (D2D) initiative. Our measurable, meaningful and manageable data is showing that higher primary care quality is associated with lower total health system cost. This is very welcome news in a very fiscally constrained health care environment.

While many primary care teams have been measuring performance, this will be new for the majority of our primary care colleagues. As we have learned, there is nothing to fear from being held accountable. But clinicians will need to receive support to help identify and capture the most meaningful and manageable data to improve care for patients.

The Quality Improvement Decision Support (QIDS) program coordinated through AFHTO is:

- Demonstrably advancing measurement, the critical pre-requisite for quality improvement, in the care for roughly one-quarter of Ontarians;
- Fostering greater collaboration and coordination among family health teams – an important step in strengthening the relationships and leadership skills needed to integrate care for patients; and
- Most importantly, incorporating the patient's perspective via a composite measure of quality that reflects what matters to patients and providers and is related to lower healthcare costs.

The QIDS program could be expanded very easily – as is now being done with the addition of 3 more quality improvement specialists to capture all 25 NPLCs – across all of primary care. ***In the 2017 Budget we would encourage the government to look at already existing models of performance measurement in primary care, especially the primary care co-designed D2D initiative, and facilitate and fund a spread strategy to measure outcomes that actually matter to patients and providers while also assisting in lower system costs.***

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