2019 Ontario Pre-Budget Submission from the Association of Family Health Teams of Ontario

Submitted To:	Timothy Bryan, Clerk Standing Committee on Finance and Economic Affairs Room 1405, Whitney Block Queen's Park, Toronto, ON M7A 1A2 comm-financeaffairs@ola.org
Address all inquiries to:	Kavita Mehta CEO, Association of Family Health Teams of Ontario kavita.mehta@afhto.ca 647-204-0212

January 29, 2019

AFHTO Pre-Budget Recommendations for the 2019 Ontario Budget

"A greater emphasis on primary care can be expected to lower the costs of care, improve health through access to more appropriate services and reduce inequities in the population's overall health"[i]. This seminar research by the late Dr. Barbara Starfield and colleagues forms the basis of what many jurisdictions will agree to be true – an investment in creating a robust primary health care system will lead to a higher performing health system with better patient outcomes and less cost to the system.

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 their concerns and preferences and providing clinical evidence-based assessment and treatment recommendations.

AFHTO and its members are already showing that they are a solution to the current issues related to hallway healthcare, but a lot more needs to be done in order to ensure we have a health care system that is truly patient-centric and focused on keeping people out of the hospital and back into their homes.

1. Mental Health and Addictions

Ontarians are on the verge of a mental health and addictions crisis. People across Ontario are waiting longer for mental health and addiction services, and hospitals report unnecessary emergency department visits from patients who have been waiting months for mental health services, often seeing the same patients coming through their emergency room doors since they cannot access services and supports in their communities. Hearing directly from primary care providers, we know that mental health is the biggest challenge for them – there are not enough resources to support our patients and wait lists for community supports are long and unwieldy. Our health care system is siloed, so now is the time to ensure that mental health and addictions supports are built directly with primary care to allow for continuity of care.

Budget Request:

We need a health system that is truly integrated, one where patients do not have to move from one part of the system to another part to get their care, especially care for mental health and addictions. In this upcoming budget, we ask the Ministry of Health and Long-Term Care work directly with primary care and mental health care providers to ensure that mental health and addictions investments are integrated in primary care.

In a 2016 survey of primary care and mental health organizations by the Canadian Mental Health Association, Ontario Division, primary care providers identified several challenges with access to community mental health and addictions supports, including: waitlists for services; specific challenges with addictions services, such as lack of availability, wait lists, or financial barriers to private services; challenges with access to hospital programs; limited access to psychiatrists; and specific barriers to services for non-insured and federally-funded clients.

We need to start treating mental health like we treat physical health – primary care providers care for the WHOLE person and that includes their mental health and well-being. These resources need to be in the community where the person lives and receives comprehensive care and not in an expensive acute centre where they only receive episodic care.

An example in action: Caroline Families First Wrap-around Program (CFF)

In talking with pediatricians and pediatric psychologists in the Burlington area, staff at Burlington and Caroline Family Health Teams discovered there was a major gap in services for children struggling with mental health concerns. The teams formed a partnership with Reach Out for Kids, the Halton Region's lead agency for child and youth mental health care, to address this gap. Their collaboration produced the Caroline Families First (CFF) program, an evidence-based wrap-around model of care.

The Caroline Families First program has broken new ground by bridging a gap between primary care and community-based mental health by utilizing a multidisciplinary team; by hiring a peer support worker; and by co-locating with referring physicians to build a circle of care.

The program uses a family-centred approach and the process is driven and designed by the participant, based on a family's self-identified care goals. Including the family in program design is unique and allows their needs to be considered throughout the process. Patient feedback and evaluation make it possible to be very responsive to their needs and suggestions, so the program is continually evolving as it continues to meet the needs of the patients and their families.

2. Home and Community Care Coordination with Primary Care

AFHTO and its members affirm that comprehensive care coordination is a dimension of quality primary care that is patient-centered and leads to effective and more seamless transitions between settings and among providers. Effective care coordination reduces duplication, increases quality of care, facilitates access and contributes to better value by reducing costs. It ensures continuity of care for patients regardless of setting, including home, community, hospital, long-term care facility or with their primary care team.

Budget Request:

In the 2019 Budget, we ask the Ministry strengthen the relationship between primary care and home and community care by transitioning the function and associated resources of care coordination to primary care. This will bring greater efficiency and patient-centredness to care. Care will be integrated, allowing for seamless transitions of care for patients.

In October 2017, AFHTO held a leadership session with 200 leaders from our member organizations – Lead Physicians and Nurse Practitioners, Board Members and Executive Directors – where 95% of participants said there needs to be improvement in the care coordination function. There is a sizable gap between care coordination support needed in their organization and what is currently in place. To help lessen the gap and to ensure seamless transitions of care, 88% of participants said they were ready to 'embed' care coordinators/system navigators in their primary care setting.

We know that home and community care coordination services provided through the former Community Care Access Centres (CCACs) was episodic – about 60% follows from a hospitalization[ii] which misses the opportunity to keep people out of hospital in the first place. In the last year, we have seen the CCACs integrated into the LHINs in an effort to address some of the fragmentation and lack of coordination. As experienced by AFHTO members, communication back to primary care providers still remains poor, although embedding Home and Care Coordinators in some teams has made some improvement.

An example in action: City of Lakes Family Health Team

City of Lakes FHT in Sudbury identified that physicians and Interprofessional Healthcare Providers (IHP) were experiencing difficulties with referrals and patient support. It was time consuming to reach the Care Coordinator, there was no consistency in who the coordinator would be, FHT providers never knew the status of their patients vis-à-vis CCAC care, and it was generally felt that patients were "falling through the cracks." Providers were frustrated and worried about their patients, particularly the frail and elderly.

The former CCAC agreed to a pilot project and allocated a part-time Care Coordinator to work with the FHT. Now instead of faxing referrals and phoning, the process has changed to a face-to-face collaborative working relationship.

Both patients and providers are enthusiastic about the role of Care Coordinators in the FHT: patient care has improved; there is improved consistency of care; Care Coordinators have ready access to physicians and nurse practitioners; Care Coordinators sometimes do joint home visits with physicians and nurse practitioners, which reduces the burden on the patient of having several visits from different providers; communication breakdowns have largely been eliminated; and, most importantly, collaboration has improved allowing for a better patient experience.

3. Increase Access to Interprofessional Team-Based Primary Care for More Ontarians

Primary care teams provide value for health dollars by speeding up access to care and offering a wider range of programs and services to promote health and manage chronic disease. They bring together the variety of skills needed to help people stay as healthy as possible. Ontario has made significant progress building a more coordinated and comprehensive primary care system to meet the needs of patients and governments by investing in interprofessional primary care teams where a range of health professionals work together to provide comprehensive primary care.

Currently only 25-30% of Ontarians have access to team-based primary care. Evidence tells us with a team-based approach to primary care, patients experience more timely access to care, better care coordination and improved management of chronic diseases. Evidence from British Columbia suggests that a very sick patient without access to high quality primary care can cost the province's system $30,000 a year. The same patient, when aligned with a care model providing comprehensive primary care, can cost just $12,000[iii].

Budget Request:

AFHTO asks the Ministry to support expansion of interprofessional team-based care across Ontario. This can start with communities that do not have a team at all and then expand to all Ontarians who wish for it. Allow for local level innovation but ensure that primary care providers are involved in the co-design on what would work best for them in their communities and for their patients.

AFHTO supports the Ontario College of Family Physicians' (OCFP) Patient Medical Home (PMH) vision that every family practice in every community across Ontario should be able to offer comprehensive, coordinated and continuing care to their populations through a family physician or nurse practitioner working with an interprofessional health care team. Freed from maximizing volume and supported by a well-functioning multidisciplinary team, primary care physicians would then have time to do the proper workup and complex care management required[iv]. To ensure there is true integration between the various professions, it is important that primary care providers be part of the co-design.

As noted by Dr. Steini Brown and Dr. Kevin Smith, "*if we fail to include clinicians, particularly physicians, in the design, implementation and leadership of integrated care, we increase the likelihood of failure*". [v]

An example in action: Guelph Family Health Team

The Board and staff set a strategic direction that decreased barriers to access at the community level and created a patient-centred culture across the organization. The Guelph FHT expanded care beyond the FHT's rostered patients as they were committed to improving overall health system effectiveness and efficiency, and to increasing accessibility to primary care for the entire community.

The FHT's diabetes program had always been open to the whole community and provided good experience to build on. Under the banner of Health Links, the FHT began to open up other services, beginning with home visit nurses and social workers in the Primary Care at Home program. Other group programs are now also being made available in the community. Their next objective is to embed some services in non-FHT affiliated physician offices to see more of the community receive access to interprofessional team-based care.

4. Supporting the Quality Agenda by Supporting Improvement

Performance measurement is 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.

Primary care teams have now submitted Quality Improvement Plans (QIP) for close to a decade and measurement is ingrained in their culture. Additionally, 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 welcome news in a fiscally constrained health care environment.

Budget Request:

In the 2019 Budget, we ask the Ministry to look at existing models of performance measurement in primary care and to facilitate and fund a strategy that spreads it across the system. This strategy must measure outcomes that matter to patients and providers while assisting in lower system costs. To support this, there needs to be further investments in quality improvement practice facilitators to help support front line providers.

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.

But we need to move away from measurement and into actual improvement – taking that data and being able to utilize practice facilitation supports in order to improve patient outcomes is the next step needed to highlight the value for dollar. The best way to do this is to move away from reliance on process measures (often with little evidence of impact on outcomes) toward outcome measures, especially those which are patient-reported, enhancing the meaningfulness of quality reporting while reducing the electronic health record documentation burden[vi].

An example in action: Northeastern Ontario Family Health Team Network

As primary care teams become increasingly careful with resources, collaborations and partnerships are often the key to creating new programs. In northeastern Ontario, FHTs have taken this idea to the next level. Twenty-seven teams have joined together as members of the Northeastern Ontario Family Health Team Network (NEOFHTN) to implement a large-scale quality improvement (QI) program tailored to the requirements of their communities.

The genesis of the NEOFHTN QI program recognizes the importance of the standardization of program measures to facilitate a shift in focus from measurement and reporting to quality improvement. The network has committed to this approach and has agreed on a common set of indicators to track performance for the nine most common programs across the region. These indicators will yield information that will help improve patient experiences and care. Standardizing these measures will allow the teams to make comparisons, share lessons and collaborate.

The network has chosen 24 indicators. By identifying areas that require quality improvement, the teams will be able to expand the common indicators for more programs to address problems in the upcoming year. This will effectively support patient-centred care.

The Association of Family Health Teams of Ontario (AFHTO) is the advocate, network and resource centre for interprofessional comprehensive primary care teams. Our members make up 184 family health teams, 5 Nurse Practitioner-Led Clinics, 1 Community Health Centre, 1 Mississauga Integrated Care Centre and 1 Indigenous Interprofessional Primary Care Team, collectively taking care of over 3 million patients.

---

[i] Starfield et al, "Contributions of Primary Care to the Health Systems and Health", Millbank Quarterly, 83(3), 2005.
ii North East LHIN (2011). LHINfo Minute. As quoted in Enhancing Community Care for Ontarians, ECCO 2.0, Registered Nurses Association of Ontario, April 2014.
[iii] Hollander, M. et al, "Increasing Value for Money in the Canadian Healthcare System", Healthcare Quarterly, 12(4), 2009.
[iv] Goroll, A. H., "Does Primary Care Add Sufficient Value to Deserve Better Funding", JAMA Intern Med, Jan 28, 2019, https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2721034.
v Brown, A. & Smith, K., "How to Deliver Integrated Care Models: Lessons from Ontario", https://healthpolicyblog.ca/2019/01/24/how-to-deliver-integrated-care-models-lessons-from-ontario/.
[vi] Goroll, A. H., "Does Primary Care Add Sufficient Value to Deserve Better Funding", JAMA Intern Med, Jan 28, 2019, https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2721034.