afhto association of family health teams of ontario

Bill 74: *People's Health Care Act, 2019*

Submission to the

Standing Committee on Social Policy

April 2, 2019

Introduction and overview

The Association of Family Health Teams of Ontario (AFHTO) would like to express their appreciation for the opportunity to submit a response and present to the Standing Committee on Social Policy on Bill 74: The People's Health Care Act, 2019.

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 185 Family Health Teams (FHTs), 6 Nurse Practitioner-Led Clinics (NPLCs) and other team-based health care providers, who provide interprofessional comprehensive primary care to over 3.5 million people in over 200 communities across Ontario. Collectively our membership is made up of over 6,000 front line health care providers, including close to 3,000 family physicians.

AFHTO supports the direction that is laid out in the Bill, especially as it relates to creating integrated care delivery systems that are now coined 'Ontario Health Teams'. For too long, patients and their families have experienced fragmentation, as they fall through the cracks of our multi-faceted and siloed health and social systems of care. The intent of this Bill to create a system that is seamless and integrated is something that AFHTO and its members in primary care have been advocating for years and it is our hope that as we look at how to implement these new models of care, primary care is at the forefront of leading the development. AFHTO looks forward to continuing to work with government in true collaboration as they begin implementation of the proposed new legislation.

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

"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 seminal 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 – the long-term relationship each person has with their family doctor 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)[ii,iii,iv,v]. The ability of primary care providers to access and coordinate care for their patients is vital to ensuring patients receive the health care they need and don't slip through the cracks. Coordinated, integrated primary care keeps people out of the hospital, and can address hospital overcapacity. Health resources are used more efficiently when people don't end up in the hospital or emergency room unnecessarily. Without strong team-based primary care, the system risks being overloaded with illnesses and injuries that could be better treated or prevented on the primary care frontlines.

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 health and often social systems 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 by providing clinical evidence-based assessment and treatment recommendations.

Strengthen the foundation needed to improve health care

Dissolving the LHINs and creating one agency – Ontario Health – to oversee Ontario Health Teams (OHTs) provides the opportunity for primary care to directly coordinate and integrate care locally to meet the needs of the population they serve. The opportunity for providers to discuss how that care coordination would best work to meet local needs is an excellent opportunity – as long as primary care providers are part of that conversation. Primary care is the entry point to the health care system. These are the health care providers who know the patients and their families the best. This is why it is critical that primary care be key in the formation of Ontario Health Teams and be allowed to lead its development. With well-coordinated, integrated primary care at the local level, patients will be less likely to fall through the cracks as there will be more seamless transitions of care through the system.

We have seen the challenges in other jurisdictions of integrated care that is led by a hospital. While hospitals absolutely play an important role in health system integration, a review of Accountable Care Organizations (ACOs) in the U.S. (which one can say the OHTs are loosely modeled after) success factors and appraisal of evidence clearly identified that hospitals that did not have primary care leadership had mixed results in actual cost savings, efficiencies and better patient outcomes[vi]. In contrast, those ACOs that were primary care led (specifically physician-led) had greater success in terms of cost savings and patient outcomes. *"If we fail to include clinicians, particularly physicians, in the design, implementation and leadership of integrated care, we increase the likelihood of failure"*[vii].

Evidence also showed that interdisciplinary (primary care) teams were associated with improved medication reconciliation, reduced service utilization, stronger provider buy-in, meeting the needs of the most vulnerable populations from rural locations, and reduced workplace stress[viii]. The deliberate inclusion of and supports for interdisciplinary teams were valued by providers and impacted their decision to join an ACO[ix]. In Ontario, family health teams (FHTs), nurse practitioner-led clinics (NPLCs) and other team-based models are already providing integrated care in over 200 communities across Ontario. But at the moment only 30% of Ontarians have access to this care. As this Bill is intended for integrated care being provided to all Ontarians, it is important that primary care be foundational in the OHTs. Team-based care can apply what they already know about collaboration, and expand it alongside more providers in a region, such as hospitals, palliative care providers and home care providers. Interprofessional primary care teams like FHTs and NPLCs have been providing integrated care from the moment they opened their door and are best to lead the development of an OHT in their community.

Recommendation #1:

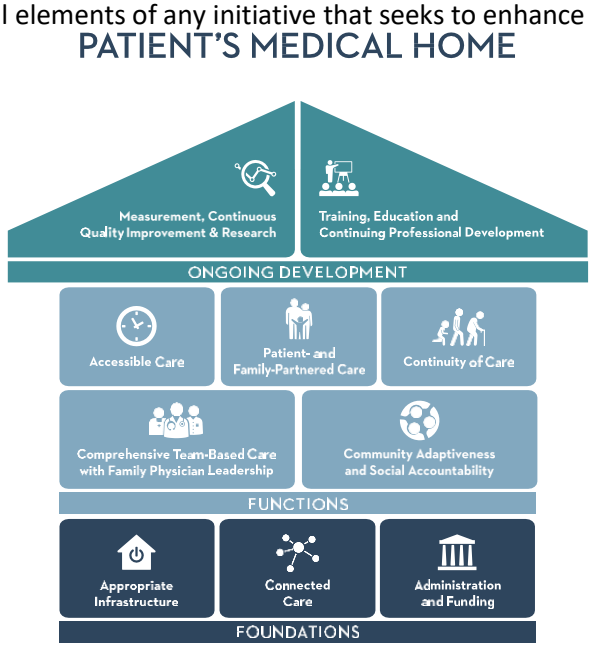
The *People's Health Care Act* notes in section 29 (2)(a) that an OHT would need to deliver at least three of several listed health services, with primary care noted as one option. Interprofessional primary care teams like FHTs and NPLCs are already providing integrated care and would best be a part of these larger integrated care teams. Primary care is also a critical part of any team as it is people's entry point to the health care system. It is what keeps people out of hospital. *It is recommended Bill 74 require primary care to be part of an OHT[1]. It is also recommended that primary care teams be the lead of an OHT in areas with highly functioning teams who can continue to be leaders in delivering truly integrated care.*

[1] NOTE: Relationships are foundational in primary care and it develops over time – while leadership in the creation of an OHT absolutely should absolutely include primary care providers (including family physicians), it should be noted that the nature of an integration should start out voluntarily as trust starts building between all health care sectors involved in the integration.

Patient Medical Home vision for truly integrated care

Bill 74 has a focus on and commitment to the effective integration and delivery of services. It is important to remember, however, that it is not always a family physician or nurse practitioner providing care. This is important for both the quality of care – the needed care may best be delivered by another provider – and for the capacity of family physicians and nurse practitioners.

The College of Family Physicians of Canada (CFPC) has presented the concept of a Patient Medical Home (PMH) and has recently released "Family Practice – The Patient's Medical Home 2019." As Ontario Health Teams (OHTs) start being developed, it is important to have a vision. AFHTO endorses the CFPC vision of the PMH as it has all the principles that are required for effective integration of care. Key features of this vision, such as accessible care, patient and family centred care, continuity of care, care that is socially-accountable and adaptive to the local community, and comprehensive team-based care are integral elements of any initiative that seeks to enhance system integration.



-The Patient's Medical Home 2019, The College of Family Physicians of Canada

PMH 2019 recognizes that a patient will not be able to see their personal family physician at every visit but can rely on the PMH's qualified team of health professionals to provide the most appropriate care responding to patient needs with continuous support and leadership from family physicians[2]. Primary care that feature health care teams have a greater capacity to offer timely access to care for their patients, with improved access and reduced wait times, resulting in greater patient satisfaction[x]. These elements align with the IHI Triple Aim - enhancing patient experience, improving population health, and reducing costs— which is widely accepted as a compass to optimize health system performance[xi]. With the inclusion of improving the work life of health care providers as part of the Quadruple Aim, front line providers will feel supported (especially given their increased workload burden and burnout) as working in a team improves the work life of health care providers, which keeps them engaged and continually providing patient-centred care.

2 AFHTO recognizes that Nurse Practitioners (NP) are also MRPs (most responsible providers) and as such, should be noted that notation related to family physician leadership can be applied to NP leadership as well.

And ensuring patient-centred care is a key element to the PMH – we were pleased to see in the preamble of the Bill there is mention that *The people of Ontario and their government, Believe that their health care system should be centred around people, patients, their families, and their caregivers* which aligns with the central objective of the PMH. Earlier in 2019, the Minister's Patient and Family Advisory Council (PFAC) described a vision that recognizes the importance of patients, families and caregivers as partners in health system delivery and, indeed, in health system development.

Recommendation #2:

While there is notation in the preamble about the importance of the patient in the development of Bill 74, it is important that there be a strong vision. The Patient Medical Home encompasses that vision – it puts the patient and the family in the center while also recognizing the importance of the Quadruple Aim through its pillars. As additional support to Bill 74 implementation and the PMH vision, the PFAC recently announced Patient Declaration of Values for Ontario which should be the grounding in the development of any OHT in the province. It is being recommended that Bill 74 (Part IV – Definitions) be strengthened by including the vision of the PMH when speaking about the Integrated Care Delivery Systems, with specific notation made to the PFAC Declaration of Values.

Collaborative governance with good change management support

A key success factor for any integrated system is governance – as we noted above already, it is important for primary care to lead the development of the Ontario Health Teams in the province. But to get to service level integration there is also a need to ensure there is trust and relationship building being done at the governance level. Studies show that a shift away from fee-for-service (or volume driven) reimbursement to population based global budget models is a contributing factor to successful ACO outcomes[xii]. With the intent of moving to one capitated budget for all those providers who participate in the development of an OHT, it will require concerted efforts of the various Boards of Directors to come together to ensure there is good line of sight around expectations, responsibilities and, indeed, accountabilities. This can only happen if there is, at minimum, collaborative governance.

Collaborative governance is defined as *the processes and structures of public policy decision making and management that engage people constructively across the boundaries of public agencies, levels of government, and/or the public, private and civic spheres in order to carry out a public purpose that could not otherwise be accomplished*[xiii]. For integrated health care systems, it is truly placing the patient at the center of care – not the organization where the care is being delivered. And that, for many, will require tremendous about of change management support. Health care organizations have been funded in siloes for decades with targets and indicators that are very specific to their funding. A move towards a shared budget will require a shift in thinking, new partnership building and fundamentally, trust.

Ensuring that participation in the development of an OHT start off voluntarily will allow those who are ready to make a change in the way they deliver care to patients participate with their eyes wide open. Coercing participation or taking a punitive approach to forcing participation by withholding supports will only anger the providers in the field and will cause a friction that will be hard to manage between the funder and the health service providers. However, it is imperative that the groups that do come together to look at integrated service delivery of care also look at integrative governance to care – defining what governance looks like initially should be done from the lens of collaborative governance and with the introduction of tools like memorandums of understanding, partnership agreements etc.…but as the relationship starts to mature, it will be difficult to have one fund holder for the partnership working with many different Boards.

It is also not known how individual family physicians fit into the equation as they are not defined specifically as a health service provider. The definition of an HSP is open-ended and through regulation may include 'any other person or entity or class of persons or entities that is prescribed' (Part 1, Section 2). AFHTO is not taking a position on the definition of the HSPs but would like clarity of how individual family physicians or physicians working in the various primary care models fit given the ambiguity of this definition of an HSP.

Recommendation #3:

AFHTO recognizes that the move toward an integrated care delivery system at the local level will require substantial change management support, not just for the providers who deliver the care but also for the Boards who have been charged with fiduciary and duty of care responsibilities. It is with that in mind that we recommend that there be an addition in Part IV of the Bill under Integrated Care Delivery Systems that specifically outlines governance of integration, including principles of collaborative governance and what the requirements will be of the Boards for the HSPs that are coming together.

Integration of Mental Health and Addictions and Home and Community Care with Primary Care

Ontarians are already in the midst 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.

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.

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. Bill 74 is taking a step in the right direction, but we need to ensure those services are available to all who need them, as they are within team-based care models.

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. And it is especially important in mental health and addictions support.

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, care coordinators/system navigators would best be embedded 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, which misses the opportunity to keep people out of hospital in the first place. As experienced by AFHTO members, communication back to primary care providers remains poor, even after the CCACs were dissolved and the care coordinators were placed in the LHINs. In fact, direct service delivery put the LHINs in a conflict of interest position, hampering their ability to be objective in their primary role of health system planning. LHINs were supposed to be in the business of planning, integrating, funding and evaluation local health systems – and not in the business of delivering health services.

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. Care coordination and system navigation is a function of primary care and should be foundational in the development of an Ontario Health Team – embedding mental health and addiction and home and community support in primary care allows for seamless transitions of care and a one point 'hub' or 'home' for their care journey.

Recommendation #4:

As Ontario Health starts becoming operational, we recommend it stay true to Part II (The Agency) Objects and General Powers and support the health service providers in the sector as outlined in the Bill and NOT be involved in directly service delivery, specifically in the area of home and community care. We ask the relationship between primary care and home and community care be strengthened 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. It should also be noted that in any application for an OHT, there should be concerted effort made to ensure that primary care and mental health and addictions supports are integrated and it is our recommendation to ensure this remains a priority at each of the local levels.

Conclusion – A Step in the Right Direction

AFHTO is pleased to see the government's commitment towards truly integrated patient-centred care. Health care providers in interprofessional team-based primary care have been working in integrated systems of care for years but have felt that there was still fragmentation in the care they were able to provide, mainly because of the disconnect between the siloes of care, from acute to home care. Primary care is the entry point to the health system and for many patients in the province, the relationship they have with their family physician or NP is everlasting and built on trust. A truly effective, high quality health care system needs to be coordinated and integrated and foundationally built in primary care, which will ensure we are delivering a sustainable health system for the future. Team-based primary care is popular with its 3.5 million patients because it provides a better patient experience, helping people avoid long and confusing waits for referrals and getting lost navigating our complex system. We need to expand this experience so that every Ontarian can get access to the care they need when they need it. We look forward to working with the government as it starts the journey on implementing this very important health restructuring plan and creating a new system of care that is focused around the patient.

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