Hallway Healthcare: A System Under Strain

A response to questions posed by The Premier's Council on Improving Healthcare and Ending Hallway Medicine first interim report

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Introduction

"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. The goal is to keep people out of hospitals in the first place – this is how to address hallway healthcare.

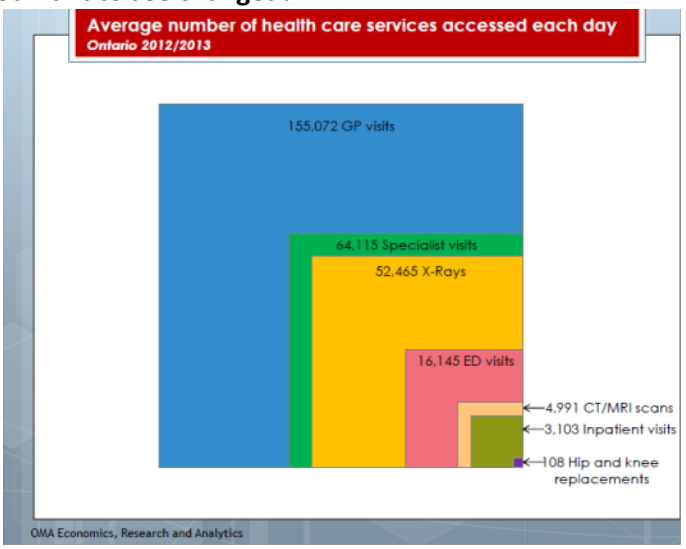
Primary care – the long-term relationship each person has with their family doctor or nurse practitioner – is key to keeping people healthy, and to keeping health system costs in check. Evidence demonstrates that investment in primary care is associated with improved system quality, equity and efficiency (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 do not 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 do not 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 the entry point to the health care system. And AFHTO's 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.

AFHTO is pleased to offer some feedback to the Premier's Council on Improving Healthcare and Ending Hallway Medicine to consider as they work towards creating a sustainable, well integrated and truly patient-centred health care system.

Responses to Questions

1. What do you think is working well, that you would *not* want to see changed?



Foundationally people that work in health care do so because they are truly passionate about patient-centred care and ensuring that they support patients, families and caregivers in their health journey – that could be from well care with preventative care, to multi-morbidity care with the addition of chronic diseases, to end of life care which may include palliative care. Primary care providers support the continuum of care – they are the quarterback for the patient, often coordinating their care with other parts of the system while managing not just the medical care but the emotional and social care that is important in keeping people as healthy as possible. The only true 'integrators' in our current system are primary care providers, who serve over 155,000+ patients **per day** across all sectors in our system – patient's home, office, hospital, long term care, hospital care, etc. Putting that in context of services that are provided elsewhere in the system (like 3,100 in-patient visits),

primary care is where the majority of people receive their care on a daily basis and that should not change.

What should not change is a shift away from preventative care – over the last decade patients are taking more ownership of their health and are looking at ways to remain as healthy as possible. This could be through preventative screening for cancer or immunization against the flu…it is imperative that the focus on prevention and wellness not change and in fact, it needs to be more robust so we can have more targeted interventions on keeping people out of the hospital. More funding needs to be provided to population health which includes a focus on social determinants of health and renewed attention to prevention and wellness care.

What should also not change are governance models that incorporate the importance of clinical governance as an important skill. As team-based care has now moved to skills-based Boards, governance still includes the actual most responsible providers (family physicians, NPs) at the table engaging in strategic direction and visioning around what would work best for their patient population. They know their patients and families the best and should be involved in making decisions as it pertains to the direction of the organization – we have worked really hard to create a cadre of governance experts and engaged clinicians who want to participate in health restructuring so it will be important that their voice remains strong at the governance level.

Relationships, relationships, relationships…built on the foundation of trust! With the move towards more integrated care it is imperative that change management be paramount in the supports provided, coupled with time needed to build cohesive and trusting relationships.

2. What local innovations in health care are you aware of that might help improve/change the way we deliver health care in the future?

Innovations are plentiful in primary care, especially team-based primary care where there has been a focus on integration and population health for the last decade. Every year AFHTO has an annual conference where we recognize our teams with a 'Bright Lights Award' for innovations that they have implemented and have looked to spread. And these innovations are through the patient lens with a focus on quality improvement and increasing efficiencies to care while ensuring people are working to their full scope. While there are a lot of examples of what teams are doing locally to support health care innovations, below are some highlighted examples:

- Belleville Nurse Practitioner-Led Clinic's Primary Care Low Back Pain Project – this integrated initiative uses musculoskeletal experts (physiotherapists and chiropractors) to provide non-medical care for individuals who do not have access to private benefits to help manage their pain. For many, the use of narcotics including opioids is the default – with the implementation of this initiative, more than 80% of patients reported less reliance on medication, including opioids, and there was a decrease in emergency room visits and referrals for diagnostic imaging. The integration of MSK experts in a primary care team that looks at the holistic health of a person is something that needs to spread – patients want care from someone they trust, someone who knows their whole story. And a small HR investment in MSK experts not only increases patient satisfaction, but it also helped reduce health care costs while dealing with the opioid crisis that currently exists.
- Manitoulin Central Family Health Team Mobile Teleophthalmology Program – Manitoulin Island is a remote area with scant health resources and a high proportion of their community living with diabetes. With the nearest ophthalmologist over a two-plus drive in Sudbury the FHT realized that they needed to implement an innovative approach to diabetic retinopathy

screening for their patients (rostered or not) closer to home. And that is where they employed the use of the Ontario Telemedicine Network Mobile Teleophthalmology Program (TOP) which allows ophthalmologists across the province to interpret images and provide timely feedback to the team on the Island. This is how care needs to be delivered in communities where resources are not plentiful – through the use of technology for care close to home.

- Sherbourne Health Centre Family Health Team Innovative cervical cancer screening for sex-trade workers – screening for cervical cancer is a preventative measure that many primary care providers do on an ongoing basis. But screening is a problem for a population that is transient and struggling with issues like poverty, homelessness, addictions and unable to seek preventative health care, like Sherbourne noticed with sex-trade workers. Knowing that the sex-trade workers would not come to the clinic, but also knowing that they have a high risk of developing and dying from cervical cancer, Sherbourne tackled that problem by taking cervical cancer screening to them by using a mobile bus during unconventional hours and with a peer leader to reach this marginalized and vulnerable group. A simple but relatively low-cost project that again speaks to providing care where the patient needs it most.

These are just three examples of local level innovations that are occurring across the province but each of them have a common thread and that is to provide care closer to home, using low tech resources (like buses and people) or high tech solutions (like virtual care) but customizing the innovation to what makes the most sense in their community.

As our colleagues in the NHS in UK have said (and what has been echoed throughout the world that have high performing health care systems), primary care is designed as the first port of call for patients, and the central provider of their needs throughout their life cycle. They know their patients and families best. Primary care providers have unique training in first contact diagnosis and management, being able to manage undifferentiated and emergent clinical presentations safely and efficiently[vi]. Research over decades in many jurisdictions confirms that they achieve high quality outcomes at lower cost than other specialties when placed at the centre of a healthcare system.

3. How do you think most people will want to interact with their healthcare providers in the future?
People want to get their care closer to home by a team of providers that know them best – that is their primary care team where they get most of their care throughout their lifespan. It is where their stories are the most robust in the shared team electronic medical record; it is where the family physician or Nurse Practitioner is providing comprehensive care from womb to tomb; it is where there is trusting relationships with people who have seen them during celebrations like a birth of a child to challenges like the death of a loved one. It is their Patient Medical Home. People want assurances that they have a 'hub' that has their story all under one roof, a hub that is well connected to other parts of the health and social systems through integrated information systems, a hub that has their well-being top of mind. And as part of that, it needs to be a place that is constantly adapting to patient needs which also includes embracing technology and ensuring that information is placed in the hands of the patient and their family.

We are already seeing innovations in the adoption of digital health for patient care being embraced by the health care community, but it is moving slowly – many primary care practices have already started using secure encrypted email or text with their patients as a way to communicate around any inquires they may have but these approaches are not well integrated in the patient's EMR. Patients want an electronic solution that has their full story which is not an unreasonable request. This not only includes their health records from other parts of the health care system (like hospitals, mental health agencies,

home care) but they also want to be able to access their record fulsomely. In order to be truly patient-centred, the patient's health record should be in the hands of the patient and who s/he thinks should get access is their decision. The electronic medical record should be part of the provincial electronic health record that incorporates all the patient information - with our digital assets and the move towards alignment, patients want a record that is up to date and accessible regardless of what part of the system they are receiving care. And full recognition that this the patient's record and not the health system's.

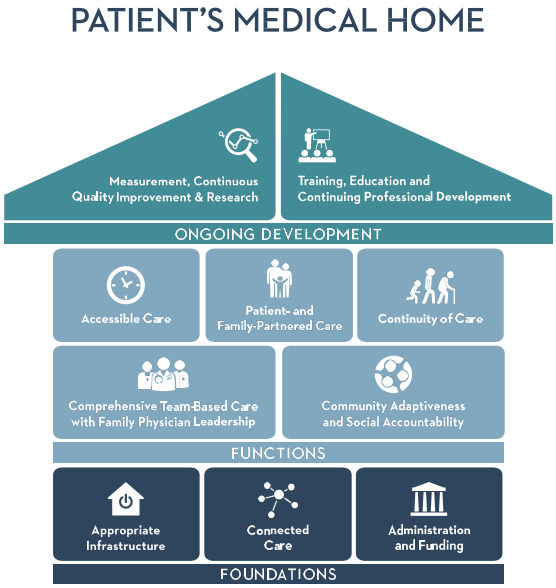
Face time with the provider is important but when it is not needed, patients want adoption of virtual care. Driving or taking public transit for a 5 to 15-minute visit is neither patient-centred nor truly accessible care – in rural or northern Ontario it can take a few hours to get to a provider and in Toronto, parking fees or trying to access public transit can be a deterrent to seeking care. In a world where information is at your fingertips when you need it, why can't health care be there too? Patients will want convenient access to their health care team but this cannot happen without changes in the way the current expectations are set up – this includes recognition of time that is needed to provide virtual care (so that is built during the day and not in the evening hours), billing requirements (virtual care should include necessary billing codes) and the need for an integrated one patient health record.

4. How do you think people can best be supported to remain longer in the community while receiving treatment/care?

As the population ages and more people spend more years living with multiple chronic conditions, demand on health care services will continue to rise. Exacerbations of chronic conditions are already the biggest source of the rise in demand in hospitals[vii]. However, sub-specialist/specialist care is not the most clinically appropriate or resource efficient approach to meeting the needs of patients living with multiple complex and chronic conditions.

They are better served by generalist care, delivered by collaborative multidisciplinary teams integrated around the patient and their carers in the community, and taking a proactive and anticipatory approach[viii]. While it is tempting to look at the pressures on hospital beds and ask how to increase bed capacity or flow rate through the hospital, the system will be more sustainable and provide a bigger impact on patients' lives if we ask how to prevent the exacerbations that are driving so much of the demand growth[ix]. Improved access to integrated interprofessional care oriented around the patient's primary team is cheaper to achieve than hospital capacity growth and provides a more appropriate and sustainable solution to the changing needs of the population[x].

Ontario needs a vision – a vision that provides a roadmap to all health care providers on what it means to provide truly integrated patient-centric care. The Patient Medical Home (PMH) and the Patient Medical Neighbourhood (PMN) is that vision and one that provides a very clear blueprint of how care should be delivered. The College of Family Physicians of Canada (CFPC) has presented the concept of a Patient Medical Home (PMH) and released its updated version earlier this year. The *"Family Practice – The Patient's Medical Home 2019"* is a vision that can be adopted 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[1]. 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[xi]. 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[xii]. 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 health and well-being of health care providers, which keeps them engaged and continually providing patient-centred care.

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

[1] AFHTO recognizes that Nurse Practitioners (NP) are also MRPs (most responsible providers) and as such, should be noted that references made to family physician leadership can be applied to NP leadership as well.

For people to remain healthier at home, Ontario needs to adopt a vision for a truly integrated, patient-centric model of care by endorsing the Patient Medical Home and Neighbourhood as the framework that all Ontarians can expect from their health care system. Without a vision, we cannot strive towards creating a high performing health care system given everyone's expectations are limited to only their siloed funding for care and service delivery.

5. What additional actions are required to help solve the challenges identified in the Council's first report?

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.

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. As the report suggests, most mental health and addictions issues are more appropriately treated in the community but with long wait times for treatments, many people seek hospital care to get faster access to care. Now is the time to invest in mental health and addictions support in community care, with an emphasis on support and recovery and minimize the need for admission to hospital. And the best place to get that care is in primary care, where they have developed trusted and long-term relationships and where the provider knows their whole health story.

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. We need to work directly with primary care and mental health care providers to ensure that mental health and addictions investments are integrated in primary care.

And a huge barrier to that integration is in the area of care coordination. AFHTO's 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.

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[xiii] 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.

And this lack of coordination is placing increasing burden on caregivers – as the Report notes, the strain that is being felt by family and friends who are caregivers of patients are the highest they have ever been. It has also led to feelings of helplessness by providers in the system who are experiencing burnout – how can we as a system strive for the Quadruple Aim when the expectations we place on providers and loved ones are so unrealistic, without the proper tools, supports and resources in place? This is unsustainable and will lead to less people choosing to work in health care – how will we manage the increasing complexity of our patients when we will not have health care resources to support them?

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. Together, these measures will bring greater efficiency and patient-centredness to care. Care will be integrated, allowing for seamless transitions of care for patients, with less individuals seeking care in the hospital.

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[xiv].

As noted above, AFHTO supports the Patient Medical Home 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[xv]. With the increase of chronic diseases including diabetes, hypertension, mental health and dementia to name a few, primary care teams are well positioned to support through their health care journey by also finding ways to deal with the social determinants of health like food security and income stability. And patients want that level of support with their trusted primary care team members.

There needs to be 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.

To better understand how AFHTO members are making a difference in their communities and across the province in the four theme areas (integration, innovation, efficiency and long-term capacity) please see below for a few examples of great successes already underway. Please link on the hyperlinks for a synopsis of their stories.

i. **Integration**:

- Couchiching FHT School Success Program – this program integrates the health and well-being of a child by building partnerships with local caregivers and educators. If a child with a health issue (mental, physical or behavioural) is affecting their ability to learn, educators can refer the family directly to the School Success Program where the FHT's interprofessional health team evaluates the child and then works closely with the family and school to co-design and implement a program that is individualized to the child's needs, whether that is medical treatment, pharmacotherapy or counselling. This is integration across the health and education systems – a model that can be implemented across the province so that children are well supported, especially during their developmental years.
- Central Lambton FHT Mental Health Success – in the rural settings across the province, mental health services are not plentiful, but the needs are great. Asking patients to get their care in larger centres are not the answer for true patient-centred care so Central Lambton FHT formed a strategic partnership with the Canadian Mental Health Association (CMHA) to co-locate CMHA resources on-site with the FHT. This has allowed for cross-training and co-facilitation of groups between the organizations, while increasing primary care access to a Rapid Assessment Intervention Team designed to support primary care youth in the community. Trust led to new approaches of care that not just benefit the patients, but also the providers in both parts of the system.

ii. **Innovation**:

- Espanola & Area Family Health Team; Powassan & Area Family Health Team; City of Lakes Family Health Team; Great Northern Family Health Team; East End Family Health Team Technology-Based Falls Prevention Program – these six teams in Northeastern Ontario worked with Public Health and the Stay on your Feet initiative to create an innovative approach to falls prevention. Data showed that one in three seniors would have a fall within one year so this program integrated a falls risk screen and assessment tool into the EMR and embedded links to community prevention and education resources (like exercise classes). This innovation allows the primary care teams to work with at-risk seniors, proactively working to keep them on their feet.

- Marathon FHT HARMS Program for Safer Opioid Prescribing through Systematic Risk Stratification and Urine Drug Testing – this program is a novel approach to the safe prescribing of opioids in chronic non-cancer pain. It uses universal risk stratification and urine testing to identify high-risk patients, keeping an eye on their opioid use and if addiction is identified, treating the addiction. Opioid addiction is even more prevalent in the north than other parts of the province so this interprofessional team-based approach to dealing with patients with chronic pain has allowed the team to have better control over opioid use in their community.

iii. Efficiency:

- Thamesview, Tilbury District and Chatham-Kent FHTs Integrated Case Management Model for the Frequent User – these three FHTs have worked together with their local Health Link and have adopted an integrated case management model that has improved the health care experience for frequent users of the health care system. The adoption of an intensive case management approach that focused on the needs of individual patients with complex needs and connecting them rapidly with community care (with the development of an integrated care plan) led to a 28.8% reduction in visits to the emergency room and a 25.9% decrease in hospital admissions in just six months of implementation.
- Markham FHT Stopping a Potential Outbreak in its Tracks – when a positive measles exposure occurred in their clinic, the providers at Markham FHT were able to turn to its electronic medical record and within four hours, the FHT was able to provide public health with a list of patients who would have been in the clinic during the time of exposure. They were also able to determine which staff members were present that day and within a half hour, the team had arranged for the staff and physicians to have urgent measles blood tests following exposure. This was not a high touch innovation activity but highlighted what an efficient health team can do to prevent a possible outbreak which would have had serious consequences for the community.

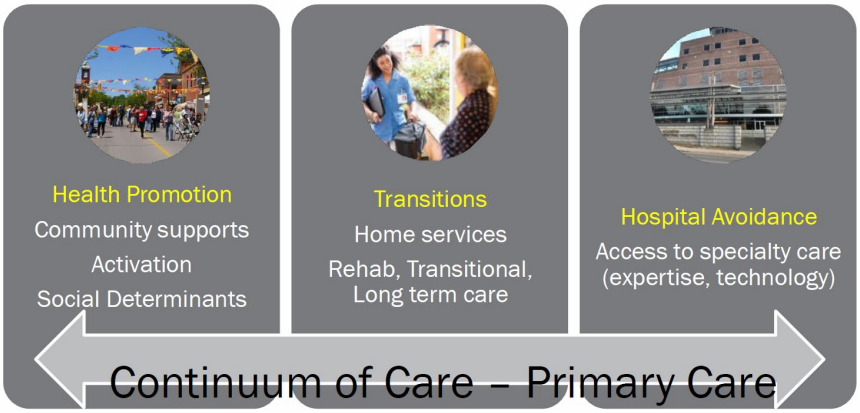
iv. **Long-term Capacity:**

- Peterborough FHT Full scope RNs in family practice improve access, continuity and reduce ER visits – long-term capacity planning is also ensuring that primary care providers are being used to their full scope. This FHT introduced a full scope role for its RNs by embracing nursing mentorship and a shared leadership model to support a healthy team dynamic. Full scope nursing was provided in several areas: preventive care (well-baby, prenatal, well woman), chronic disease prevention and management (lifestyle, smoking cessation, asthma, COPD, diabetes), care for the elderly (cognitive screening, advanced directive, palliative care), acute care (UTI, respiratory, wound care), care coordination for complex cases, procedures and specialized care (trans care, ADHD assessments). By allowing full scope nursing it freed up the time of the physicians so that they could provide care for patients that required more support while increasing the satisfaction of the all team members.
- Prince Edward FHT Hospital@Home Program: Bringing the Hospital to the Patient - Prince Edward FHT's Hospital@Home program recognized that there was a limited amount of resources available in a health system that was already under a lot of stress and when given the option, patients would prefer to heal in the comfort of their home rather than in a hospital setting. This innovative initiative offers appropriate acute care patients the option of at-home treatment, diverting them to an initiative that wraps the necessary care around them in their own surroundings. When allowed to work collaboratively and with a lens of

truly integrated patient-centred care, integrated primary and home care will help address the current fragmentation that exists.

6. **Are there any risks and/or unintended consequences the Council should consider when reviewing the proposed actions?**
While primary care has not often been involved at the forefront of new policy initiatives, we have identified a strong willingness on behalf of primary care leaders to ensure primary care plays a central role in delivering more joined-up care[xvi]. We have repeatedly heard that primary care leaders' chief frustration is not being able to deliver more of the potential of primary care in driving improvement. *"If we fail to include clinicians, particularly physicians, in the design, implementation and leadership of integrated care, we increase the likelihood of failure".* [xvii]

A notional engagement strategy that is limited to the written word will not engage primary care providers – this is a sector that truly believes in the power of relationships and in order to hear about what would work best, it is important to listen to their stories. There is some really good work that is already happening in the province and it is important to build on these successes – it will be important to not tear down this work but look at ways to expand and spread.



-Couchiching FHT Orillia Area Approach to Care

The continuum of primary care is not just comprehensive but across the full spectrum of a patient's health journey, where integration and coordination are part of the expectations. A more comprehensive primary care engagement strategy would meaningfully engage with primary care providers (and their patients) around what would work best for them, especially as we know that primary care is truly the foundation of a high functioning health system and the most utilized part of the health care system.

7. **List and briefly describe concrete suggestions your group has that could support primary care involvement in the scale and spread of the Ontario Health Team model provincially and locally?**
"Integrated care" ISN'T integrated unless it's built around primary care[xviii] - jurisdictions around the world would agree with this statement as does AFHTO and its members.

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. Therefore, 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.

Evidence shows 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[xix]. The deliberate inclusion of and supports for interdisciplinary teams were valued by providers and impacted their decision to join an ACO[xx].

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 Ontario Health Teams are 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.

AFHTO has been working in collaboration with the Ontario College of Family Physicians (OCFP) to develop the first-ever Ontario primary care virtual network. With backbone support from the Change Foundation and coaching support from Dr. Robert Varnum, GP Section Head in the NHS UK, our inaugural meeting on April 25, 2019 with 150+ engaged primary care leaders led to a litany of ideas of how we can help with the health system restructuring currently underway. Tangibly the following supports/tools/resources can be developed/shared to support primary care involvement in the scale and spread of OHTs across the province:

- The development of a 10 point 'Action Plan' to encourage 'joined-up'[2] care – the UK has developed a 10 High Impact Actions to release time for care document that is a blueprint for what is needed for each general practice in order to realize their full potential in delivering joined-up care. Ontario's virtual primary care network would like to develop a similar document for primary care in the province that will be built on the pillars of the PMH.
- Working with the Change Foundation will also allow AFHTO and OCFP to utilize their impressive skillset in the areas of co-design and integration with a focus on change management – the OHT initiative requires new partnerships to be crated and that is going to require time and coaching/mentorship. We are hoping by working together we can provide that. And working with the OMA and the Section of General and Family Practice at the OMA will allow us to collectively have a strong vision and a cohesive voice for the development of OHTs that are led by primary care.
- Along with the change management is the development of practical tools that enable partnerships – AFHTO has worked with the OMA over the last few years to co-create partnership agreements (data sharing, access to EMR), Memoranda of Understanding templates (expansion of team-based resources) and other tools to help support the team-physician dynamic and ensure that all parties are working in a relationship that is well

[2] The UK has moved a more patient-friendly label for integration which is known as joined-up care which resonated quite a lot with the providers on the call.

understood. This will be important to consider as physicians are integrated into OHTs and is something that AFHTO has focused on since the inception of the FHT initiative.

- To encourage a culture of integration locally, we would like to support primary care and primary care providers with ongoing education around the importance of governance in creating an integrated health care system, built on patient safety – this is something AFHTO has been doing for years with their members, through our *Effective Governance for Quality in Primary Care* training. In the last few years, the focus of that work has shifted to collaborative governance with the lens of coordination and integration where appropriate. This work is critical in the ongoing development of OHTs and we hope we can continue to support teams.
- For many years, AFHTO and its members have embraced quality and quality improvement as foundation to their work, especially as it relates to demonstrating better patient outcomes and patient safety. While many primary care teams have been measuring performance, this will be new for the majority of our primary care colleagues, especially physicians. As a result, they will need to receive support to help identify and capture the most meaningful and manageable data to improve care for patients. AFHTO's members are happy to support this important work (this has already included making our EMR queries public) and are working towards creating a culture of improvement collectively.

AFHTO and its members are ready and willing to support the health system restructuring underway and would invite members of the Premier's Council to engage and involve them in the conversation. As interprofessional team-based care is an exemplary example of integration already, our teams are well poised to speak about the enablers of success, the barriers currently in place and the innovations they employed to meet those challenges.

Conclusion

The findings in the First Interim Report by the Premier's Council exposes many of the challenges in the health care system today – a siloed system that is fragmented creating a frustrating and sometimes dangerous health care journey for patients and caregivers. With the recent move towards integrated care, there is hope that patients will start receiving seamless transitions of care and health care providers will feel supported and better equipped to deal with the complexity they face each day.

Health care providers in interprofessional team-based primary care have been working in integrated systems of care for years but have felt that there is still fragmentation in the care they are able to provide, mainly because of the disconnect between the siloes of care, from acute to home care, from mental health and addictions to long-term 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 nurse practitioner is everlasting and built on trust.

A truly effective, high quality health care system needs to be coordinated, integrated and foundationally built in primary care, which will ensure we are delivering a sustainable health system for the future. Upstream prevention in the community with primary care reduces health care system burden, leading to a better patient experience and less cost to the system.

AFHTO and our members are here to help.

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.

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