It Takes a Team

Interprofessional Primary Care
as the Foundation of Health System Transformation

2020 Ontario Pre-Budget Submission

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AFHTO Pre-Budget Recommendations for the 2020 Ontario Budget

AFHTO members provide comprehensive primary care to over **3.5 million people** in over **200 communities** across Ontario. More than **one in four** Ontarians are cared for by our members.

The Association of Family Health Teams of Ontario (AFHTO) is the not-for-profit association representing team-based primary care. We provide leadership to promote high-quality, comprehensive, well-integrated interprofessional primary care for the benefit of Ontarians. We are the advocate and resource to support the spread of knowledge and best practice among 191 interprofessional primary care teams, including family health teams (FHTs), nurse practitioner-led clinics (NPLCs) and others who provide team-based care.

The seminal research by the late Dr. Barbara Starfield and colleagues forms the basis of a principle on which jurisdictions in Canada and around the world agree – an investment in creating a robust primary health care system will lead to a higher performing health system with better patient outcomes and less costs. And, more importantly, it will keep patients out of hospital hallways by giving them the care they need closer to home.

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]

When Ontarians are sick, hurt and at their most vulnerable, they often turn first to their primary care providers—their family physician or nurse practitioner—to provide them with trusted, person-centered and complete care. Primary care is the foundation of people's health care: it supports them throughout their lifetime with care that is comprehensive, promotes health and wellbeing, and works to prevent, detect, treat and manage illnesses.

Evidence shows that investment in primary care is associated with improved system quality, equity and efficiency, that when taken together results in reduced cost to the health system.[i,ii,iii,iv] The ability of primary care providers to access and coordinate care for their patients is vital to ensuring people receive the health care they need without slipping through the cracks. Coordinated, integrated primary care can help solve hallway health care – because the best way to get people out of hospital is to prevent them from ending up there in the first place.

AFHTO is pleased to provide recommendations for addressing some of the challenges straining our health system. Together with government, we will build more coordinated, integrated and person-centered health care for the people of Ontario.

Recommendation #1: Increase Access to Interprofessional Team-Based Primary Care for Ontarians Who Need It

High-quality primary care is team-based and patient-centered: looking at the whole person, not just their illness, and offering a wide range of services to help people be as healthy as possible. Ontario has

made significant progress in building more integrated, coordinated and comprehensive primary care. As modernization continues, smart investments in interprofessional primary care will be critical.

As the population ages, more people will spend more years living with multiple chronic conditions, significantly increasing strain on health services. Chronic conditions are already the biggest source of the rise in demand on our hospitals.[v] And referral to a specialist is not appropriate or cost-effective when complex and chronic patients can be better cared for by their primary care team.

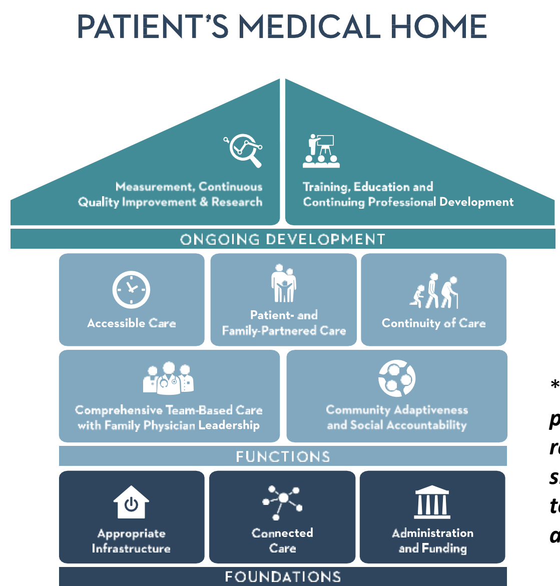
A Smart Investment

Only about 30 per cent of Ontarians have access to team-based primary care. Evidence tells us that 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 $30,000 a year. The same patient, when aligned with a care model providing comprehensive primary care, can cost just $12,000.[viii]

And care extends beyond the physical. We know that 80 to 90 per cent of a person's wellbeing can be determined outside of the health care system since social determinants of health are main factors in keeping people healthy and out of the hospital. Primary care teams are well equipped to support patients' social health – important initiatives like social prescribing to help address social isolation, as well as providing housing and income support, are important to support and expand.

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 the people they serve. This framework provides a vision for health care that Ontario needs to adopt as we undergo significant transformation and move towards integrated health.

People want to get their care closer to home and from a team of providers who know them best. That is their primary care team – the team that supports them throughout the milestones of their lifetime with trusted, person-centered and complete care. It is where their stories are the most robust in the shared team electronic medical record (EMR), and it is where the family physician or nurse practitioner provides comprehensive care from womb to tomb. It is their Patient Medical Home.



**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.*

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

An Example of How Team-Based Primary Care Helps Patients

How we get there:

Government should work with the sector to support the expansion of interprofessional team-based primary care across Ontario. This can start with communities that do not have a team at all and then expand to all Ontarians who need it. Allow for local level innovation but ensure that primary care providers are involved in co-design as they know what would work best for them in their communities and for their patients. As OHTs start rolling out in the province, ensure comprehensive primary care is at the heart of the health system so that patients get care from the right provider at the right time and in the right place.

The number of Canadians with dementia is rising. Today, over 240,000 Ontarians are living with dementia. By 2038, this number is expected to nearly double to over 430,000. [ix] *Seniors ages 65 to 79 with dementia are twice as likely to stay in hospitals than those without dementia, contributing to increased hallway health care.* [x]

At the Centre for Family Medicine (CFFM) Family Health Team in Kitchener, Dr. Linda Lee started MINT Memory Clinics that offer people living with dementia and their caregivers convenient access to high-quality, coordinated dementia care that's closer to home. The clinics train primary care providers, including physicians, nurses, and social workers, and partner with specialists and community services to deliver complete, compassionate care – all in one location.

"The MINT Memory Clinic provided my friends with compassionate and professional care at a time when they felt isolated and lost," said Bill Weiller of Kitchener-Waterloo, who has been caring for two people living with dementia. "These centres across the province provide crucial connection and resources for individuals with memory loss disorders as well as support for the family and friends who love them. I can guarantee I am not alone in the hope that MINT Memory Clinics receive the funding they need to remain in operation and continue their good work."

Ninety per cent of people living with dementia can have their health care needs met within local MINT Memory Clinics. The innovative, integrated model supports the government's commitment to build capacity for community care and to improve transitions from hospital to home, which reduces hallway health care.

Recommendation #2: Invest in Clinical Leadership to Ensure Successful Rollout of OHTs

Primary care is absolutely foundational to the successful transformation of Ontario health care. The province is moving towards more integrated care with the development of Ontario Health Teams, but "integrated care" ISN'T integrated unless it's built around primary care.[vi]

Primary care providers know patients and their families best. It is critical that primary care be key in the formation of OHTs and empowered to lead their development.

> ***Primary care is the entry point to the health care system.***
>
> ***"If we fail to include clinicians, particularly physicians, in the design, implementation and leadership of integrated care, we increase the likelihood of failure."*** [xi]

Other jurisdictions have faced challenges when integrated care is primarily led by hospitals. While hospitals play an important role, health system modernization will not achieve the outcomes we are striving for without primary care leadership. A review of the success factors and appraisal of evidence of Accountable Care Organizations (ACOs) in the United States demonstrated that hospitals without primary care leadership had mixed results in cost savings, efficiencies and patient outcomes.[vii] In contrast, ACOs that were primary care led had greater success in cost savings and patient outcomes.

> ***How we get there:***
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> ***Primary care leaders have a strong willingness to play a central role in delivering more joined-up care. They are ready to help drive improvement in our health system. We call on the Ministry to support primary care leaders' participation in health system transformation by investing in and supporting clinical leadership.***

Successfully building integrated care in OHTs, led by primary care, will require government support for current and future family physician leadership. These clinical leaders are the best resource government has for shifting the profession and the health system towards a shared vision and purpose. But the scope of work facing them is significant: it cannot be managed by one or two individuals alone.

Ontario needs to develop a team of leaders at practice, organization and community levels to drive change on the ground and across all practice models. Developing family physician leadership capacity is critical as many physician leaders approach retirement. Succession planning will be important; more family doctors are needed to broaden the physician pool, so leadership capacity is not compromised. And we need to support front-line providers by freeing up time from their unrelenting workload.

Recommendation #3: Embed Mental Health and Addictions Support in Primary Care

Ontario is on the verge of a mental health and addictions crisis. People across the province wait months for mental health and addiction services, and many end up in hospital emergency departments rather than getting the support they need in the community. It is often the same patients coming through hospitals' emergency room doors again and again.

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. Mental health resources need to be in the community where the person lives and receives comprehensive care and not in an expensive acute care centre where they only receive fragmented, episodic care. Often, these resources are best offered by the patient's trusted family physician or nurse practitioner.

We have heard from primary care providers that mental health is the biggest challenge for them – there are not enough resources to support patients and waits for community supports are too long. We need to see mental health and addictions supports embedded in primary care so we can better provide continuity of care for patients – and we can't wait for the full roll-out of OHTs to achieve this.

How we get there:

We need a health system that is truly integrated, where patients do not have to move from one part of the system to another to get their care, especially for mental health and addictions. Government should work with primary care and mental health care providers to ensure mental health and addictions investments are embedded in primary care. With mental health being the number one pain point in primary care, the Ministry should rapidly roll out the publicly funded structured psychotherapy program so more Ontarians have access to supports when they need them.

An Example of How Team-Based Primary Care Helps Patients

Patients with severe mental health challenges often have to wait up to two years to access intensive hospital-based programs. At Family First FHT, they offer a program that provides evidence-based group interventions to patients most in need to help them regulate their emotions and reduce self-harm behaviours. The program was launched in September 2018 with a flexible format allowing patients to enrol in one of the three 4-week modules responding to their individual treatment needs. This resulted in a significant reduction in emotion dysregulation and increased patient empowerment and functioning. As well, the team successfully reduced barriers and stigma associated with accessing specialised services, so more patients are likely to get the help and care that they need.

The program reduces the demand on hospital-based care and empowers patients in their community, while shortening wait times and producing results. It also fostered an inclusive community of care providers and patients who work together toward recovery.

Recommendation #4: Help End Hallway Health Care by Embedding Home and Community Care Coordination with Primary Care

Comprehensive care coordination is a key dimension of quality, patient-centred primary care, and it is essential to ensure seamless transitions between settings and among providers. Effective care coordination reduces duplication, facilitates better access, contributes to better value by reducing costs and, above all, results in a better experience for patients. It ensures continuity of care regardless of setting, including home and community, hospital, long-term care and team-based primary care.

Current coordination services for home and community care provided through the LHIN Home and Community Care Program are episodic. About 60 per cent of care coordination follows a hospitalization[viii], which misses the opportunity to keep people out of hospital in the first place. In the last few years, we have seen some improvement in the integration of home and community care with primary care, but change has been sporadic at best. Our members on the front lines tell us communication back to primary care providers remains poor. Embedding home and community care coordinators in some teams has, however, shown improvements.

We need a health system that is truly integrated; one where patients do not have to move blindly from one part of the system to another part to get the care they need. Care coordination and system navigation is a key function of primary care and should be foundational in the development of Ontario Health Teams. To be most effective, these critical supports must be embedded in primary care—the most effective setting to facilitate seamless transitions in care and offer patients a single-point of contact or ‘hub’ in their health care journey. After all, home care is really just primary care in the home.

How we get there:

The relationship between primary care and home and community care needs to 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 in care for patients. It will also allow for greater continuity of care, which will lead to better patient safety and prevent the patient from having to tell their story over and over again.

An Example of How Team-Based Primary Care Helps Patients

The Central Lambton FHT was the first in its region to embed a clinical care coordinator in the team. The care coordinator has worked with health care providers to help patients who are in and out of hospital deal with multiple comorbidities, and to help those who are struggling to manage their health. Physicians regularly speak with the care coordinator about their concerns and goals for patients, so they can ensure that the highest-quality, patient-centred care is delivered; ensure the patients know they are not on their own; and reduce unnecessary emergency room visits. The successful model is now being spread across the region.

"Sometimes you don't really know what you can do with respect to a patient need or what resources are available and from that perspective I would talk to Christy (care coordinator) and say this is the problem. The reason physicians are so appreciative is now we are able to extend patient care that's of high quality to when the patient actually needs that care. Patients are getting a superior quality of care," says Dr. Enoch Daniel, a family physician at Central Lambton FHT.

Recommendation #5: Support Digital Health Options in Primary Care

In a world where information is at your fingertips when you need it, why can't health care be there, too?

A huge focus of ongoing health system transformation is the adoption of digital health tools to support patient care and cut red tape for health care providers. To modernize care in Ontario, the government is seeking to adopt digital health solutions that will support effective health care delivery and ongoing quality and performance improvement, leading to a better patient experience.

People want assurances that they have a 'hub' that has their story all under one roof, is well connected to other parts of the health and social systems, and that has their well-being top of mind. It needs to be a place that is constantly adapting to patient needs, which includes embracing technology and ensuring information is placed in the patient's hands.

The health community is already embracing innovations in digital, but progress is slow. Many primary care practices are using secure encrypted email or text with their patients to better communicate and meet patient needs, but these approaches are not well integrated in the patient's electronic medical record.

In-person visits with one's primary care provider are, and will remain, important, but when they are not needed, patients want to be able to access care virtually. Commuting for a 5- to 15-minute visit is neither patient-centred nor truly accessible care. In rural or northern Ontario, it can take hours to get to

a provider, and in our large urban centres, parking fees, heavy traffic or public transit can deter people from seeking necessary care.

Patients want convenient access to their health care team, but this cannot happen without modernizing our current model and thinking about how care is delivered. This includes recognizing the time that is needed to provide virtual care, addressing billing requirements so physicians can be appropriately compensated for providing virtual care, and providing an integrated, one-patient health record.

An Example of How Team-Based Primary Care Helps Patients

The Peterborough FHT opened a virtual care clinic for residents without a family physician or nurse practitioner. The clinic provides primary care and connects patients with services in the community, including specialists. It has also been designed to recruit new physicians to Peterborough as it will track people without a primary care provider who might roster with a new physician.

With over 8,000 people in Peterborough without a family physician, this virtual clinic is an innovative approach to providing comprehensive primary care by having the patient seen by a full scope registered practical nurse who works virtually with a physician in managing the care of the patient. The patients are seen by the same physician during their visits to ensure continuity of care and to help build the therapeutic relationship between the patient and the physician. Patients of the virtual clinic are then placed on the Peterborough FHT wait list and transferred with their chart to physicians seeking patients.

"The VCC (virtual care clinic) has been a godsend for me personally. Moving to Peterborough two years ago I and my family have been unsuccessful in securing a family doctor. Without this service I would be burdening the ER at PRHC (Peterborough Regional Health Centre) for unnecessary purposes," says one patient testimonial.

How we get there:

Adopt a digital health strategy that is rigorous and co-designed by the providers and patients who access it every day. Ensure it is not fragmented by sector but rather interoperable and accessible, regardless of where patients may be physically (or virtually) receiving care. Ensure that there are billing codes to recognize that care delivered digitally (secure email, text, videoconference, etc.) is valued as much as an in-person visit would be. Get closer to the vision of having one electronic health record that tells the full patient story.

Conclusion – A Step in the Right Direction

AFHTO is pleased to see the government's commitment to truly integrated, patient-centred care. Health care providers in interprofessional team-based primary care have been working in integrated models for years. Primary care is the entry point to the health system, and for many patients 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 if it is going to be sustainable.

Team-based primary care is popular with its 3.5 million patients because it provides a better patient experience, while helping people avoid long and confusing waits for referrals or preventing them from getting lost in our complex system. We need to expand this experience so every Ontarian can access the care they need when they need it.

We look forward to working with the government as it moves forward with its ambitious plan to modernize health care and to create a new integrated system of care focused around the patient.

AFHTO and our members are here to help.

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