afhto association of family health teams of ontario
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July 30, 2020

Dear Members of the OMA Negotiations Committee,

We would like to thank you for inviting the Association of Family Health Teams of Ontario (AFHTO) to provide feedback to the committee on the upcoming Physician Services Agreement and to participate in your consultations. As you are aware, physicians working with family health teams (FHTs) are essential in ensuring patients receive high quality and timely access to care. Collectively, we also support Dr. Barbara Starfield's observation that comprehensive, relationship-based, patient-centered care is the foundation of a sustainable healthcare system. And that relationship is strong in primary care.

We have had the opportunity to engage in consultation and dialogue with some of our physician leaders and would like to provide their feedback for consideration in the upcoming negotiations. These recommendations are applicable to physicians affiliated with FHTs but could apply to any physician that works in the various patient enrolment models (PEMs) in Ontario.

1. What are the top three negotiation priorities of your organization?

There are several priorities and recommendations that we have shared with the Primary Care Working Group (PCWG). However, we can distill those recommendations into three main priorities:

i. Increased access to capitated models of PEMs while also increasing access to team-based care
ii. Permanent billing codes for virtual care and investments in electronic medical record integration
iii. Investment and recognition of clinical leadership while also supporting the organization of primary care

Increased access to capitated models of PEMs while also increasing access to team-based care

Access is a very broad area and encapsulates many elements of care delivery, but foundationally we believe more Ontarians deserve access to comprehensive team-based care and more family physicians deserve access to interprofessional health care providers to help support their patients.

Although this was known prior to the pandemic, the inequity in how physicians are remunerated was brought to light during COVID-19. Physicians that are paid fee for service saw their compensation decrease substantially as they struggled to maintain patient volumes, while worrying about their overhead and paying their staff. This is coupled with the fact that the number of physicians allowed to join comprehensive, organized payment models like FHOs has led to physicians being forced into non-team, transactional models of care like solo practices. Research shows that patients not attached to organized primary care practices in Ontario receive lower quality care, which has widened over time[i]. The ability to move physicians to capitated models of payment has been restricted over the years to underserviced areas, and this two-tiered payment approach has destabilized the family

physician work force and created an even further fragmented, unsustainable primary healthcare system.

Priority: 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[ii]. Stabilizing the family physician workforce should be a priority to ensure primary care is the foundation of the healthcare system. There also needs to be an increase in the number of physicians being able to practice in blended capitated models like a FHO, so that patients can take comfort in knowing that their family physician will always be there to provide care.

There has been a strict limitation over the last few years of having more physicians join team-based models of care like FHTs, which has meant more Ontarians have not been able to access interprofessional care. In addition, family medicine residents have been trained by exceptional family physician teachers in the team-based models of care, but upon completing residency, they are finding it difficult to practice in the model in which they have been taught. Patients receiving care that is centered on their needs from a team that knows their story is a major tenet of the Patient Medical Home, allowing for continuity of care, higher patient satisfaction, and increased provider satisfaction[iii]. This is a principle AFHTO strongly agrees with.

Priority: Increase access to team-based care for more patients by adopting the Patient Medical Home vision within the Patient Medical Neighbourhood. Advocate for increased access for physicians who wish to join team-based models of care and ensure funding is available to increase the number of interprofessional health care providers (IHPs) to support the expansion of team-based models, like FHTs, to ensure all patients who need interprofessional care are receiving it.

Permanent billing codes for virtual care and investments in electronic medical record integration

Family physicians and primary care teams pivoted quickly to provide care for their patients by moving to virtual care to ensure seamless and continued care, while also protecting the acute care system should there have been an influx of people diagnosed with COVID-19. Within 48 hours, the primary care sector went virtual despite no additional funding or change management support. Previous virtual care billing codes were resurrected to allow physicians to bill for virtual visits. Something that has taken years to implement happened very quickly, which highlighted that you can make a quick policy implementation when needed.

While the sector pivoted quickly to virtual care, there are still changes that need to be made as the move is not just a response to the pandemic but a catalyst on how care can be delivered in the future. Not only should the virtual care billing codes become permanent, there should be inclusion of the secure messaging modality along with already existing phone and video. Additionally, the platforms should be integrated within the electronic medical record (EMR) and not standalone to ensure continuity of care. Virtual care should also only be enabled if there is a relationship with the patient; otherwise, we will have issues of pop-up virtual walk-in clinics that erode continuity and the trusted relationships that patients have with their family physicians.

As we become more digital, patients are asking for alternative ways to communicate with their healthcare teams, often looking for immediate access to their providers. Whether it is email, text messaging, or web inquiries, these methods of communications are being demanded by patients. The lack of economic incentives to encourage physicians to consider these modes of communication is a huge barrier to its uptake.

Ontario Telemedicine Network (OTN) was the platform of choice for the Ministry, mainly because it is an existing provincial asset that falls under the purview of Ontario Health (OH). However, the OTN platform is cumbersome and, given it does not integrate well with the primary care EMR, it is difficult to use. Outside the Greater Toronto Area, many teams also said that the platform was challenging to rely on because of dropped calls during video visits. As a result, many primary care providers moved towards integrated EMR solutions (e.g. Telus' Akira, Accuro's Medeo) that are more seamless for patient care and are much more reliable. But this came at a cost.

The pause of OntarioMD subsidies to enhance and optimize the use of EMRs has meant that integration with these modes of communication and better integration of patient information with the other forms of EMRs in other healthcare sectors has come to a standstill. More attention needs to be paid on building a sustainable, integrated, and interoperable electronic health record that includes the primary care EMR.

Priority: Permanent billing codes need to be built into the Schedule of Benefits that addresses all digital modes of communication, including secure messaging. Billing for virtual visits should only be done if there is a trusted relationship between the patient and family physician based on the principle of continuity and a relationship that has existed for at least two years.

Priority: To help facilitate virtual tool integration within the EMR, one-time infrastructure costs and ongoing subsidies need to be negotiated so that primary care EMRs can continue to be optimized and utilized to their full extent. This includes online booking and the ability to integrate with digital modes of communication, such as email and video visits. Other virtual care tools, not just OTN, need to be supported and funded so that there is better integration within the EMRs.

Investment and recognition of clinical leadership while also supporting the organization of primary care

With healthcare transformation like Ontario Health Teams (OHTs) currently underway, more physicians must be involved in leadership roles at the beginning and throughout the process of change.[iv] Successfully building integrated care in OHTs, led by primary care, will require funding support for current and future family physician leadership. These clinical leaders are the best resource we have 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 frontline providers by freeing up time from their unrelenting workload.

Priority: Recognizing that physician leadership is integral in implementing the province's priorities, there needs to be provision of financial support for physician leadership development and remuneration for physicians in leadership roles, including when being asked to consult on an ad hoc basis. There must be funding available to support clinical leadership and no longer can family physicians be expected to be the only ones at the planning tables not being paid to be there. Leverage the co-designed Made in Ontario 10 High Impact Actions, developed through the Primary Care Virtual

Community, to support what is needed to free up time so family physicians can participate in more joined up care.

We have allowed the status quo to be good enough in primary care and have not engaged in more innovative and joined up approaches to care. As we move towards better connected care, there is an opportunity to organize primary care as the foundation of the health system at the local level. But this will require a change in some of the ways the sector is organized and a willingness to do things differently. The move towards integrated care through OHTs will necessitate elements of accountability as community expectations will affect how each partner will be expected to adhere to principles of partnerships between their community partners and the patients in the population.

Priority: Support the Ontario College of Family Physicians three-way improved accountability by defining elements for implementation: physician accountability (to self, to their profession, to their colleagues, to their funder, to their patients), patient accountability (to their physician, to the system), and government accountability (to the patient, to the physician, to the system).

Priority: Family physicians are innovating across the province in how they are structured and how they are organized. As OHTs continue to develop, each region should be able to organize primary care (through sustainable funding) and take lessons learned from existing family practice networks like the East Toronto Family Practice Network or the Mississauga Halton Primary Care Network. An organized primary care system will be the driver that is needed to create the integrated care that patients, families, and caregivers need, and it will ensure that family physician clinical leadership is recognized as an important element to building the foundation of the health care system.

2. Are there Ministry priorities you are aware of that align with your organization's interests and if so please explain

Ontario Health Teams

The biggest government priority that aligns with AFHTO's interest is the move towards integrated care through the Ontario Health Teams (OHTs) initiative. But "integrated care" isn't integrated unless it's built around primary care.[v] Primary care is foundational to the successful transformation of Ontario's health care system. Primary care providers, especially family physicians, know patients and their families best. It is critical that primary care be key in the formation of OHTs and be empowered to lead their development. *If we fail to include clinicians, particularly physicians, in the design, implementation and leadership of integrated care, we increase the likelihood of failure.*[vi]

As Ontario moves towards further integrated care, there are barriers that do not allow for a population health approach to care. For example, at the team-based level, we know that there are multiple FHOs/FHNs that are affiliated with one FHT. In the interest of efficiency and to meet after hours requirements, there can be consolidation of these FHOs/FHNs to offer care after hours to all patients affiliated with the FHT. However, this currently leads to outside usage reports and negation if the patient does not go to their rostering FHO/FHN. This applies even if that practice group is a member of the one FHT, which breaks down the concept of the 'one team' model. As we look to 'joining up' primary care by encouraging family physicians to work more closely with their colleagues and partners in OHTs, the concept of negation discourages a collaborative and organized primary care system in communities.

For Ministry consideration: All affiliated physician groups with one FHT should be treated as a collective and not be subjected to negation in the spirit of greater office efficiencies and collaborative care. Family physicians working towards integrated care by participating in the OHT concept of care delivery should also not be subjected to negation, especially if they are working collaboratively with their colleagues to provide accessible and ongoing care for their patients and the population in their community. How can integrated care be provided when there are disincentives to discourage collaboration?

Better Integration of Public Health with the Health Care System

The World Health Organization recognizes that "primary care plays a significant role in… differentiating patients with respiratory symptoms from those with COVID-19, making earlier diagnosis helping those who are vulnerable cope with their anxiety about the virus, and reducing the demand for hospital service are all roles primary care play."[vii]

The pandemic has exposed a lot of gaps in our healthcare system and one of the most glaring is related to the disconnect of the public health system with the rest of the healthcare system. The massive health system transformation that is currently underway, especially the formation of the OHTs and the Ministry consultations related to the modernization of public health and emergency services, presents an opportunity for better alignment between public health and primary care. This will provide upstream care to prevent hospitalization and reduce hallway healthcare, especially since the OHTs are predicated on the principles of the Quadruple Aim, which aims for better patient and population health outcomes.

For Ministry consideration: In alignment with the Quadruple Aim and ensuring that there is focus on population health, it is important that public health be better integrated within the health system planning as a full partner that, alongside primary care, ensures prevention, health promotion, wellbeing, and chronic disease management be part of the full continuum of care for patients and the population being served.

Quality Improvement

Engaging primary care practices in quality improvement (QI) activities is essential to achieving Bodenheimer's quadruple aim of improving the health of the population, enhancing patient experiences and outcomes, reducing the cost of care, and improving the provider experience[viii], something that the Ministry has identified to be important in the OHT initiative.

However, for even the most determined practice, meeting its improvement goals can be daunting as it requires identifying areas for improvement, understanding and using data, planning, making changes, and tracking performance over time[ix]. But above all, this work requires dedicated time – time to review reports, time to verify patient panels, time to develop improvement strategies, time to implement, and time to evaluate.

For Ministry consideration: To encourage more physicians and physician practices to participate in quality improvement, there should be a QI billing code or additional, new monies set aside to support QI activities. Lessons learned in Saskatchewan and other provinces would help build a robust program for an Ontario Physician Compensation Quality Improvement Program. Additional resources should include practice facilitation and change management support, which needs to include quality improvement decision support specialists (QIDSS) who can support physician groups with their QI

work. And for physicians who already work in team-based care and have ready access to QIDSS, they should be required to participate in initiatives like the QIPs.

3. What are the health care system/policy priorities that should be addressed in these negotiations?

Better Collection of Data and a Move Towards Supporting Social Determinants of Health (SDOH)

While the provincial response successfully prepared for and managed acute care capacity, other care settings and vulnerable communities were exposed to the harsh realities of the full pandemic. This was evidenced in the outbreaks among residents of long-term care and retirement homes, shelters, migrant seasonal farm workers, and others – all vulnerable settings where minimal attention was paid to ensure their safety. Data related to the impact of the spread was also not known because data collection was rudimentary at best, with little attention being paid to the SDOH and race of individuals and the impact that was having on managing the spread. With the appointment of Dr. Jane Philpott to head up the Ontario Health Data Platform, there will be focus and expectation on breaking down how data is collected and stored. And this will mean that all providers working in the health system in Ontario will be expected to participate in better collection of data, including collecting SDOH and race information from patients.

As medical and social complexity increases, so does the need for things like social connectedness. Social isolation was highlighted during this pandemic as a factor that increased feelings of loneliness, anxiety, and depression. One way to address this is through social prescribing. Social prescribing is an integrated and streamlined way to support patients' health and wellbeing by addressing the social determinants of health, particularly the need for social connectedness[x]. It is a structured pathway for referring people to a range of non-clinical services, and it seeks to address people's needs in a holistic way. The pathway involves a social prescription from a primary care provider, like a family physician, who refers patients to a navigator that connects them to a suite of social community development supports drawn from the assets of the community[xi]. As we prepare for a potential second wave and for future pandemics, it is paramount that planning happens now to ensure that the most vulnerable and isolated in society are not forgotten ever again.

Health Care System Priorities:

- *We know that 80-90% of our health and wellbeing is determined by factors outside the mainstream health system. The pandemic highlighted that the most vulnerable are at the highest risk for exposure and most of their needs are based in addressing their SDOH. It is important that social prescribing be ramped up and spread so that individuals who are highest risk get access to much needed support. Family physicians can take comfort in knowing that the holistic health and well-being of their patient is being taken care of.*
- *The move towards recognizing complexity is welcome and supported, especially as patient visits become more multifaceted in primary care. To collect the non-medical information, it is important that SDOH data, including race, be voluntarily collected. To help support uptake, there can be an 'equity modifier' incentive that could be implemented for collection of this information, similar to the negligible one-time payments made when a patient is attached through Health Care Connect.*

Crisis in Mental Health and Addictions

We have heard from primary care providers that mental health and addictions (MHA) 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.

During this pandemic, we have seen an increase in opioid overdoses and an increase in addiction to alcohol, smoking, and cannabis as people used these substances as a coping mechanism to deal with their anxiety related to the pandemic. We have also seen that healthcare providers are feeling helpless with the lack of supports for their patients and also for themselves. We need a plan today on how to manage this massive wave of MHA, not just in patients but also in healthcare providers.

Health Care System Priorities:

- *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. Government should work with primary care and mental health care providers to ensure mental health and addictions investments are embedded in primary care, especially as MHA is the number one clinical pain point in primary care.*
- *As part of the bilateral agreement between the federal government and the province, Ontario is receiving $1.9 billion over 10 years (which was to be matched by the Ontario government) to create a more robust mental health and addictions system that is better connected, with more MHA supports to people in the province. Other than an initial roll out of $174 million in the FY 2018/19, there has been no further commitment made with these funds. With the MHA burden due to COVID and most people going to primary care first to get their care, it is important that the system be ready to address this in their communities.*

Modernizing Home and Community 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 Ontario Health (LHIN) Home and Community Care Program are episodic. About 60 per cent of care coordination follows a hospitalization[xii], 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 primary care has, however, shown improvements. After all, home care is really primary care in the home.

Health Care System Priorities:

- *As we have seen with the tragedy that has unfolded in long-term care, patients living in congregate settings were at the highest risk in acquiring COVID-19. As complexity increases, so does the need for better integration with other parts of the health and social systems. With the passage of Bill 175, Connecting People to Home and Community Care Act, 2020, there is a mechanism to modernize home and community care by ensuring these supports are embedded in primary care.*
- *The bilateral Canada-Ontario Home and Community Care and Mental Health and Addictions Services Funding Agreement will also see an investment of $2.8 billion invested in home and community supports in the province, but we have not seen any commitments made. During the pandemic people were told to stay at home and we saw home care volumes decrease by as much as 30% - why was more home care not provided to people in their homes? With the hallway healthcare crisis and no plan to deal with alternative levels of care (ALC) post discharge, people want care to be delivered at home and need their primary care team to be central to that care.*

We thank the OMA Negotiations Committee for permitting AFHTO to make recommendations to the upcoming Physician Services Agreement. We look forward to meeting the committee members on August 7th when we can discuss these recommendations. We consider the OMA to be one of our most important partners and look forward to our ongoing partnership.

Yours sincerely,

Dr. Tom Richard
President and Board Chair

Kavita Mehta
Chief Executive Officer

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[i] Kiran, T., Kopp, A., and Glazier, R.H. *Those Left Behind From Voluntary Medical Home Reforms in Ontario, Canada.* Annals of Family Medicine, November/December 2016, 14(6), 517-525.

[ii] Shi L, Starfield B, Kennedy BP, Kawachi I. Income inequality, primary care, and health indicators. J Fam Pract. 48 (1999), 275--84.

[iii] The Canadian College of Family Physicians. *A New Vision for Canada: Family Practice- The Patients Medical Home 2019.* Retrieved from https://patientsmedicalhome.ca/files/uploads/PMH_VISION2019_ENG_WEB_2.pdf. Accessed July 9, 2020.

[iv] Canadian Society of Physician Leaders. *Accepting our Responsibility: A blueprint for physician leadership in transforming Canada's health care system*. Available at: https://www.canadianhealthcarenetwork.ca/files/2017/02/CSPLWhitepaper2017.pdf Accessed July 10, 2020.

[v] Dr. Robert Varnum, GP Section Head, NHS in UK. Primary Care Virtual Care Network Meeting#1, April 25, 2019.

[vi] Smith, K. & Brown, A. *How to Deliver Integrated Care Models: Lessons from Ontario.* Health Policy Blog: University Health Network & University of Toronto Dalla Lana School of Public Health. Available at: https://healthpolicyblog.ca/2019/01/24/how-to-deliver-integrated-care-models-lessons-from-ontario/. Accessed July 10, 2020.

[vii] WHO Western Pacific Region. "Role of primary care in the COVID-19 response: interim guidance 26 March 2020. https://iris.wpro.who.int/bitstream/handle/10665.1/14510/Primary-care-COVID-19-eng.pdf

[viii] Bodenheimer, T, and Sinsky, C. *From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider.* The Annals of Family Medicine November 2014, 12 (6) 573-576.

[ix] Taylor, E. et al. *Quality Improvement in Primary Care.* Agency for Healthcare Research and Quality. Available at: https://www.ahrq.gov/research/findings/factsheets/quality/qipc/index.html. Accessed July 9, 2020.

[x] Social Prescribing in Ontario. *Alliance for Healthier Communities*. June 2019. Available at: https://www.allianceon.org/sites/default/files/documents/Rx-Community-Progress-Report-EN-June2019-web.pdf. Accessed July 10, 2020.

[xi] ibid