The Heart of Health Care

Delivering Better Primary Care for Ontarians

2021 ONTARIO PRE-BUDGET SUBMISSION

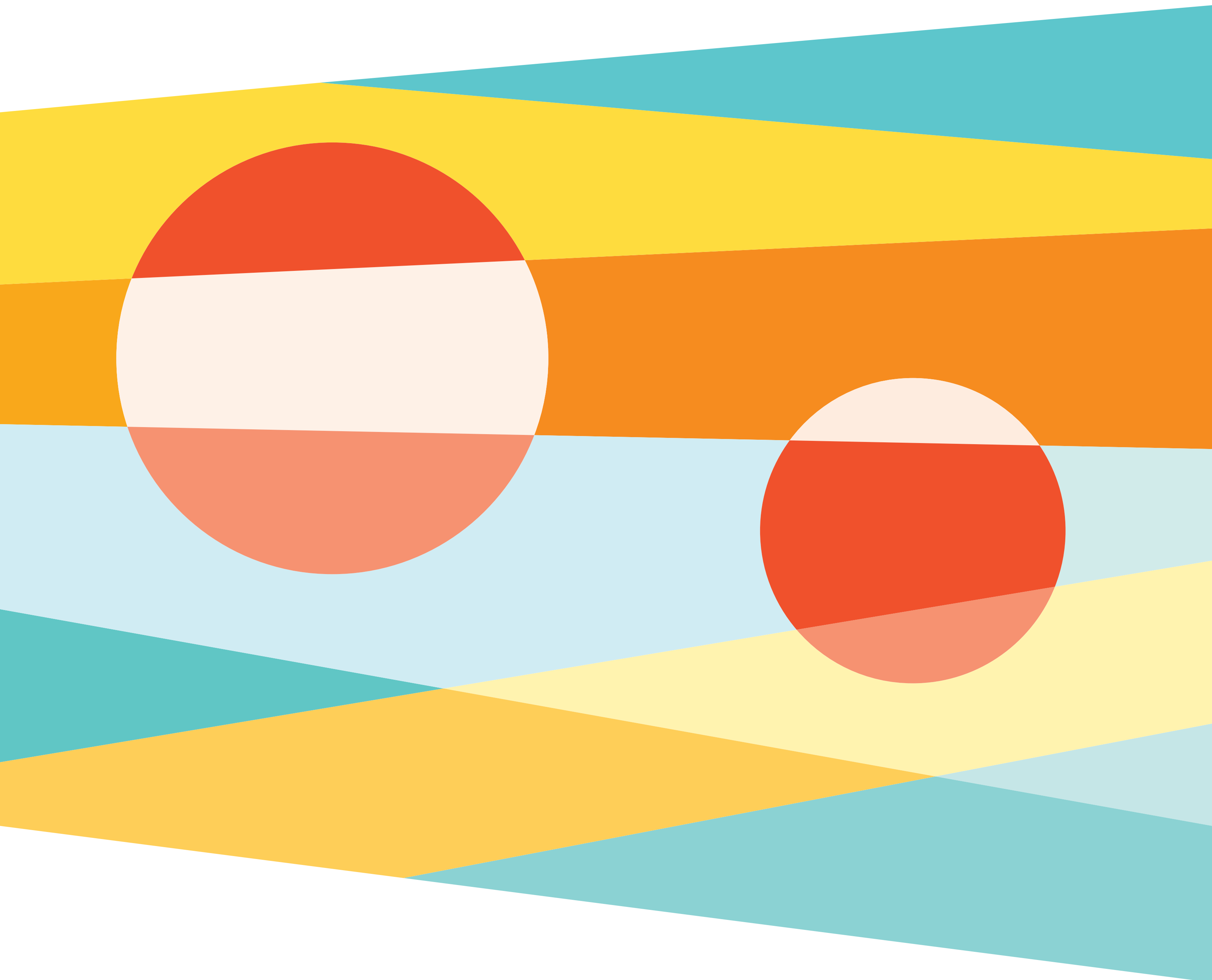
Submitted by:

Association of Family Health Teams of Ontario

Ontario College of Family Physicians

Nurse Practitioners' Association of Ontario

OMA Section on General & Family Practice



INTRODUCTION

COVID-19 has changed our daily lives in ways big and small. But it hasn't changed everything.

By building a system with primary care at the heart of health care, we can give the people of Ontario **more access to better care, more integrated care, and more accessible and continuous care.**

Our relationship with our family physician or nurse practitioner is still a relationship of trust. Not just because of their expertise — we trust them because he or she knows us, sees the pressures we face, celebrates our victories, asks about our family, understands our values.

That relationship is at the centre of a healthy life. This trusting relationship will be critical in helping Ontarians feel confident and safe in getting the COVID-19 vaccine once it's available for them, and it will continue to be more important than ever with the pandemic's complex and unanticipated impacts on health and wellbeing for years to come.

Ontarians today have innumerable points of access to our health system — their family physician or nurse practitioner, their primary care team, walk-in clinic, pharmacy, hospital, physiotherapist, specialist, to say nothing of the amount of information, and disinformation, they can access online. Navigating the health system and evaluating complex medical information can be bewildering.

As we rebuild our health system around the patient and make it easier for people to get accessible and appropriate care closer to home, it's more important than ever to have the continuous relationship of knowledge and trust that's uniquely provided through primary care: a health professional who sees the big picture of a patient's circumstances and has a relationship foundationally based in trust.

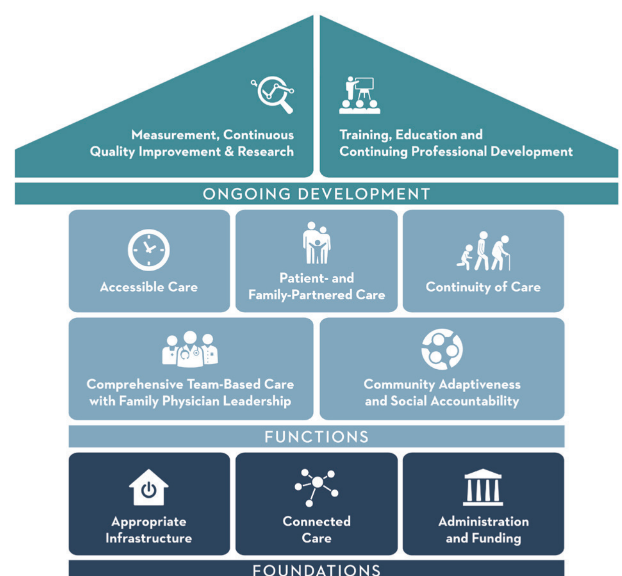
With vaccines being distributed, there is a light at the end of the COVID-19 tunnel. As we emerge from this crisis and continue with the Ontario government's bold transformation to end hallway health care and create a better, more integrated, and patient-centred health system, there is an opportunity to strengthen primary care's central role.

Primary care is the heart of health care. In the pages that follow, we outline a vision that would give the people of Ontario **more access to better care, more integrated care, and more accessible and continuous care.**

A VISION FOR PRIMARY HEALTH CARE

Originally developed by the College of Family Physicians of Canada, the Patient's Medical Home (PMH) and Patient's Medical Neighbourhood (PMN) vision ensures that patients are provided with comprehensive and integrated health care services that are continuous and connected to all parts of the health care system, as necessary.

Evidence worldwide supports that primary care practices that adhere to the PMH principles not only improve care and the patient experience, health outcomes, and provider satisfaction, but also lead to fewer hospital admissions and ER visits, more system savings, and better use of public resources – helping government achieve its goals of health system transformation and ending hallway health care. Collaboration within and across interdisciplinary health care providers is a core principle of the PMH.[i ii iii]



RECOMMENDATION 1

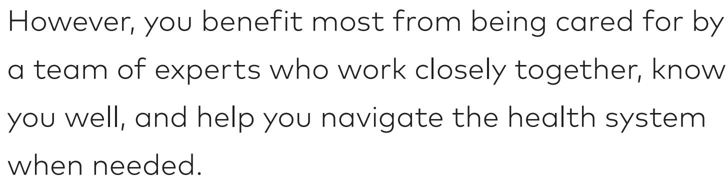
More Access to Better Care: Expanding Interprofessional Team-Based Primary Care

Given the breadth of perspectives of providers on a team, **primary care teams are well placed to address the profound clinical, behavioral, and mental health care demands** that are emerging and will continue to emerge throughout the pandemic.[v]

Team-based care results in better health outcomes, better patient service and satisfaction, and better use of precious health system resources.[iv] However, approximately 10 million Ontarians do not have access to this model of care. Less than one in three people in this province are being cared for in a primary care team. This must change.

Chronic illnesses like diabetes don't go away just because there's a pandemic. We know that even as the virus threatens to overwhelm our health system, it's vital to continue providing care to keep people healthy and out of hospital. Every Ontarian needs access to a family physician or nurse practitioner, and experience has shown that the best and most patient-centred care is provided when that family physician or nurse practitioner works as part of a team.

The long-term relationship of trust between the family physician or nurse practitioner, the primary care team, and the patient is part of the concept of care continuity. There will be times when you need to seek specialist care, appropriately go to hospital, or receive services from a community pharmacy.



However, you benefit most from being cared for by a team of experts who work closely together, know you well, and help you navigate the health system when needed.

Our health is impacted by a multitude of factors that interact in complex ways. A trusted team that pools their specialized skills and knowledge of a patient will provide better care than the sum of their individual expertise. Having one point of contact for a wide range of services makes health care more accessible and less confusing. No one should have to tell their story over and over to different health care providers.

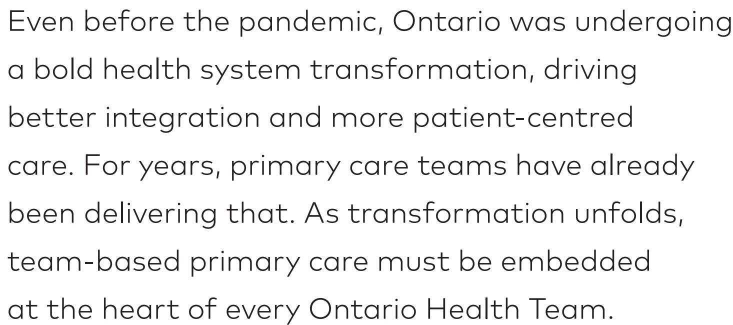
COVID-19 has placed tremendous strain on institutional care. Hospitals are stretched to their limits. But well organized, effective team-based primary care reduces hallway healthcare as it is best at helping patients manage complex and chronic illnesses, like diabetes and heart disease. It is better at promoting health and preventing disease. It takes a whole-patient and integrated care approach that focuses not just on physical health but also on mental health and wellbeing. It considers the impact of challenges in everyday life, like unstable employment or a lack of access to quality housing, that can contribute to sickness – and COVID-19 has only increased these kinds of stressors on countless Ontario families.

A PATIENT'S STORY

Mr. G is a 65-year-old male with obesity, diabetes, and associated neuropathy, who also suffers from depression and anxiety that are exacerbated by social isolation. He was on multiple medications, including high dosage of pain narcotics and muscle relaxants, and facing financial limitations, food insecurity, and poor housing conditions.

Mr. G was connected to CarePoint Health, a model that builds on the philosophy of the Patient's Medical Home. A family physician diagnosed him with ADHD, but, before initiating treatment, liaised with the team's community pharmacist, social worker, and registered dietitian on his assessment and treatment plan. With support from the team, Mr. G lost 26 pounds in five months, his energy and concentration levels increased due to adjusted medication, and he is building his skills for sustained behavior change by receiving counselling for depression and anxiety.

He has been connected with local churches and food banks that serve fresh produce and hot meals and provide socialization opportunities. His eligibility is currently being assessed for home and community care services.



Even before the pandemic, Ontario was undergoing a bold health system transformation, driving better integration and more patient-centred care. For years, primary care teams have already been delivering that. As transformation unfolds, team-based primary care must be embedded at the heart of every Ontario Health Team.

How Government can help

Ontario must commit to a 10-year, $750 million funding strategy to ensure every Ontarian has access to team-based primary care when needed.

Within five years, access to this care must be expanded to, at minimum, half the population with priority on people who need it the most, such as those with complex and chronic illnesses, those with mental health and addiction challenges, and those hoping to live safely at home for as long as possible.

Within 10 years, every Ontarian who needs it must have access to team-based primary care.

STEPHEN'S STORY

Stephen is a patient at Dufferin Area Family Health Team (DAFHT) who struggled with chronic pain from rheumatoid arthritis. He was referred to DAFHT providers to help him better manage his pain and quit smoking.

Stephen was also struggling with the cost of his medications and not being able to work. The team, including a physician, occupational therapist, pharmacist, nurse, and respiratory therapist, supported Stephen with his health goals. They helped with pain management, getting ODSP to help pay for his medication, and him quitting smoking.

'I feel incredible now compared to when I first started with them…I thank (the team) with all my heart for being there and helping me." His story can be watched here.

RECOMMENDATION 2

More Integrated Care: Embed Mental Health and Home Care in Primary Care

Ontarians are experiencing more mental health challenges because of COVID-19 – and the impacts are likely to last.[vi]

- More than **⅓ of Ontarians** continue to report their mental health has worsened since April
- Over **half of Ontarians** are concerned about their own mental health
- **83% of Ontarians** agree the strain on mental health will worsen the longer the outbreak continues

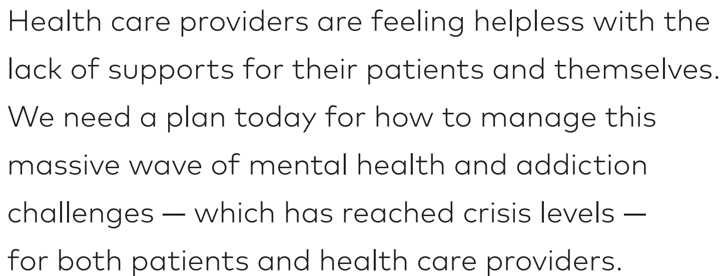
Evidence shows that patients with mental health and addiction challenges are **six times more likely** to visit family physicians than other patients, and that they are high users of health care across all settings, with especially high use of primary care services.[vii viii ix]

As Ontario's government reforms our health system to make it more integrated and patient centred, it is building upon work that team-based primary care has been delivering for years.

In particular, mental health and addiction and home and community care depend on the same bedrock relationship of trust and deep knowledge of the patient that primary care is built upon. This is *human* care, close to home; it is *continuous* care from a team of providers that have knowledge of a patient's circumstances beyond one illness or injury. It is care that is intended to promote wellness and protect against harm, not just fix a problem. As such, it makes sense to embed mental health and addiction and home and community care in primary care. Health system transformation provides the opportunity to do so.

Integrate Mental Health and Addiction Support with Primary Care

Ontario is in a mental health and addiction crisis that COVID-19 is making worse. We have heard from family physicians and nurse practitioners that mental health and addiction present the biggest challenge for them, but there are not enough resources to support patients, and the wait lists for community and specialist supports are too long.



Health care providers are feeling helpless with the lack of supports for their patients and themselves. We need a plan today for how to manage this massive wave of mental health and addiction challenges — which has reached crisis levels — for both patients and health care providers.

No provider in our health system knows their patients better than their family physician or nurse practitioner. They have deep relationships of trust, so are best placed to identify and help people facing these often sensitive and stigmatized challenges. Primary care, especially team-based primary care, can compassionately and comprehensively help people with mental health and addiction challenges by delivering whole-person and complete care and, when needed, helping patients navigate the health system and ensure smooth transitions in care.

This is an urgent and pressing need — one that cannot wait for the full roll-out of Ontario Health Teams to address. It is critical that we take decisive action now to better integrate mental health and addiction supports in primary care. People's lives depend on it.

How Government can help

Government must work with family physicians, nurse practitioners, primary care teams, and mental health care providers to develop a plan to integrate and embed mental health and addiction supports and resources in primary care.

A PATIENT'S STORY:

A 63-year-old man went to the Waterloo Region Nurse Practitioner-Led Clinic's Rapid Access Addiction Medicine (RAAM) Clinic for support on his prescription opioid use. He had been prescribed opiates for pain management after a workplace accident 12 years prior. The patient's primary care provider had passed away, and his new provider was not comfortable with opioid prescribing.

The RAAM counsellor discussed goals and available community supports with him and sent referrals to withdrawal support counselling. The nurse practitioner started him on Suboxone for a couple of weeks to help manage opioid withdrawal symptoms, with the counsellor remaining available for any questions.

He has now been clean from opioids since October 2020, and says he is amazed that his pain is being managed without them. He has seen an improvement in daily life, including being able to continue working full-time.

Integrate Home and Community Care with Primary Care

Anybody who has had a loved one who needs health supports to stay in their own home understands the stress and emotional burden that accompanies this difficult situation. Having to help a parent, grandparent, or another family member navigate a complex and often confusing health system without help, as they tell their story over and over again, is the last thing anyone wants. Our loved ones need a trusted guide — somebody who has been part of their care team for years and knows them well. That's found in primary care.

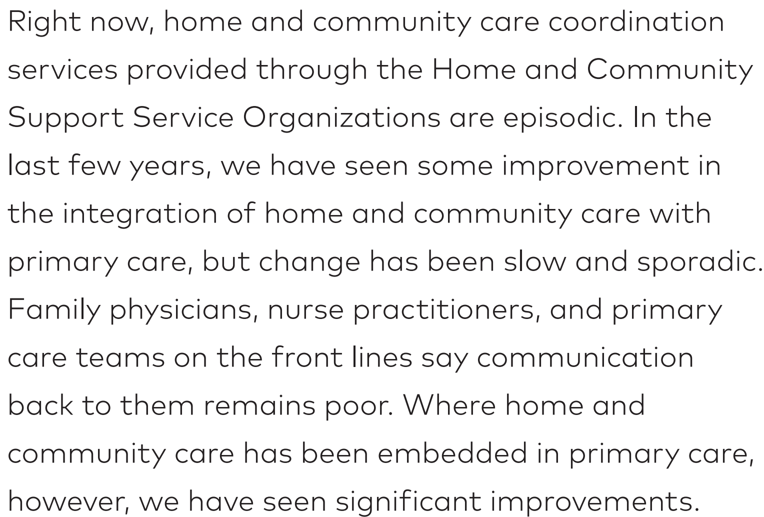
Comprehensive care coordination, which includes knowledge of the social care system, is key to quality and patient-centred care and is essential to ensure seamless transitions between settings and among providers. Embedded in primary care, care coordination would reduce duplication and inefficiency, enable seamless transitions in care, and allow more flexibility and integration in care planning. Patients would move through the system and between providers with a single care plan.

Better access, continuity, and coordination would lead to better outcomes. This approach would contribute to better value by reducing costs and — most importantly — making life easier for patients and caregivers going through a difficult transition. It would support them through the complexity of the health and social systems by ensuring they have ongoing, consistent support for system navigation.

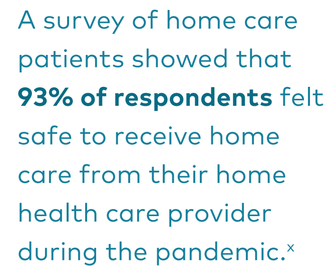
IN THE COMMUNITY

South Georgian Bay Ontario Health Team has launched a Home Monitoring Program for providers to care for patients with suspect or confirmed COVID-19 and to prevent cases from possibly worsening. Patients are taught how to monitor symptoms. They receive the equipment needed to do so and have daily nurse-led virtual visits from home.

"Patients with COVID-19 may only have mild symptoms when they are first diagnosed, but things can progress quickly, especially from day 5-10 after the onset of symptoms," says Dr. Mark Quigg, a family physician with Georgian Bay Family Health Team. "Through this program, our nurses are able to proactively identify patients who are showing signs of silent hypoxia and get them into treatment before their oxygen levels become critical and they require intensive care. This is especially important as the number of COVID-19 cases in our community continue to rise and potentially become more contagious. Any efforts to reduce the use of intensive care resources is essential to the integrity and sustainability of our health care system."



Right now, home and community care coordination services provided through the Home and Community Support Service Organizations are episodic. 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 slow and sporadic. Family physicians, nurse practitioners, and primary care teams on the front lines say communication back to them remains poor. Where home and community care has been embedded in primary care, however, we have seen significant improvements.



A survey of home care patients showed that **93% of respondents** felt safe to receive home care from their home health care provider during the pandemic.[x]

High quality, integrated, home and community care that is embedded in primary care not only improves the patient experience, but also helps Ontarians remain healthy and safe at home — where they want to be — for as long as possible, while relieving pressure on congregate settings, such as hospitals and long-term care homes.

How Government can help

Government must strengthen the relationship between primary care and home and community care by transitioning the function and associated resources of Ontario Health Home Care and Community Support Service Organization care coordination to primary care.

RECOMMENDATION 3

More Accessible and Continuous Care: Strengthen Virtual Care Foundations in Primary Care

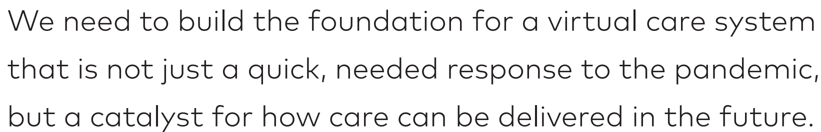
"My experience using the Virtual Care Clinic, offered through the North Simcoe Family Health Team, has been seamless, even during COVID. Working through a nurse coordinator, I met my family doctor online. He was very thorough. I have since received telephone call appointments with him. All in all, I'm very pleased with the process."

Patient

More than **96% of primary care physicians** were able to continue to provide high-quality patient care, either virtually or in person, in spring 2020 when the pandemic struck. By fall 2020, **this rose to over 98%.**[xi]

COVID-19 has wrought significant changes on how we work and live — and the same is true in primary care. Family physicians, nurse practitioners, and primary care teams pivoted quickly to care for their patients at the start of the pandemic. By moving to a model of virtual care, where appropriate, they ensured their patients continued to receive the care they needed, seamlessly and safely. Within just 48 hours, nearly the entire primary care sector had adopted virtual care options for patients.

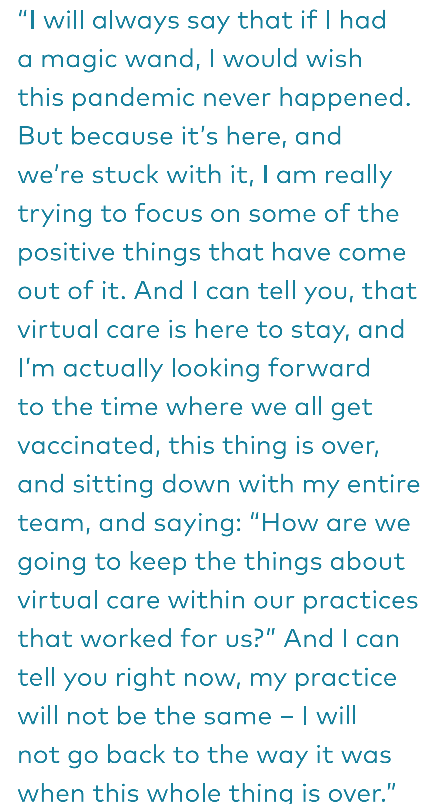
The public health threat of the growing pandemic necessitated this shift. But while COVID-19 may have provided the impetus that pushed Ontario into the twenty-first century of virtual care, digitally enabled care is here to stay. As Ontario works to make care more accessible and to empower patients when it comes to their own health decision-making, virtual care offers the promise to combine convenience with the continuity offered by primary care. It combines the power and ease of use offered by cutting-edge technology with the familiar trust and knowledge embedded in the primary care relationship. It will remain an important piece of how we deliver high-quality primary care moving forward.



We need to build the foundation for a virtual care system that is not just a quick, needed response to the pandemic, but a catalyst for how care can be delivered in the future.

It is critical that virtual care billing codes become permanent and that all of primary care is supported with the IT and administrative resources needed to provide high-quality virtual care, so these positive changes are locked in. This should include the ability to leverage all channels for communicating with patients — including secure messaging, phone, and video – and the full integration of a variety of approved platforms with patients' electronic medical records. Providers should have a patient's relevant health information, no matter how they choose to access care.

Patients deserve the same convenient access to their regular and trusted family physician, nurse practitioner, and primary care team that is offered through other virtual care providers.



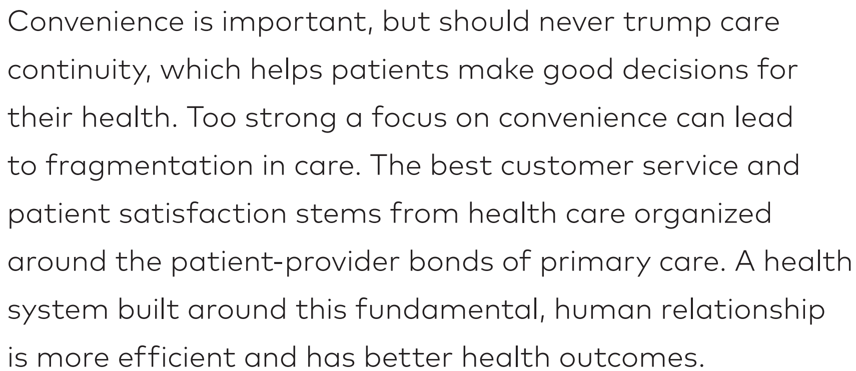
"I will always say that if I had a magic wand, I would wish this pandemic never happened. But because it's here, and we're stuck with it, I am really trying to focus on some of the positive things that have come out of it. And I can tell you, that virtual care is here to stay, and I'm actually looking forward to the time where we all get vaccinated, this thing is over, and sitting down with my entire team, and saying: "How are we going to keep the things about virtual care within our practices that worked for us?" And I can tell you right now, my practice will not be the same – I will not go back to the way it was when this whole thing is over."

Family Physician

How Government can help

Government must work with the Ontario Medical Association to implement permanent billing codes into the Schedule of Benefits that address all digital modes of communication, including video, phone, and secure messaging.

Government must also provide the necessary IT and administrative resources required by physicians, nurse practitioners, and primary care teams to provide comprehensive virtual care, so patients continue to receive continuity of care, no matter how they choose to access that care.



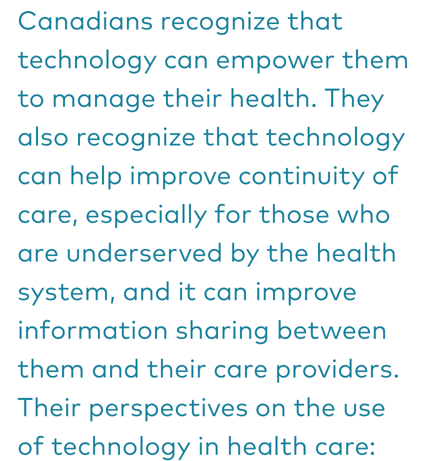
Convenience is important, but should never trump care continuity, which helps patients make good decisions for their health. Too strong a focus on convenience can lead to fragmentation in care. The best customer service and patient satisfaction stems from health care organized around the patient-provider bonds of primary care. A health system built around this fundamental, human relationship is more efficient and has better health outcomes.

When a patient does require care from outside of their usual primary care team, patients should have confidence in knowing that their information is being shared with their circle of care, and family physicians and nurse practitioners deserve to know that the primary care EMR is the source of truth for most patient information.

In a digital world where information is at our fingertips when we need it, health care should be there too. Patients want to access information and care online, via email, text, or the web. We should make it easier for them to get that from a trusted person or team who knows their needs and values and with whom they have an ongoing relationship.

How Government can help

To help facilitate virtual tool integration within electronic medical records (EMRs), upfront infrastructure funding and ongoing subsidies must be provided 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, phone, and video visits.



Canadians recognize that technology can empower them to manage their health. They also recognize that technology can help improve continuity of care, especially for those who are underserved by the health system, and it can improve information sharing between them and their care providers. Their perspectives on the use of technology in health care:

- **92% of Canadians** want technology that makes health care as convenient as other aspects of their lives
- **80% of Canadians** believe investing in health care technology should be a top government priority
- **9 in 10 Canadians** who used health technology in the past year say it saved them time
- **8 in 10 Canadians** who used health technology in the past year were better able to manage their health
- **9 in 10 Canadians** say COVID-19 has shown them that virtual care tools can be important alternatives to in-person visits

Source: Canada Health Infoway National Survey

CONCLUSION

COVID-19 has been a tremendous challenge for policy makers, health providers, and frontline workers.

It has disrupted all our lives. Tragically, many of us have been sick or have lost loved ones. And yet the pandemic is showing how Ontarians come together when the going gets tough. It is showing how we can rise to the occasion. It is showing how with hard work, creativity, and compassion, we can help and protect our loved ones, our neighbours, and the millions of others living in communities across this province.

Above all, the pandemic offers a once-in-a-lifetime opportunity to harness that energy to reform and strengthen our health care system. Bold system transformation was already under way before the pandemic hit. Now we have the chance to make things better for generations to come. But any changes we make need to be built upon the deep bond of trust and understanding that only exists between patients and their family physician or nurse practitioner.

By working together and putting primary care at the heart of health care, where it belongs, we can give Ontarians **more access to better care, more integrated care, and more accessible and continuous care.** Our twenty-first century health system will be built on an unshakeable bedrock, to the benefit of Ontarians for generations to come.

[i] John JR, Jani H, Peters K, Agho K, Tannous WK. The Effectiveness of Patient-Centred Medical Home-Based Models of Care versus Standard Primary Care in Chronic Disease Management: A Systematic Review and Meta-Analysis of Randomised and Non-Randomised Controlled Trials. International Journal of Environmental Research and Public Health. 2020; 17(18):6886.

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[iv] Alberta Medical Association. Evidence Summary: The Benefits of Relational Continuity in Primary Care. 2017. Las accessed January 2021: https://actt.albertadoctors.org/file/top-evidence-summary-value-of-continuity.pdf

[v] Holmes EA, O'Connor RC, Perry VH, Tracey I, Wessely S, Arseneault L, et al.Multidisciplinary research priorities for the COVID-19 pandemic: a call for action for mental health science. Lancet Psychiatry. 2020;7(6):P547–60.

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[ix] Watson, DE, Heppner, P, Roos, NP. Population-based use of mental health services and patterns of delivery among family physicians, 1992 to 2001. Can J Psychiatry. 2005;50(7):398–406.

[x] Caring for Ontarians Safely at Home during COVID-19, Ontario Community Support Association, Home Care Ontario, Fall 2020

[xi] Keeping the Doors Open: Maintaining Primary Care Access and Continuity During COVID-19 https://www.dfcm.utoronto.ca/ file/2420/download?token=bhwrs6VO

SUBMITTED BY:

The **Association of Family Health Teams of Ontario (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. We are an advocate and resource for family health teams, nurse practitioner-led clinics, and other interprofessional models.

The **Ontario College of Family Physicians (OCFP)** is the only organization focused exclusively on the value and experience of being a family physician in Ontario. It advocates for family medicine and primary care, and provides continuing professional development tailored to the needs of Ontario's 15,000 family doctors to support the delivery of quality care in Ontario.

The **Nurse Practitioners' Association of Ontario (NPAO)** is a not-for-profit organization and is widely respected and recognized as the professional voice of over 4,000 nurse practitioners in Ontario, including nurse practitioner-led clinics. Our goal is to ensure NPs are a key part of the healthcare system so they can deliver upon the promise of compassionate, patient-centered care.

The **Section on General & Family Practice (SGFP)** is a section of the Ontario Medical Association (OMA), representing all of the 15,000 family doctors across Ontario in negotiations and policy.