Report of the Working Group to the Primary Healthcare Planning Group

August, 2011

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Acknowledgment and Disclaimer

The Co-chairs of the Working Group on Primary Care Governance and Organization are grateful to the members of the Working Group. Their collective wisdom and insights are reflected throughout the document.

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Please Note: Membership on the Working Group on Primary Care Governance does not indicate full endorsement of every recommendation in this report. While the Co-chairs were guided by the critically important input of the members of the Working Group, this document was also influenced by our literature review and by in depth discussions with other stakeholders.

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Glossary of Acronyms and Definitions

AA	Accountability Agreement (sometimes referred to as a Health Service Accountability Agreement)
AHAC	Aboriginal Health Access Centres
BSM	Blended Salary Model
CCM	Comprehensive Care Model
CHC	Community Health Centre
CHF	Congestive Heart Failure
COPD	Chronic Obstructive Pulmonary Disease
EMR	Electronic Medical Records
FFS	Fee for Service
FHG	Family Health Group
FHN	Family Health Network
FHO	Family Health Organization
FHT	Family Health Teams
FP	Family Physicians
GP	General Practitioner
HSAA	Health Service Accountability Agreement (sometimes referred to as an Accountability Agreement)
HSP	Health Service Provider*
ICES	Institute for Clinical and Evaluative Sciences
NP	Nurse Practitioner
NPLC	Nurse Practitioner Led Clinic
OTN	Ontario Telemedicine Network
PC	Primary Care
PHC	Primary Health Care
PHPG	Primary Healthcare Planning Group
PHU	Public Health Unit
PEM	Patient Enrolment Model
PPCCN	Provincial Primary Care and Cancer Network
RN	Registered Nurse
RNPGA	Rural Northern Physician Group Agreement
THAS	Telephone Health Advisory Service
WG	Working Group
WGG	Working Group on Strengthening Primary Care Organization and Governance

* An organization and/or individual professional providing health services

Executive Summary

Governance involves the combination of structures, processes, policies and procedures to ensure that an entity delivers value (i.e. the expected outcomes) to its "shareholders". In the case of Ontario's publicly-funded healthcare system, the "shareholders" are the people of Ontario who fund the system and expect to receive excellent care from their system. In this document, the term "governance" refers to these functions and not necessarily to a governing body. There are three fundamental control functions in the governance of the healthcare system aimed at achieving its goals:

1. Planning and resource allocation to support success;
2. Monitoring; and,
3. Holding accountable and subsequent rewarding (i.e., resourcing contingent on performance).

Since a strong, equitable and high functioning primary care sector is essential for positive population health outcomes and the sustainability of our healthcare system, it is time to develop a more effective organizational and governance structure to support the primary care sector in the delivery of high quality care for all Ontarians.

In addressing the issue of primary care organization and governance, the key questions for our working group were how to ensure coordination and integration among primary care practices (i.e. family practices, Family Health Teams, Community Health Centres and Nurse Practitioner Led Clinics, etc.), and how to coordinate and integrate the activities of these primary care practices with other health and healthcare services in a geographic region. We focused our attention at two levels: (1) at the patient level to ensure that patients received high quality and coordinated care, and (2) at the population level within a natural referral area and/or a region to ensure that planning is effective and that economies of scale and scope are realized.

Our Working Group, made up of sector leaders with a range of experiences and perspectives, surveyed healthcare systems across a variety of jurisdictions, including the United Kingdom, Australia, British Columbia, and the United States. In addition, the Working Group members paid attention to structures already in place in Ontario that could be leveraged to provide support to the primary care sector. This review, joined with their vast experiences, informed the final report written by the co-chairs. Because our working group was both large and diverse, the Co-Chairs had a goal of using the Working Group's input to inform our recommendations. Membership on the Working Group, therefore, does not necessarily indicate support for all of the recommendations in this report.

Central to our recommendations is the need to give strong voice to family physicians, primary care nurses and other primary care professionals and to ensure their active involvement in the governance functions of the primary care sector – locally, regionally and provincially.

At the regional and provincial level, the voice of primary care practitioners is needed to ensure that what we refer to as a "**strong form of governance"** (i.e. a body with the **authority** to achieve the three functions of governance noted above) is not seen as "managing" primary care practices but rather as enabling healthcare professionals at the local and regional levels to meet the goals of the *Excellent Care for All Act*, 2010. While the functions of governance could be at the level of the Ministry, we believe that this authority, balanced by the strong voice of the primary care sector, should be assigned to a **single focal point in a geographic zone**. We assume that it would occur most effectively at either the level of the Local Health Integration Networks (LHINS), or a functionally equivalent body should LHINs be modified in the future, (Option A); at a sub-system level that we refer to as Integrated Health Systems (IHSs) (Option B); or a combination of both options (Option C).

We believe that both structures (or a combination of them) can achieve effective primary care governance, but only if these governance structures are given greater control and authority for planning,

monitoring and funding than is currently granted to the LHINs. We would envision that most practices will be agreeable to signing Memorandums of Understanding (MOUs) or the more enforceable Accountability Agreements with the LHINs (or IHSs) as the basis for resource allocations to better meet the needs of the individual practice populations. This recommendation implies the strengthening of the LHINs or the establishment of IHSs, which we believe is eminently doable.

In each of the governance models we propose, the Ministry would set provincial goals for which LHINs or IHSs (or a combination of both) would be accountable. These regional structures would develop plans to ensure population health needs are met with the balanced input of primary care providers and representatives from the broader healthcare system. The LHINs or IHSs would have the discretion to reallocate resources to ensure the greatest value for the province's healthcare investments; physician remuneration currently under the joint OMA-Ministry agreement would not be affected. Using the current Health Service Accountability Agreements (HSAA) framework, health service providers, including those in primary care, would sign accountability agreements with the regions (LHINs or IHSs) that would ultimately roll-up to meet a region's needs. To ensure both bottom-up and top-down planning processes, regardless of the form of regional governance, "tables" --- referred to in the document as Primary Care Councils and Sub-Councils --- are proposed to bring primary care providers together to better ensure coordination and integration in a community. Lastly, in order to achieve economies and avoid duplication of services, we suggest that the MOHLTC instruct Health Quality Ontario (HQO) and e-Health Ontario to provide centralized support to these governing bodies.

This report was written with the goal of better addressing population health needs using current system resources whenever possible, and implementable in the short to medium term. We believe the Ontario has many of the essential elements in place to develop an effective, well-governed primary care system with the capacity to further engage and support primary care providers in the delivery of high quality patient care.

In summary, this paper provides three viable governance options:

Option A: **A regional governance model based on LHINs or a LHIN-like structure that performs the three functions of governance.**

Option B: **A governance model based on naturally occurring referral areas (termed "Integrated Health Systems") that performs the three functions of governance.**

Option C: **A nested option that involves an overarching regional governance model based on LHINs or LHIN-like structures, along with Integrated Health Systems in naturally occurring referral areas.**

Present in all three options would be Primary Care Councils and Sub-Councils to ensure a voice and planning support for the LHINs and/or the IHSs.

Consolidated List of Recommendations

It is the position of the Working Group on Primary Care Organization and Governance that, if implemented, the following reforms and recommendations will help to strengthen primary care and health system governance and need to be addressed regardless of the chosen governance model:

Recommendation #1

The Ministry, with reference to the *Excellent Care for All Act, 2010*, announces its commitment to improving Accountability, Access, Efficiency and Quality in Primary Care. The achievement of this directly depends on an effective governance function.

Recommendation #2

The Ministry communicates to providers and Ontarians the view that good governance involves: (1) Planning and resource allocation, (2) Monitoring and (3) Holding accountable with subsequent rewarding contingent on performance.

Recommendation #3

The Ministry pursues the implementation of Option A (Governance based on a LHIN Regional Structure), B (Governance based on Integrated Health System), or Option C (Hybrid Model). Importantly, Options A and C can still be effectively pursued should current health region structures and systems (i.e. LHINs) be modified in the future.

Recommendation #4

The Ministry, whether it supports Option A or Option B or Option C, be willing to provide sufficient resourcing and funding authority to these regional structures so that their governance activities are not impeded.

Recommendation #5

The regional governance structures establish MOUs between themselves and "Primary Care Councils" based on provincial standards.

Recommendation #6

The regional governance structures provide support and infrastructure for primary care planning "tables" (e.g., Primary Care Councils and Sub-Councils) so that communities of providers can meet their individual and collective accountabilities and meaningfully contribute to local and regional planning.

Recommendation #7

The regional governance structures be given authority to write and enforce accountability agreements between themselves and all health services provider organizations in their jurisdiction including primary care providers. This implies the transfer of current accountability agreements with the Ministry (e.g., those between FHTs, NP-Led Clinics and the Ministry).

Recommendation #8

The Ministry continues to enhance e-Health Ontario and IT initiatives to support regional governance structures so that regional governance structures have reliable and timely data to support the three

elements of health system governance. Primary care, through EMRs/EHRs, requires a robust capacity for quality improvement capabilities and system-wide interconnectivity.

Recommendation # 9

Recognizing that many primary care providers, regardless of their funding model, will be initially challenged to meet accountability requirements under our proposed plan, the Ministry move to incent and support effectively all family practice models to strengthen their ability to function as true group practices capable of delivering comprehensive care. Since solo practice physicians may be especially challenged to meet accountability requirements under our proposed plan, the Ministry further support these physicians to practice in multi-physician/virtual group models.

Recommendation #10

Because Governance and Accountability are so inextricably linked, our Working Group also wishes to show support for the following four recommendations by the Working Group on Accountability.

(Accountability Working Group Recommendation #1)

To ensure the work of the Primary Health Care Planning Group and its constituent working groups continues, the Ministry should create a time-limited Primary Health Care Secretariat tasked with implementing the recommendations of this initiative. At a minimum, the mandate of the Secretariat should include the following:

- Prioritize the recommendations of the working groups and develop an implementation plan for action;
- Work with professional associations and other primary care stakeholders to develop and contribute to the implementation plan;
- Assign resources to support implementation activities;
- Adapt and amend the recommendations to reflect changes in the environment, such as regulatory/legal changes, fiscal changes, etc.
- Track progress with respect to the implementation of key recommendations.

(Accountability Working Group Recommendation #2)

The Ministry, in consultation with professional associations, patient groups and other stakeholders in primary care, should develop a clear and measurable statement of goals and objectives for which the primary care system is to be held to account. At a minimum, these goals and objectives should include:

- timely access to care (including after hours)
- relationships with other parts of the health system
- patient satisfaction
- provider satisfaction
- appropriate resource utilization
- patient outcomes (e.g. immunization rates, prevent care rates)
- attraction and retention, distribution of health human resources in primary care.

(Accountability Working Group Recommendation #3)

The Ministry, in partnership with Health Quality Ontario and others, should develop and implement measurement and monitoring strategy to identify how the primary care system is performing in reference to its goals and objectives. Attributes of the measurement and monitoring strategy should include:

- On-going, proactive measurement and monitoring
- Inclusion of patient feedback as an indicator of performance
- Development of benchmarks
- Regular reporting to stakeholders, providers and the public

(Accountability Working Group Recommendation #4)

The Ministry, in consultation with professional associations representing Interdisciplinary Health Providers, should develop a formal mechanism to track and analyze the activities of Interdisciplinary Health Providers to better understand the impact they are having in primary care, including in CHCs and NP-led Clinics.

I. Background

A. Development and Establishment of the Primary Health Care Planning Group

At the McMaster Health Forum in June 2010 on the topic of "Supporting Quality Improvement in Ontario", a number of stakeholders and experts identified the need for an overarching framework for strengthening Primary Health Care in Ontario. Forum participants concluded that two parallel initiatives should be pursued. These include:

1. A small planning group to draft and build consensus on an approach for strengthening primary healthcare in Ontario, and to plan a summit at which the proposed approach would be debated, finalized, and approved by a broad-based group of key stakeholders, including citizen and patient groups, and representatives from Local Health Integration Networks and from public health units; and,
2. The Quality Improvement and Innovation Partnership to convene one or more meetings to discuss the need and a plan of action for a strategic alliance focused on supporting quality improvement in primary healthcare, and then provide leadership and support to the strategic alliance.

The purpose of the Primary Health Care Planning Group is to address the first plan of action, as outlined above. The mandate of the Primary Health Care Planning Group includes the following activities:

- Draft and build consensus on an approach for strengthening primary healthcare in Ontario; and,
- Address key issues such as the rationale for primary healthcare investments; articulation of goals related to improving access and quality within primary care; a plan to monitor and evaluate progress against the goals, and; assess the impacts of investments and activities.

Membership of the Primary Health Care Planning Group includes representatives of the following organizations: Ministry of Health and Long-Term Care; Ontario Association of Ontario Health Centres; Ontario College of Family Physicians; Ontario Medical Association; Registered Nurses Association of Ontario.

The Planning Group proposed a framework for Strengthening Primary Healthcare in Ontario. The framework proposes (represented in Figure 1) that in strengthening primary care we should focus enhancing accountability and governance, and improving quality, access and efficiency. Five working groups were established, representing key areas of analysis deemed important to achieve this mandate.

Figure 1: Proposed Framework for Strengthening Primary Health Care in Ontario

B. Mandate of the Working Groups on Strengthening Primary Care Organization and Governance

There has been a significant investment during the last few years to address the emerging shortages in health human resources in the primary care sector and, to some limited extent, the organization of primary care services through the introduction of new blended funding models that support group practices amongst family physicians (FPs/GPs), as well as team-based models of care delivery. A cohesive organization and infrastructure that can help to articulate and set a direction to achieve primary healthcare goals is missing; likewise for standard setting and monitoring.

The Working Group on Strengthening Primary Care Organization and Governance (WGG) was established as one of five working groups of the Primary Healthcare Planning Group (PHPG) to develop a proposal to create effective and sustainable organization and governance of primary healthcare in Ontario by leveraging the current primary care models. In addressing this purpose, the WGG did not concentrate its efforts on the governance of individual practices but rather on the task of providing recommendations in four domains aimed at enhancing care for all Ontarians. The domains can be illustrated by way of the following two-by-two matrix:

Table 1: The Domains of Primary Care Organization and Governance

	Horizontal Integration Within the PC Sector	Vertical Integration of PC with Other Parts of the Health System
Patient Level	**1. How can primary care resources be more effectively linked to each other to provide better quality care for patients?** *For example, if a Family Health Team has developed expertise in dementia, it might support patients in the community attached to another family practice to provide access to that needed service.*	**2. How can the healthcare system ensure more effective coordination and integration of patients between primary care and other health system resources?** *For example, a "table" might focus on ensuring seamless care during pregnancy, delivery and postpartum, using the most appropriate care providers in the most appropriate setting to meet the needs of families.*
Strategic Planning Level	**3. How can primary care providers in a community or region more effectively work together to plan for the varied needs of all patients locally and/or regionally?** *For example, if a certain region has a high number of unattached patients or a provider moves away, primary care providers would come together to address these patients' primary care needs.*	**4. How can a governing body (e.g., LHINs) effectively align, plan for and resource appropriate health providers to ensure the effective and efficient provision of health services for a population?** *For example, a governing body might direct funds to primary care to develop health promotion programs focused on the social determinant of health to reduce demands on the acute care system.*

Horizontal Integration within the Primary Care Sector (Quadrants 1 and 3):
Horizontal integration is about connecting primary care providers (intra-, inter-, multi-, trans-disciplinary) to each other more effectively to make the best use of the available resources - both at the patient and the strategic planning level. Horizontal integration at the patient level includes designing mechanisms (virtual or structural) to more effectively link primary care providers (e.g. family physicians, nurses/NPs, mental health and social workers, dietitians, pharmacists, etc) so that they can provide better quality care to their individual patients and their collective community. At the strategic planning level, horizontal integration would focus on creating formal linkages amongst various primary care practices that are geographically, demographically and clinically aligned to gain economies of scale and establish accountability for access, quality of care, and coordination of activities within a community and/or a geographic region. This may also entail changes in current policies and practices to permit greater coordination (e.g., allowing patients registered in one family practice or a FHT to be seen in another).

Vertical Integration of Primary Care with other health system providers (Quadrants 2 and 4):
Vertical integration at the patient level is about ensuring better care coordination between primary care and the other health providers in Ontario (e.g., CCACs, acute care, specialty medical care, mental health, public health, community and social services, palliative care, long term care, etc.) At the strategic planning level, vertical integration is about establishing formal linkages between the primary care sector and the other parts of the health system, including non-primary care provider organizations, as well as those involved in health system planning, funding, and monitoring (e.g. LHINs, PHUs) to ensure the high quality, seamless care for patients.

Governance:
Governance involves the combination of structures, policies and processes to ensure that an entity delivers value to its “shareholders” (i.e. produces the expected health outcomes within the allocated funding envelop). In the case of Ontario’s publicly-funded health system, the “shareholders” are the people of Ontario who fund the system and expect to be well-cared for by that system. In this report, the term “governance” refers to “functions”, not necessarily a specific governing body --- though we believe that the charge to administer this function should be given to a designated governance structure (options to consider are described later in this report). Governance involves the following (Figure 2): 1) Planning and resource allocation; 2) Monitoring; and 3) Holding accountable and subsequent rewarding.

Figure 2: The Three Functions of Governance – Virtual Circle

Please Note: The objectives of the other Working Groups (i.e. Improving Accountability, Access, Efficiency, and Quality) directly depend on an effective governance function.

C. Working Group Structure and Work Plan:

The Working Group on Strengthening Primary Care Organization and Governance (WGG) was established by the Primary Healthcare Planning Group (PHPG). It was composed of primary healthcare experts and representatives from academic and research institutions, professional associations, regulatory colleges, Local Health Integration Networks (LHINs), providers and other system leaders. (See Appendix A for Terms of Reference the Working Group on Strengthening Primary Care Organization and Governance) The WGG was supported actively by the Ministry and met over a period of 3 months. The Co-Chairs (Brian Golden, Sandra Rotman Chair in Health Sector Strategy at The University of Toronto, and Jan Kasperski, Chief Executive Officer of the Ontario College of Family Physicians) provided regular bi-weekly briefings to the PHPG and the Ministry lead on this project, Susan Fitzpatrick, Assistant Deputy Minister, Negotiations and Accountability Management Division.

The WGG had a phased approached the development of its proposal:
1. Develop the Principles for the Governance Strategy
2. Establishing the Current State of the Primary Care Sector and the Change Imperative
3. Exploring and Validating Options
4. Confirming Long-Term Vision and Short- and Medium- Term Priorities

The Working Group was relatively large and diverse, and as a result, the co-chairs conducted a variety of individual stakeholder interviews beyond the three WGG meetings conducted between April and June.

D. Principles for Developing a Strategy

The WGG established the following principles in developing a strategy for sustainable and effective organization and governance of primary care:

1. **Centrality of Primary Care:** Ensures and promotes the importance of primary care in the system as the foundation of the healthcare system. Supports primary care practitioners to deliver comprehensive services and to maintain continuity of care as the essence of primary care service delivery.

2. **Collective Responsibility and Joint Planning:** Governance and organizational structures will enable primary care to take collective responsibility to meet the primary care needs of all patients at a local level. Planning would be both bottom-up and top-down.

3. **Maintains Current Employment Relationships and Associated Compensation Channels:** While accountabilities may change, employment relationships are maintained (e.g., physicians do **not** become employees of government and those compensated by OHIP remain so).

4. **Excellent Care for All (ECFA):** Supports ECFA's intent to make "health care organizations responsible and accountable to the public and focused on creating a positive patient experiences and delivering high quality care."

5. **Professionalism and Stewardship:** Confidence that healthcare clinicians and administrators intend to act in the best interests of patients and their families (professionalism) and that government will support professional obligations --- and not unintentionally create disincentives for doing so (Stewardship).

6. **Team-based:** Supports inter and intra-professional primary care delivery (i.e. interdependent, collaborative care models amongst healthcare professionals)

7. **Simplicity and Flexibility:** An effective vertical and horizontal organization of primary care is one that is simple and feasible to implement across the province while at the same time flexible so that it can be customized to allow for the heterogeneity of population and local needs.

8. **Patient or Client Centred:** An approach in which patients/clients are viewed as whole persons in the context of their family and community; it is not merely about delivering services where the client is located. The "patient-centred clinical method" involves advocacy, empowerment, and respecting the client's autonomy, voice, self-determination, and participation in decision-making."

9. **Leverage and Limited Duplication:** Where possible, uses existing resources and structures.

10. **Single Focus:** Aims for a single coordinating and integrating body within a focal point or geography.

II. Current Organization of Primary Care in Ontario and the Change Imperative

A. Internal Organization of Primary Care in Ontario†

Primary care reform/renewal in Ontario has focused initially on providing more health human resources to provide greater access to primary care. There has been a dramatic increase in the number of medical school placements, and family medicine training positions, a new medical school devoted to meeting the needs of rural and aboriginal Ontarians, as well as, the training of family practice nurses, nurse practitioners and physician assistants and the incorporation of dietitians, mental health and social workers, and pharmacists into practices. It has relied greatly on developing new contractual agreements for services (payment models for physicians, and incentive rewards for their performance) that have resulted in the development of several models of primary care delivery during the fifteen years. These include various physician compensation models, non-physician delivery models including midwives, inter-professional care models such as Family Health Teams, Nurse Practitioner-Led Clinics, intra-professional care models such as Shared-Care and Collaborative Care Models between family doctors and consulting specialists, in addition to specialized or alternative models to address unique circumstances such as rural or northern primary care. In addition, an increased number of Community Health Centres have been established in hard to serve communities.

Each of the models is associated with a basket of funding which is tied to an accountability agreement including those developed through OMA/MOHLTC negotiations. Most health service providers including Community Health Centres have their accountability agreements with the LHINs. Since all other primary care accountability agreements are held by the MOHLTC, the potential for creating greater coordination and integration is challenging and the stymieing of planning is great.

A listing of these models is included in Table 2. In addition, Appendix B provides a selective overview of relevant pilots and initiatives currently underway in Ontario. These various strategies have reduced the number of people in Ontario who do not have a family physician from 15% to 6.5%; however, there are close to 850,000 people who still require comprehensive and continuity of care by a family physician and other primary care professionals. Over 80%, people of with a family doctor are formally rostered and the number of physicians providing care in family practices/Family Health Teams through capitation-based funding models has increased exponentially in recent years. Over 3% of the population are receiving their care in NP-Clinics and Community Health Centres.

In addition to, or embedded within some of these accountability and funding mechanisms for family physicians are premiums and bonuses to support specific areas of practice, such as preventative services and after hours coverage. Depending on the physician group practice model (see the above table), an individual physician would be eligible for a selection of incentives in keeping with the individualized funding models.

Table 2: Overview of Primary Care Models in Ontario

Provider	Primary Care Model	Description
Physician	Comprehensive Care Model (CCM)	Solo physicians providing comprehensive primary care services to enrolled patients and some after hours care.
	Family Health Group (FHG)	Groups of physicians (3 or more) providing comprehensive primary care to enrolled patients on a 24/7 basis (through office hours and Telephone Health Advisory Services) through a blended funding model weighted towards fee-for-service.

† Much of the current section draws on the work of the Accountability Working Group as one of the objectives of governance is to create a system whereby accountability can be best achieved.

<table>
<tr><td rowspan="3"></td><td>Family Health Network (FHN)</td><td rowspan="2">Groups of physicians (3 or more) providing comprehensive care to enrolled patients on a 24/7 basis (through office hours and Telephone Health Advisory Services), compensated through blended funding models weighted towards capitation payments. Chronic disease management, disease prevention and health promotion are integral to these models. The main difference between FNH and FHO is the capitation base rate payment and the basket of core services with FHOs having a larger basket of services and correspondingly larger base rate payment.</td></tr>
<tr><td>Family Health Organization (FHO)</td></tr>
<tr><td>Fee for Service (FFS)</td><td>Physicians compensated for services performed according to the Schedule of Benefits. Many “focused practice” physicians receive fee-for-service payments.</td></tr>
<tr><td rowspan="4">Inter/intra professional</td><td>Family Health Team (FHT)</td><td>Inter-professional teams of family physicians, nurses, mental health and social workers, dietitians, pharmacists and other health providers (IHPs) providing comprehensive primary care to enrolled patients. Governed by a Board of Directors. IHP and operational funding established through agreement between FHT Board and ministry; physician funding through separate agreements in most cases.</td></tr>
<tr><td>Nurse Practitioner Led Clinics</td><td>Teams led by Nurse Practitioners and consisting of RNs, RPNs, collaborating physicians and others to provide primary care services to unattached patients. Patients have access to services through their primary care NP. NPLCs are governed by a Board of Directors that receive funding through an agreement with the Nursing Secretariat of the MOHLTC within a salary model of compensation.</td></tr>
<tr><td>Community Health Centres</td><td>CHCs are community-governed primary healthcare organizations that provide comprehensive, accessible client and community centred care through inter-professional teams of providers. They are integrated with social services and grounded in the community development approach. Services are designed to eliminate system-wide barriers to accessing healthcare such as poverty, homelessness, geographic isolation, cultural/language barriers, severe, persistent mental illnesses, etc.</td></tr>
<tr><td>Aboriginal Health Access Centres</td><td>Aboriginal community-led, primary healthcare organizations that provide a combination of traditional healing, primary care, cultural programs, health promotion programs, community development initiatives and social support services to First Nations, Metis and Inuit communities both on and off reserve.</td></tr>
<tr><td rowspan="4">Specialized</td><td>First Nations Agreements</td><td rowspan="4">Special alternate payment or salaried arrangements with providers delivering primary care in unique circumstances, such as rural and northern Ontario, to high needs populations, etc.</td></tr>
<tr><td>FP Focused Practice models</td></tr>
<tr><td>Homeless Shelter Agreements</td></tr>
<tr><td>Rural Northern Physician Group Agreement (RNPGA)</td></tr>
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B. Integration and Collaboration of Primary Care with other Parts of the System

Currently, relatively few formal linkages do not exist between PC providers and the rest of the healthcare system, although there are many informal ways in which various parts of the sector interact to better support and integrate with primary care providers.

Hospitals: Funded by and accountable to the 14 LHINs. While midwives and some primary care nurse practitioners provide care in hospitals, family physicians and/or consulting specialists provide the majority of hospital-based medical care. Family physicians provide emergency services, psychiatric services, obstetrical intra-partum care, well-baby care, inpatient care and outpatient services, oncology services, palliative and chronic care, as well as undertaking administrative, research and educational functions. Their relationships with hospitals vary, however, across different settings. At one end of the spectrum, mainly in rural areas, but also at some urban sites such as Credit Valley, William Osler, FPs may be the most responsible physician overseeing all aspects of clinical care, and at the other end, in urban settings, FPs may not be routinely informed when their patients are admitted or discharged. This occurs most often, but not only, when the FP does not have hospital privileges at that hospital. In some cases, even if FPs have maintained their hospital privileges, they may not be notified when their patients are admitted or discharged, especially when the patient is admitted directly for specialist care. In many Academic Health Science Centres (excluding those with family practice inpatient units) and some larger community hospitals, FPs do not have admitting privileges and care is provided exclusively by other specialists. In these institutions, some FPs may act as hospitalists, emergency physicians or clinical associates who work with other specialists to provide day-to-day inpatient or outpatient management (e.g. assisting oncology specialist). In some cases, the contracted services are very clear, in others it is less formalized with “hospital privileges” being the most common method of supporting FP engagement with hospitals. The lack of standardization results in varied payments.

Intra-disciplinary linkages: Family physicians and consulting specialists have a long and strong history of working together to provide care for patients. Specialty care in Ontario can be provided in clinics, specialty hospitals, and sometimes in PC group offices. Family physicians are the “gatekeepers” to the system in that other specialists rarely see patients without referral from FPs. In some cases, FPs often lose track of these patients after they have been referred to specialists and specialty clinics. To overcome some of the problems in the referral model of care and to provide more effective care for patients with multiple co-morbidities, many consulting specialists are engaging in “Shared-care”, “Collaborative Care Networks” or “Communities of Practice” with family doctors to bring their joint knowledge and skills to the care of patients. In addition, several examples exist in which family physicians in various communities, regions and provincially have developed Networks, Councils, Associations and Committees to work together to address patient care and system-wide issues. The OCFP’s “Leadership” Connect is one example of a Network with regional and provincial arms linking family physicians.

Cancer Care Ontario: CCO has established a provincial program that is managed centrally and implemented regionally. Family physicians (i.e. Regional Primary Care Leads) are supported by CCO to liaise with other family physicians in their region to better integrate the cancer system with family practices. The PC Leads form a provincial network called the “Provincial Primary Care and Cancer Network” (PPCCN), coordinated by the Provincial PC Lead and a small management group. Each Regional PC Lead was provided with a standardized, centrally developed contract to champion screening and improve earlier detection of cancer in his/her region and to facilitate “shared-care” throughout the cancer patient’s journey.

Diabetes Ontario: This is a regional model of a MOHLTC program that includes the development of the Diabetes Regional Coordinating Centres. Family physicians were recruited by the RCCs and provided with a contract to serve as “Regional Diabetes Leads” to help improve the provision of diabetes care amongst family physicians and other primary care providers.

Community Care Access Centers (CCACs): Funded by and accountable to the LHINS. CCACs are geographically aligned with the 14 LHINs and are responsible for providing information and referral services, hospital transition planning, home care and access to long term care for their communities. The CCACs are also responsible for the Care Connect program, designed to support and find primary care for unattached patients. While there is no formalized provincial approach, there exists a range of partnerships and/or initiatives intended to integrate CCACs and primary care across the Province. Examples of these partnerships include embedding CCAC Care Coordinators in Family Health Teams and physician practices to provide care coordination and system navigation to patients and the practitioner /team (HNHB, Champlain, Waterloo Wellington); supporting primary care-focused chronic disease management (South West); and providing an interdisciplinary team to primary care to support under-housed and homeless populations (Toronto). Many CCACs also provide transition support to connect primary care to patients after a hospital discharge.

Local Health Integration Networks (LHINs): CHCs are the only primary care practices that are funded by LHINs and accountable to their Boards. While other family physicians are not funded by the LHINs --- ***and we are not suggesting that their OHIP payment scheme should be altered*** --- they play an integral role in ensuring that a community's population health needs are met. While the LHINs recognize the value of engaging FPs in involving them in planning and priority setting at the local level, local planning practices across the LHINs for the engagement of FPs vary. To this end, Primary Care Councils or Networks have been established in several LHINs. LHINs have conducted engagement sessions to inform family physicians of their Integrated Service Plans (ISPs) and most LHINs have tried to engage them in providing input prior to finalizing their ISP.

Please Note: Though there has been discussion across political parties about the future of LHINs (e.g., a smaller number of LHINs or the elimination of LHINs), this report assumes the continued functioning of LHINs or some future body that has the same or similar responsibilities and functions and is built around geographic regions.

Public Health Units (PHU): Governed by a Board of Health under the Health Promotion and Protection Act, and administered by a Medical Officer of Health and recently mandated to include a Chief Nursing Officer, PHUs are municipal health agencies who administer health promotion and protection programs, such as communicable disease control, immunization, and food premises inspection. There are no formal linkages between PHUs and primary care practices; however, informal links are present within most PHU catchment areas. Several Medical Officers of Health make routine outreaches to the primary care sector. These efforts have become more visible in pandemic planning and the increased focus in family practices on the health of individuals in their practices and not just on the provision of healthcare. Public Health Nurses are more actively involved in the primary care sector, especially in the care of people presenting to CHCs.

Provincial Primary Care Associations: The Ontario Association of Health Centres of Ontario (AOHC) and The Association of Family Health Teams of Ontario (AFHTO) are provincial organizations that have been established to provide support for CHCs and FHTs. AOHC supports CHCs and most "Community-led" FHTs, whereas AFHTO tends to support the "Mixed Community/Provider-led" FHTs and "Physician-Led" FHTs. While these organizations do not have "governance" responsibilities for CHCs or FHTs, they function as mechanisms to link CHCs and FHTs to share some resources and innovations and to support the engage of their member organizations in quality improvement activities.

C. The Governance Change Imperative

The Governance Change Imperative is anchored in the belief that a strong and well-organized primary care sector is the key factor in achieving positive population health outcomes and the sustainability of our publically funded healthcare system. Great strides have been made in the last 15 years; however, in light of the resources available in intra-professional team models that are not available in other models, there

are concerns being expressed that we have created a "two-tiered primary care system". Much more is needed at the local, regional and provincial level to even the playing field to ensure that each Ontarian receives equitable access to the services they need to remain as healthy and stable as they can as long as they can. While improvements in care are needed at the practice level, "equitable' access to primary care (i.e. the most care for those most in need) will not occur without system-wide alignments of goals and objectives, appropriate resource allocations and a focus on accountability within the framework of the 'Excellent Care for All" Act. The functions of governance are critical in realigning the system to create the "patient/client centred' model that we aspire to provide for Ontarians.

As noted above, governance involves the three-function virtuous circle of: (1) Planning and resource allocation, (2) Monitoring, (3) Holding accountable and subsequent rewarding[‡]. In Ontario, there are not currently any primary care governance structures that effectively ensure that these activities are achieved and that the needs identified within each quadrant in Table 1 are met. Those structures that do exist were created often as a result of an ad hoc creative effort and may achieve some but not all of the needed functions of governance; however, there are some that were created to achieve purposeful results. These structures indicate the willingness of primary care practitioners to engage in the work of governance and bode well for the implementation of structures that focus on quality patient care. Consider for instance the Accountability Working Group's comment:

"Although accountability agreements and various incentives and premiums form the basic accountability and funding infrastructure in the primary care system, these alone are not sufficient to ensure parties are being held responsible for their activities. On-going monitoring, measuring and, where necessary, corrective action or remediation are key elements in how accountability is operationalized as these activities can inform parties on both sides of the accountability relationship if established goals and objectives are being realized and how to rectify if not." ("Improving Accountability in Primary Care-FINAL", pp. 5-6)

Based on our review of Ontario and other jurisdictions (below), we believe that the three elements of effective primary care governance can only be achieved when all three elements come under the responsibility of a single governance structure; however, that governance structure needs to informed by the strong voice of primary care providers through their active participation in its planning and decision-making processes. In theory, this could be the MOHLTC proper, the LHINs, or another structure to be formed (though with the input of others, e.g., the colleges, various professional bodies, etc.). We do not believe that effective coordination and integration within the primary care sector and between primary care and other health system providers can be achieved with different loci of accountability. Moreover, we do not believe that a "top-down" approach will work, without first and foremost, a strong focus on the creation of "bottom-up" structures that provide for a cogent voice amongst primary care providers at the local, regional and provincial levels.

Each governance option has strengths and weaknesses, addressed in a later section of this report. In addition to selecting the appropriate governance structure, the MOHLTC will have to decide how much authority rests in the selected governing body from the ability to bring parties together (so called "tables") but not mandate behaviours, to greater authority through accountability agreements and performance management.

[‡]Our report, based on numerous reviews of rewards and incentives in health care, takes as a given that rewards/incentives have a powerful effect on the behaviors of individuals and organizations (See reviews by Deber and Wodchis, 2007 and Golden and Sloan, 2008). We also acknowledge that much remains to be learned about the effective use of rewards and incentives, and that poorly designed systems may result in unintended consequences. Thus, we support the use of rewards and incentives to influence behavior, but recognize the need to monitor their impact and redesign them, as necessary.

III. Organization of Primary Care in Other Jurisdictions

Our review of other jurisdictions that have made notable advances in primary care include systems in the United Kingdom, Australia, New Zealand, United States, Alberta and British Columbia. All systems reviewed are non-profit, though they may “sub-contract” to private enterprises, or what Raisa Deber refers to as “private for profit small businesses” (e.g., physician practices which may, in fact, “earn a profit”) nd, with the exception of Kaiser-Permanente in the U.S., publicly funded and administered. These systems are not reviewed because they represent a model for Ontario, but they are illustrative of some options available to Ontario. See Appendix C for a Scan of Primary Care Organization and Governance in Selected Jurisdictions.

Veterans Health Administration (United States)

While the patient population served by the Veterans Health Administration (VHA)is more homogeneous that Ontario’s, in many ways, the Veterans Health Administration’s transformation from 1994-1999 is most similar to the changes experienced in Ontario; hence, we begin our review of other jurisdictions with the VA (Golden and Martin, 2004). In the mid 1990s, the Veterans Health Administration shifted their system from a hospital-centric system to a primary care focused system with a centralized and decentralized model of governance in many ways similar to the MOHLTC/LHIN organizations in Ontario.

Each region in the VA was organized into one of 22 Veterans Integrated System Networks with each VISN included the full complement of health system resources (hospitals, primary care, mental health services, community services, long term care, and home care*).* VISN are led by a VISN Director responsible for achieving centrally set and monitored health and fiscal targets (set in Washington by the equivalent of Ontario’s MOHLTC). The budget for each VISN was determined based on risk-adjusted population-based health predictions. Performance metrics were set and monitored for each VISN. Numerous back office operations were centrally managed for maximum effectiveness (e.g. the development of what became a world class information system with fully operational EHRs occurred within 4 years). Critically important to the success of the VA during this period was full operational and budget control by the VISN Directors (and the concomitant reduction of “corporate” staff in Washington), and a single planning and monitoring focal point in each VISN (i.e., the office of the VISN Director). Each Director was accountable for achieving centrally set directives; however, they had discretion to meet local population health and service needs. Directors were incented, therefore, to use their budgets effectively and efficiently, and, within just a few years, there was a substantial shift away from the acute care sector and a greater emphasis on primary care, prevention, and community supports. Exhibits 1 and 2 reveal the success VHA transformation (excerpted from Edmondson, Golden, and Young, 2007).

Exhibit 1: Selected Organizational Successes of the Veterans Health Administration

Operational Success
▪ The Operations and Management of 52 Hospitals merged into 22 IHSs
Operational Efficiency
▪ Reduced per patient costs by 25% (based on constant dollars). ▪ Closed 55% (28,886) of acute care hospital beds. ▪ Reduced bed days of care per 1,000 patients by 68%. ▪ Decreased staffing by 12% (25,867 FTEs). ▪ Increased ambulatory surgery from 35% to >75% of all surgeries. ▪ Eliminated 72% (2,793) of all forms and automated the rest. ▪ Introduced a universal access and identification card (a “semi-smart” card).
Patient Satisfaction
▪ Improved performance on the American Customer Satisfaction Index. In 1999, 80% of VHA users were more satisfied with experience than two years ago. The VHA score on the index is 79 vs. 70 score for private hospitals.

- Patient satisfaction scores for outpatient care (based on the VHA national surveys of patients) have improved by more than 15%.

Exhibit 2: Selected Clinical Successes of the Veterans Health Administration

Convenience and Accessibility of Care
▪ Increased patients treated by >24% (700,000). ▪ ~350,000 (36%) fewer admissions per year. ▪ A 48% increase (25 to 37 million) in ambulatory care visits. ▪ Established 302 new community-based outpatient clinics (without new funding). ▪ Telephone-linked care programs established at all hospitals.
Clinical Outcomes
▪ Overall 30-day mortality and morbidity rates dropped 9% and 30%, respectively, from 1994 to 1997, with no change in patient risk profile. Mortality rates were the lowest or equal to U.S. lowest comparables for colectomy, abdominal aortic aneurysm repair, carotid endarterectomy, cholecystectomy and hip replacement.
Outpatient-Oriented Primary Care
▪ Implemented universal primary care. ▪ Percentage of surgeries performed on an outpatient basis increased from approximately 35% to over 75%. ▪ Percentage of patients receiving cancer screening for early detection of several types of cancers has increased substantially (e.g. colorectal cancer screening from approximately 34% to 74%). ▪ Percentage of patients receiving treatments for preventing or controlling disease has increased substantially (e.g. cholesterol management for heart disease from approximately 74% to almost 100%).

Australia – Divisions of General Practice

Divisions of General Practice were established in Australia in 1992 as voluntary, non-for-profit, and government-funded organizations with the aim to support enhance quality, access, integration, and to focus on chronic disease prevention and management. The Divisions are governed by a Board of Directors (predominantly GPs) with management support from non-GP staff. While they do not have a direct clinical role, they provide infrastructural support to practices in their respective regions and have a role in translating populations and public health initiatives to primary care. They are funded according to a weighted population formula and are budget holders for some national initiatives, including those that improve the access of GPs to other primary healthcare providers. These divisions are largely advisory and represent a "table" around which the divisions can bring together primary care providers to address population needs within a geographic zone. They have relatively little authority to hold care providers accountable for performance; however, "accredited practices" that demonstrate high quality care based on the Royal Australian College of General Practitioner's *Standards for General Practice* become eligible for significant government supported incentives, such as funding for chronic disease management and inter-professional team supports. This combination of effective supports and the incentive process has resulted in quality improvements in the practices and the system, in general as more than 90% of general practices are accredited and many for the third or fourth times.

New Zealand – Primary Health Organizations

Primary Health Organizations (PHOs) were established in New Zealand during the 2002-2005 timeframe as local level, non-for-profit organizations for the provision of essential primary care services to an enrolled population. PHOs are administered as a part of the activities of District Health Boards and have an explicit requirement to include a broad group of healthcare providers in their decision making process. PHOs are directly accountable to the Government via the District Health Boards and have the authority to hold funds and enter contractual agreements with general practices. In a similar fashion to Australia, New

Zealand's practices are supported to undergo an accreditation process called the "Cornerstone" program based on the "*Aiming for Excellence"* program originally developed in Australia. It was this program that was used as the model for the McMaster/OCFP Quality in Family Practices program and "The *Quality* in family practice Book of Tools".

United Kingdom – Primary Care Groups/Primary Care Trusts

The UK's Primary Care Groups (PCGs) were established in 1997 to provide general practitioners with fund-holding responsibilities for primary, secondary and tertiary services, and became "Primary Care Trusts" (PCT) in 1999. PCTs were established to devolve power and an increased range of responsibilities to the regions. By continuing to place primary care at the centre of the National Health Service (NHS), PCTs were expected to engage local communities in the decisions that affect their local health services. PCTs have a broader mandate than the organizations in New Zealand and Australia in that they are involved health planning, primary care development, a range of secondary and tertiary purchasing, and the delivery of primary care, as well as public and community health services. As part of the restraint process, the UK is currently discussing a process of eliminating the PCTs and reverting to funding holding by the GPs (i.e. a return to PCGs to reduce administrative costs in the NHS).

Primary Care Organizations in Australia, New Zealand and the U.K.:

Key Attributes:
In an effort to transform the primary care landscape, the primary care organizations in the United Kingdom, Australia, and New Zealand have been established in the past two decades as "organizations that seek to increase the influence of primary care organizations, and in particular general practitioners, in health planning and resource allocation". While the aims of the objectives of these organizations vary, their fundamental purpose is to establish links between activities at the micro level of care delivery (clinical care delivered by individual practitioners and quality improvement activities) and the macro level of care delivery (systems responsible for policy, funding, and infrastructure).

Common Features:

- They differ from professional organizations and are primarily funded by governments.
- They are regionally organized and are responsible for the needs of both the community and primary care clinicians.
- Have responsibilities for access, quality of care, and coordination of primary care activities within their region.

Identified Benefits:

- Substantial physician participation and satisfaction.
- Improved access, particularly to after-hours services.
- Optimized use of electronic medical records.
- Facilitation of quality improvement and assurance activities.
- A focus on the prevention and management of chronic conditions.
- Reduction in diagnosing and prescribing costs.

Kaiser Permanente (United States)

Established in 1945, Kaiser Permanente consists of the Kaiser Foundation Health Plan and the Kaiser Foundation Hospitals which are integrated with independent physician group practices called Permanente Medical Groups. The Health Plan is the insurance arm of the organization, while the hospitals and medical groups provide all clinical services. Both primary care and specialist physicians in the Kaiser system are shareholders or partners and salaried employees of the Medical Groups. Kaiser owns and operates most of its own ambulatory facilities and hospitals. Kaiser is responsible for the complete care

cycle for the patient which promotes a focus on prevention and care outside the acute care sector. The goal is to minimize the need for care through good population-based “health’ practices.

Alberta – Primary Care Networks

Primary Care Networks (PCNs) were formed in 2005 in Alberta as voluntary groupings of FPs who continue to own and operation their own practices. A joint venture agreement is created between Alberta Health Services and the physician group which is responsible for forming a non-profit corporation. The partnership creates a governance committee that provides oversight for PCN strategic directions and a structure to handle daily operations. In addition to Fee-For-Service payments, PCNs receive $50 per patient that is used to hire allied professionals to create inter-professional teams to assist with the provision of chronic disease prevention and management, to increase access to after-hours service, and to better coordinating home care, mental health and public health services. PCNs range from a group of 3 doctors to more than 200 with an average of 60 family physicians per PCN.

British Columbia – Divisions of Family Practice

“Divisions of Family Practices” (DFPs) (i.e. affiliations of family physicians 11) were launched in 2009 by the General Practice Services Committee (GPSC), a joint British Columbia Medical Association/Ministry of Health Services (MoHS) initiative. While the initiative is intended to give physicians a stronger collective voice and more impact in their community, the Divisions prime purpose is to assist the family physicians to work together with three purposed in mind: 1) to improve their clinical practices; 2) to offer comprehensive patient services, and 3) to influence health service decision-making in their community. Membership in any DFP is open to all FPs with common goals and/or in the same geographic area. Three prototype DFPs are currently in development and are being designed to work with their local health authority (HA) and community agencies through a Collaborative Services Committee (CSC), co-chaired by both a DFP and an HA representative. The CSC will develop and implement solutions to issues facing the delivery of health services at the community level across the continuum of care. Any initiatives requiring additional funding will require the support of the Division, local HA and BC’s Ministry of Health Services.

IV. Exploring Options for Ontario

Caveat: Our working group believes that the recommendations below may need to be modified contingent on the recommendations of the other working groups.

A fundamental decision in designing a primary care system, and the governance system for primary care, in particular, concerns "control". Namely, who governs? How do they govern (e.g. the level of input from providers)? And what is the extent of their authority and over what (e.g., budgets, financial and clinical performance metrics)?

A relatively weak form of governance creates a "table" around which various stakeholders can gather to identify population needs and coordinated ways by which stakeholders can achieve their objectives. Such tables can also be used as mechanisms for the diffusion of "best practices". Importantly, these tables rely a great deal on good will, a culture of cooperation and the ability to identify mutually beneficial objectives among stakeholders. In general, however, they have no formal authority and instead must rely on persuasion. That being said, amongst dedicated healthcare professionals, they can be effective in meeting most established objectives.

While "tables" may address some of the functions of governance, it would be unusual for them to be able to achieve the results expected of a stronger form of governance, whose need is implied in the report by the Working Group on Accountability. The stronger type of governance would be given the authority and control to a governing structure to achieve its 3 primary functions:

1. Planning and resource allocation
2. Monitoring
3. Holding accountable and subsequent rewarding

The recommendation of this Working Group is that a "bottom-up" and "top down" planning process be put into place to ensure a strong and cogent voice for family physicians, primary care nurses and other primary care professionals at the local, regional and provincial levels. Primary Care Councils/Sub-Councils, (i.e. "tables") should be established for each of the three options below to support primary care providers to meet their individual and collective goals for which they are accountable.

Primary Care Councils and Sub-Councils

Since care is delivered primarily at the local level, each of the three options below incorporates the concept of **Primary Care Councils and Sub-Councils. Primary Care Councils would be established at the LHIN or equivalent level (options A and C) and Sub-Councils would be established at the micro-region level (Options A, B and C).**Similar to those in British Columbia and Australia, the Primary Care Councils/Sub-Councils, locally and/or regionally would be "tables" to identify and jointly plan for addressing primary care needs, and would work cooperatively with other health service providers in their community. They could be given some discretionary funds to incent behaviours, but, in general, would have limited ability to hold providers accountable.

The PCCs could be established by building on the existing Councils, such as the OCFP's Leadership Connect and those established by the LHINs or the MOHLTC that have the potential to ensure health professionals contribute significantly to regional planning. Councils could be established at one of the local Family Health Teams or CHCs. The advantage of this approach is that the FHT is already in place; the centre of the Council could rotate over time across FHTs in a region. Another variant of this model would be to provide support for the Councils from local hospitals, CCACs, Public Health Units or the

regional CCO centre. This approach would involve engaging the management and the infrastructure from these organizations to assist with support functions.

The membership would include representation from: Family Health Teams, Community Health Centres, Aboriginal Health Access Centres, NP-Led Clinics, Family Health Organizations, Family Health Networks, Family Health Groups, Solo Practitioners, Consulting Specialists and Specialized Clinics, Relative Hospital(s), Mental Health/Social Services, Public Health, CCAC and CCO. These councils would be chaired or co-chaired by a primary care professional(s).

Additional features to note:

- Each Council would assist in the coordination of resources to meet the primary care needs of the population as outlined in the accountability agreements between LHINs and, or IHSs **(described below in Options A and B)** and the HSPs.
- Performance of the PCC would be reflected in the progress made by each health service provider's accountability agreement with the LHIN and/or IHS. The PCC would support the ability of each HSP to meet their targets.
- MOUs would be established between each PCC and LHIN or IHSs. The MOU developed by LHIN CEO Paul Huras in the Southeast could be used as a starting point for new PCCs.
- Regional performance indicators would be coordinated and monitored by HQO.
- The PCC would represent the primary care sector to the Ministry of Health and Long Term Care and the broader system. The chairs of each PCC would be expected to attend planning sessions of two types: 1) with the chairs of the other PCCs (in the other LHINs or IHSs) to discuss primary care planning issues relevant throughout the province and 2) with representatives from the broader system to give input and build relationships.
- Representatives from the Primary Care Sub-Councils would form the membership of the Primary Care Councils in a manner similar to the South East Primary Care Council co-chaired by Dr. Glenn Brown and Paul Huras.

The options below are intended to address the governance needs highlighted in Table 2, namely achieving horizontal and vertical integration at the patient level and strategic planning level.

A. Option A: A Regional Governing Structure:

Assuming LHINs, but achievable with alternative regional structures

1) **All HSPs within a region accountable to the LHIN; and,**
2) **"Primary Care Councils/Sub-Councils (i.e. "Tables") established and supported for coordination and integration, locally and regionally.**

Description

Like the VISNs of the Veterans Health system and Primary Care Trusts in the UK, LHINs (or another type of regional body) have the potential to effectively provide the 3 functions of health system governance. Indeed, many suggest that the strengthening of primary care should have been one of the central goals of LHINs, but that their success in doing so has been variable. We believe that a more fully evolved LHIN-type governance structure can strengthen primary care in Ontario. For this to occur, the following major condition must be satisfied:

- Change accountability agreements of Family Health Teams (FHTs), Nurse Practitioner Clinics (NPs) and specialized models so that all are accountable to LHINs. The LHINs on the other hand would be expected to appropriately resource these providers so that they may meet their agreed upon accountabilities.

Accountabilities would have to be separately determined for the small percentage of FPs/GPs in non-enrolled models, taking in to account the different nature of those practices. While physicians in the various enrolled models (i.e. FHGs, FHNs, FHOs and FHTs) would continue to be paid through OHIP, agreements could be established between the LHINs and the physician groups in their regions in return for the supports needed to meet LHIN objectives which would continue to be aligned with reasonable patient objectives in these practices Many we interviewed --- consistent with the literature reviewed --- suggested that it is difficult to align the goals of these models and other health service providers (HSPs) in LHINs when they are accountable to the MOHLTC while other health service providers (e.g., Community Health Centres, hospitals, CCACs, mental health and other community-based providers and long term care facilities) are accountable to LHINs. This dual reporting structure largely prohibits LHINs from planning --- and funding --- across providers to meet a region's population health needs.

- In addition, in developing a strong governance model with provider voice at the local and regional level, the following features would be promoted:
  - Primary Care Councils and Sub-Councils would be established in natural referral areas within the region (see description above).
  - Whenever possible, LHINs would rely on existing resources (e.g., the research infrastructure of Depts of Family Medicine) for planning and monitoring.
  - The Ministry-LHIN-OMA tripartite agreements would be maintained.

Advantages
- Uses existing management resources; although PCCs may require additional infrastructure funding.
- Allows the LHIN to reallocate funding to focus more attention on population health rather than just healthcare, and to strengthen (where appropriate) non-hospital based care providers in order to lessen the demand on the acute care sector.
- Allows for local input and adaptation but also incorporates regional priorities.
- Provides a table for regional coordination between the sub-councils, which can be important for resource allocation/coordination, among other goals. For example, if one micro-system has only two GP-Anaesthetists, and another region has three, the regions can coordinate schedules/vacation/education between all five.

Disadvantages
- This approach requires the coordination of all sub-councils within a region and rolling them up to the PCC. All system design decisions imply trade-off between local responsiveness and economies of scale (related to cost) and scope (related to sharing of resources and capabilities).

Necessary Conditions
- Many of the LHINs have evolved since their founding. The Ministry must be willing to give the LHINs sufficient autonomy and authority to discharge their duties. Critically, this involves having strong governance and management skills to function effectively as a “fund-holder” for the majority of health services in their region.
- Coordinating and integrating IT functions of the primary care providers within the LHIN to enable communication and efficiency in patient care is essential. Information Technology is also the key factor in the effective management of indicators/performance.
- The Ministry must be willing to make a small up-front investment in management resources to ensure structures are set up as intended. Savings from effective coordination will be evaluated to demonstrate value. (As an example, the OCFP recently presented the MOHLTC with a proposal to oversee an educational program to train Family Health Teams to set up their own Memory Clinics based on the highly successful Memory Clinic at the Family Medicine Clinic FHT in Kitchener. By decreasing the percentage of patients with mild cognitive impairments referred to Regional Geriatric Programs from a high of 87% at $1500 per patients to an average referral rate of 7 to 9% with cost

absorbed by the FHT budget, the model has the potential to, not only accrue system savings, but also to reduce wait-times for these highly specialized services.)

B. Option B: Formalize Integrated Health Systems (IHS)

Based on the informal "Multi-Specialty Provider Networks" identified by ICES

1. **All HSPs within a network accountable to the IHS; and,**
2. **A "Primary Care Council" (Table) established and supported for coordination and integration.**

Description

- Formalize IHSs based on ICES' description of current referral patterns (approximately 70); each of these networks has 1 or more hospitals.
- IHS budget would be allocated to IHS office to meet full set of community needs, creating incentive for IHS leadership to allocate resource to most appropriate, least expensive providers over time (e.g., health promotion vs. acute care)
- Each Integrated Health System (IHS) would have its own CEO and Board of Directors. He or she would be CEO of the IHS only, and not any of the service providers.
- The IHS would report directly to the MOHLTC, with the MOHLTC holding ultimate control to performance manage the IHS and replace, if necessary, the IHS leadership.
- The IHS would receive funding from the Ministry and use it to purchase services to meet patient population needs.
- The IHS would establish accountability agreements with each of the services required, including CCAC, hospitals, long term care and primary care.
- The IHS could draw on management resources existing at its central hospital, as well resources in the local CCACs, Public Health Units, etc.
- Each IHS CEO would establish a "table" or Advisory Council with representatives from all clinical and service areas, including primary care.
- Each IHS would have a Primary Care Council **(see description in Option A)** whose representatives would connect with their counterparts in the other IHSs across the province, meeting annually or more frequently as needed.
- Whenever possible, IHSs would rely on existing resources (e.g., the research infrastructure of Depts of Family Medicine) for planning and monitoring.

Advantages

- Locally sensitive – allows for local input and adaptation (including identification of problems and goals at the practice level).
- Leverages sophisticated systems typically resident in hospitals (e.g., IT).
- Like the experience of the VA, this allows the IHS to reallocate funding to focus more on health than healthcare, and to strengthen (where appropriate) non-hospital-based providers in order to lessen the demand on the acute care sector.
- Allows for local input and adaptation but also incorporates regional priorities.
- Though central Toronto may be seen as an anomaly due to the size and number of hospitals, many community hospitals are already serving an integrating function with the primary care sector through the Departments of Family Medicine/Medical Advisory Committees. However, incentives are not aligned to put a community's needs over the hospital's needs. A separate IHS governance structure would ameliorate a hospital centric-bias of perspective.
- Alignment of hospitals, specialists and family physicians/other primary care professionals to promote local input and planning, and shared accountability.
- Provides the context within which to engage hospitals and physicians on shared accountability to incentivize best practice and integrated care.
- Potential integration of primary, secondary, tertiary and community care with potential to include CCACs, LTC, allied health professionals.

- Provides a platform for Accountable Care Organizations (ACO), a system of care that collectively serves a specific population, can be held accountable for quality, are large enough for accurate performance measurement, and have the ability to implement system quality improvement.

Disadvantages

- Creates approximately 70 leadership groups and attendant costs (e.g., salary). Cost could be mitigated by some shared services across the IHS in a region. To avoid the above costs such as salary, the local hospital CEO could also be named CEO of the IHS.

Please note: We do not advise such a joint employment arrangement (i.e., whereby the hospital CEO also acts as the IHS CEO) since doing so would make it likely that a hospital-centrism will be reinforced, counter to our working principles. Hospital CEOs may be challenged to achieve the kinds of resource reallocations that were experienced in the VA as it shifted from an acute care to a primary care and community focus.

- It may be challenging to remunerate hospital CEOs or other highly experience administrators at their current levels if they were to migrate from their current roles to one solely responsible for the leadership of the IHS.
- As mentioned above, all system design decisions imply trade-off between local responsiveness and economies of scale (related to cost) and scope (related to sharing of resources and capabilities). This option implies substantial coordination demands across IHSs and may lead to local optimization of resources and system sub-optimization as IHS would not have a vantage point to see across a bigger geography.

Necessary conditions

- An effective IT infrastructure is essential.
- Some up-front investment in management resources needed as per comments under option A.

C. Option C: Joint LHIN and IHS Nested Governance

1. **An overarching regional governance model based on LHINs or LHIN-like structures (macro level);**
2. **Integrated Health Systems in naturally occurring referral areas (meso level);**
3. **One Primary Care Council at the LHIN or equivalent regional level;**
4. **Primary Care Sub-Councils for each IHS.**
5. **The necessary conditions, advantages and disadvantages described for options A and B would apply. Compared to Options A and B, Option C also has the advantage of greater local sensitivity but with an additional infrastructure cost (which may be justified by enhanced performance).**

Description

Option C represents a hybrid governance model, combining features of Option A and Option B. As noted earlier, all governance structures involve trade-offs. There are two main advantages of Option C. First, it provides the local sensitivity described in Option B and also allows the integration potential described in Option A. However, Option C also involves additional administrative costs which need to be compared alongside the potential performance advantages. Whenever possible, existing resources would be leveraged for planning and monitoring to minimize these additional costs.

V. Recommendations

It is the position of the Working Group on Primary Care Organization and Governance that, if implemented, the following reforms and recommendations will help to strengthen primary care and health system governance and need to be addressed regardless of the chosen governance model:

Recommendation #1

The Ministry, with reference to the *Excellent Care for All Act, 2010*, announces its commitment to improving Accountability, Access, Efficiency and Quality in Primary Care. The achievement of this directly depends on an effective governance function.

Recommendation #2

The Ministry communicates to providers and Ontarians the view that good governance involves: (1) Planning and resource allocation, (2) Monitoring and (3) Holding accountable with subsequent rewarding contingent on performance.

Recommendation #3

The Ministry pursues the implementation of Option A (Governance based on a LHIN Regional Structure), B (Governance based on Integrated Health System), or Option C (Hybrid Model). Importantly, Options A and C can still be effectively pursued should current health region structures and systems (i.e. LHINs) be modified in the future.

Recommendation #4

The Ministry, whether it supports Option A or Option B or Option C, be willing to provide sufficient resourcing and funding authority to these regional structures so that their governance activities are not impeded.

Recommendation #5

The regional governance structures establish MOUs between themselves and “Primary Care Councils” based on provincial standards.

Recommendation #6

The regional governance structures provide support and infrastructure for primary care planning “tables” (e.g., Primary Care Councils and Sub-Councils) so that communities of providers can meet their individual and collective accountabilities and meaningfully contribute to local and regional planning.

Recommendation #7

The regional governance structures be given authority to write and enforce accountability agreements between themselves and all health services provider organizations in their jurisdiction including primary care providers. This implies the transfer of current accountability agreements with the Ministry (e.g., those between FHTs, NP-Led Clinics and the Ministry).

Recommendation #8

The Ministry continues to enhance e-Health Ontario and IT initiatives to support regional governance structures so that regional governance structures have reliable and timely data to support the three elements of health system governance. Primary care, through EMRs/EHRs, requires a robust capacity for quality improvement capabilities and system-wide interconnectivity.

Recommendation # 9

Recognizing that many primary care providers, regardless of their funding model, will be initially challenged to meet accountability requirements under our proposed plan, the Ministry move to incent and

support effectively all family practice models to strengthen their ability to function as true group practices capable of delivering comprehensive care. Since solo practice physicians may be especially challenged to meet accountability requirements under our proposed plan, the Ministry further support these physicians to practice in multi-physician/virtual group models.

Recommendation #10

Because Governance and Accountability are so inextricably linked, our Working Group also wishes to show support for the following four recommendations by the Working Group on Accountability.

(Accountability Working Group Recommendation #1)

To ensure the work of the Primary Health Care Planning Group and its constituent working groups continues, the Ministry should create a time-limited Primary Health Care Secretariat tasked with implementing the recommendations of this initiative. At a minimum, the mandate of the Secretariat should include the following:

- Prioritize the recommendations of the working groups and develop an implementation plan for action;
- Work with professional associations and other primary care stakeholders to develop and contribute to the implementation plan;
- Assign resources to support implementation activities;
- Adapt and amend the recommendations to reflect changes in the environment, such as regulatory/legal changes, fiscal changes, etc.
- Track progress with respect to the implementation of key recommendations.

(Accountability Working Group Recommendation #2)

The Ministry, in consultation with professional associations, patient groups and other stakeholders in primary care, should develop a clear and measurable statement of goals and objectives for which the primary care system is to be held to account. At a minimum, these goals and objectives should include:

- timely access to care (including after hours)
- relationships with other parts of the health system
- patient satisfaction
- provider satisfaction
- appropriate resource utilization
- patient outcomes (e.g. immunization rates, prevent care rates)
- attraction and retention, distribution of health human resources in primary care.

(Accountability Working Group Recommendation #3)

The Ministry, in partnership with Health Quality Ontario and others, should develop and implement measurement and monitoring strategy to identify how the primary care system is performing in reference to its goals and objectives. Attributes of the measurement and monitoring strategy should include:

- On-going, proactive measurement and monitoring
- Inclusion of patient feedback as an indicator of performance
- Development of benchmarks
- Regular reporting to stakeholders, providers and the public

(Accountability Working Group Recommendation #4)

The Ministry, in consultation with professional associations representing Interdisciplinary Health Providers, should develop a formal mechanism to track and analyze the activities of Interdisciplinary Health Providers to better understand the impact they are having in primary care, including in CHCs and NP-led Clinics.

VI. Conclusion

Strong governance is the capstone to an effective primary care strategy. As such, the objectives of the other four Primary Care Working Groups (on improving quality, access, efficiency and accountability in primary care) can only be met fully if supported by a reliable system of primary care governance and one endorsed by health professionals. The recommendations contained in this report, based on our review of other jurisdictions and the input of expert committee members, represent bold but necessary changes to how primary care is supported in Ontario. We believe the sustainability of our health system hinges on the province's commitment to greater support for primary care.

VII. Select List of Work Cited

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Appendix A: Strengthening Primary Care Organization and Governance – Terms of Reference

1. Background

A number of governance models are currently employed in primary healthcare in Ontario and there several ways in which primary healthcare interacts with other parts of the system. However, a cohesive governance model that can help to articulate and set a direction to achieve primary healthcare goals is missing and gaps remain in the way the primary healthcare sector is –organized, both internally and in relation to the rest of the system.

2. Objectives

To develop a proposal to create effective and sustainable organization and governance of primary healthcare in Ontario by leveraging the current primary care models.

3. Key Areas of Focus

- Collaborations with other parts of the health system to enhance transitions through the continuum of care
- Framework for organization and governance of primary healthcare sector

4. Areas of Discussion for All Working Groups

1. Review and validate the current state and change imperative
2. Identify long-term vision and goals for each of the proposed areas
3. Identify short- and medium- term priorities for 2011-2014
4. Develop an action plan for achieving goals and priorities identified above
5. Develop monitoring and evaluation plan to monitor progress against the goals and priorities identified above

5. Specific Questions

1. What are the strengths and weaknesses of Ontario's current organization of primary healthcare?
2. How can the current primary care infrastructure be leveraged to strengthen governance in primary care?
3. What are the next steps in evolution of primary care organization and integration in Ontario?

6. Communications:

The communication and sharing of any materials developed by the Working Group will require prior approval by the Primary Healthcare Planning Group.

7. Reporting and Support

Working Group participants will report to the Co-Chairs. The Co-Chairs will resolve dispute and disagreement as they arise. The Co-Chairs are Brian Golden & Jan Kasperski.

The working Group Co-Chairs will report to the Primary Health Care Planning Group, chaired by Susan Fitzpatrick, ADM, Negotiations and Accountability Management Division, Ministry of Health and Long-Term Care. Secretariat support is provided by the Ministry of Health and Long-Term Care.

8. Meeting Frequency and Timeline

The following dates and times have been held for meetings during the months of April-June with the final report of the Working Group to be submitted to the Primary Healthcare Planning Group by June 30th, 2011.

- First Meeting: Thursday April 7, 2011 from 8:00 am to 10:00 am
- Second Meeting: Monday May 9, 2011 from 10:00 am to 12:00 pm
- Third Meeting: Monday June 6, 2011 from 1:00 pm to 3:00 pm

Appendix B: Selective Overview of Relevant Pilots and Initiatives Currently Underway in Ontario

Leadership Connect

The Ontario College of Family Physicians (OCFP) was provided with a Primary Health Care Transition Fund grant from the Ministry of Health and Long Term Care to establish the "Leadership Connect". The purpose of the grant was to establish a series of regional organizations (i.e. "tables") throughout the province that would support family physician leaders to connect to identify problems and their solutions to issues that impact on patient care – in their practices and in the system, in general. The Leadership Connect consists of academic leaders, hospital Chiefs of the Departments of Family Practice (Chiefs of Staff in the smaller hospitals), the family physician leads of the FHNs, FHGs, FHOs and FHTs and the OCFP's Board members.

The Leadership Connect pilot project resulted in several regional organizations that still meet on a regional basis and an informal provincial-wide structure that is used by the OCFP for two-way communications with family physicians in leadership positions throughout the province. As an example, the physician leaders in the Central West/Mississauga Halton LHINs meet on a regular basis. The structure of this group also includes the 5 Medical Officers of Health in the two LHINs. The LHIN and CCAC CEOs are often in attendance, as well. "Family Medicine Hamilton" serves similar planning, problem-solving and information sharing functions. The OCFP's guest list for any of their planning Symposiums or Forums includes the members of the provincial-wide Leadership Connect. This initiative provides strong indications of the interest of family physicians leaders in working together locally and provincially.

Family Practice Councils

Recently, the Ontario College of Family Physicians(OCFP) and the Ontario Medical Association (OMA) entered into discussions to work with the LHINs to support the expansion of the "Leadership Connect" model to include regional Councils in each LHIN that would be independent but supported jointly by the LHIN, the OMA and the OCFP. While this structure is viewed positively as it bodes well as a stepping stone to better address the four quadrants at local/regional level, and at the provincial level, much more work would be needed to create a cohesive organizational structure in many regions of the province that includes family physician leaders, other primary care providers and the rest of the healthcare system. Currently, over 9,000,000 Ontarians are rostered with a family physician and some of them receive care within inter-professional Family Health Teams. Most patients are served by family physicians that practice in a system that often places barriers in the way of well-coordinated care. The Councils were envisioned as a means to address the inequities in the primary care sector and to give rise to a strong voice in the planning of the system.

The Association of Ontario Health Centres/ the Association of Family Health Teams of Ontario/RNAO-NPAO

The first two organizations (i.e. AOHC and AFHTO) were established and function as major supports for the individual CHCs and the FHTs, respectively. Their purpose is similar. Both organizations, advocate on behalf of their members, the individual CHCs/FHTs. While the AOHC supports quality improvement activities in the individual CHCs, the Quality Improvement and Innovation Partnership (QIIP) provided a similar function with the FHTs. Both organizations provide tables amongst their members to network and share best practices (clinical and administrative). While AOHC has been operational for many years and has impact at the local, regional and provincial levels, AFHTO has only been operational for a relatively few years and, during its developmental stages, has been supported by the OCFP. It shows great promise and is gaining momentum with great potential to become as strong and supportive of its

members as the AOHC. The NP Clinics are supported by the RNAO/NPAO in collaboration with the MOHLTC's Nursing Secretariat with a similar focus in mind.

While the majority of people receive their primary care in family practices, the FHTs currently care for approximately 2,000,000 people. When all 200 FHTs are fully functioning, they are expected to provide care for more than 3,000,000 people who are rostered to family physicians. Given the health and social service needs of patients seen in CHCs, their volumes are relatively low. Similarly, NP Clinics see a relatively small proportion of the population. Over time, the CHCs and NP-led Clinics should have the capacity to care approximately 500,000 people. Both FHTs and NP Clinics are new and evolving so their focus tends to be internal at this time. The same holds true for the new and expanded CHCs. The organizations supporting these models of care have the potential to address issues in all four quadrants for their member organizations.

"Super" FHTs

Four city-wide FHTs were created in Hamilton, Barrie, Peterborough and London through the merger of existing individual family practices under a single governance structure. These consist of several physician groups (FHO/FHNs) with representation on the governing board that includes other healthcare providers and citizens. Funding is provided to the city-wide FHTs which, like all the other FHTs (200 in total), are the single entity accountable to the Ministry. The funding for interdisciplinary health providers is used to allocate providers to the constituent parts, as determined by the Board. Through this FHT model, physician groups can develop economies of scale by pooling human and other resources (e.g. EMR, social workers, and dietitians) and better address the needs of their community. The CCACs are embedded in these Family Health Teams and provide care coordination and system navigation support to the FHTs and their patients.

The Partnerships for Health/Collaborative Care Networks/ Communities of Practice/the Virtual Ward

The Canadian Home Care Association partnered with the OCFP, the CCACs in Halton and Mississauga and the Calgary Regional Authority to conduct a demonstration project to better align CCAC case managers/home care nurses with family practices. This successful project led to several CCACs assigning case managers to family practices, especially FHTs and was the foundation for the "Partnerships for Health – A Chronic Disease Prevention and Management Initiative" in the South West LHIN. The Partnership used diabetes as the proxy for all chronic disorders to implement Ontario's Chronic Disease Prevention and Management Framework. Central to the initiative was a partnership between family physicians and CCAC case managers. The role of the case manager was expanded to include direct support for patients with diabetes. The case managers assist patients to navigate the healthcare system, thereby increasing access to community resources and providing linkages with specialist services and tertiary care, where appropriate. This model functions within the first three quadrants.

The OCFP has established a number of "Collaborative Care Networks" that are changing the relationship between consulting specialists and family doctors from a referral model to a cost-sparing mentoring and coaching model. While the model is anchored in an educational model of providing family doctors with "just-in-time" guidance and advice and formal CME/CPD, the process of bringing specialists (psychiatrists and FP-psychotherapists, geriatric specialists, neurologists, endocrinologists, cardiologists, etc.) to the table to discuss issues with family doctors has led to identified solutions in all four quadrants; however, their main focus tends to be "quadrants" 1 and 2. The Networks function as province-wide entities; however, in some cases, local networks have developed under the umbrella of the Collaborative Care Network.

There are several examples of programs that have been funded to develop "Communities of Practice" to improve care for certain subsets of the population. The 18 Month Enhanced Visit led by the Ministry of Children and Youth in collaboration with the Offord Centre, the OCFP, Public Health and community-

based children service providers such as the Early Years Centres has used “physician champions” and public health nurses to enhance the quality of well-baby visits to ensure a “best start” for every child and to identify and intervene as early as possible with children exhibiting developmental issues.

While provincial-wide Networks such as the Cardiac Care Network or the Stroke Network have been organized using a disease-specific model, to date most the Networks tend to engage providers of secondary or tertiary care services – and often ignore the primary care sectors contributions to patient care. In the primary care sector the reverse is often true. The Quality Improvement and Innovation Partnership, now part of Health Quality Ontario, created “Communities of Practice” to improve care in Family Health Teams for patients with specific conditions. The “Dementia Network”, is an example of an organization that created a disease-specific Community of Practices aimed at quality improvement and the sharing of best practices and innovations. The Network addresses the needs of providers of dementia care in all sectors of the system.

The “Virtual Ward” model being demonstrated in Toronto is anchored in efforts to address high readmission rates by providing transitional medical support and care coordination services to patients post discharge. The ward extends hospital-based specialist support such as hospitalists (family physicians predominately) into the community to manage the care of the patient in the home settings post discharge. Hospital based physicians are supported by a CCAC Care Coordinator, pharmacist and nurse practitioner to support the patients transitions back to primary care.

Cancer Care Ontario’s Provincial Primary Care and Cancer Care Network

Cancer Care Ontario (CCO) in 2008 launched an initiative to engage with family physicians across the province to improve care for all patients with cancer throughout the cancer journey from prevention to end of life care. Initially, CCO recruited a Provincial Clinical Lead: Primary Care who purposefully recruited 13 family physician leaders as Regional Primary Care Leads. Together they form a Provincial Primary Care and Cancer Network that jointly developed a framework and structure on how to engage and what to do to improve screening practices in primary care. Cancer Care Ontario’s Primary Care Program, initially focused on the ColonCancerCheck program, and is currently expanding to breast and cervical screening. The Ontario Cancer Plan 2011-2015 calls for the Primary Care Strategy to expand to enable improved cancer care throughout the cancer journey, from prevention and screening to end-of-life care and survivorship. Through the primary care and cancer engagement strategy the network plans provincial initiatives, share regional challenges and successes, and enables a cadre of leaders to integrate and engage primary care with the cancer system. PPCCN members interact frequently, through electronic media, monthly webinars and bi-annual meetings in Toronto. PPCCN is composed of:

- 14 Regional Primary Care Leads (RPCLs)
- Provincial Primary Care Lead
- Primary Care Program Manager
- 14 Regional Administrative Leads (RALs)
- Provincial Primary Care Advisor, Diagnostic Assessment Program.

The Regional Primary Care Leads (RPCLs) have the objective to bring the voice of primary care to the cancer system and the voice of the cancer system to the primary care sector. The Primary Care Leads have been establishing informal and formal regional networks in their geographic areas. The most advance Network is in the South West LHIN which has evolved into a Regional Primary Care Network that still focuses attention on the cancer services with an increased focus of more general health service planning.

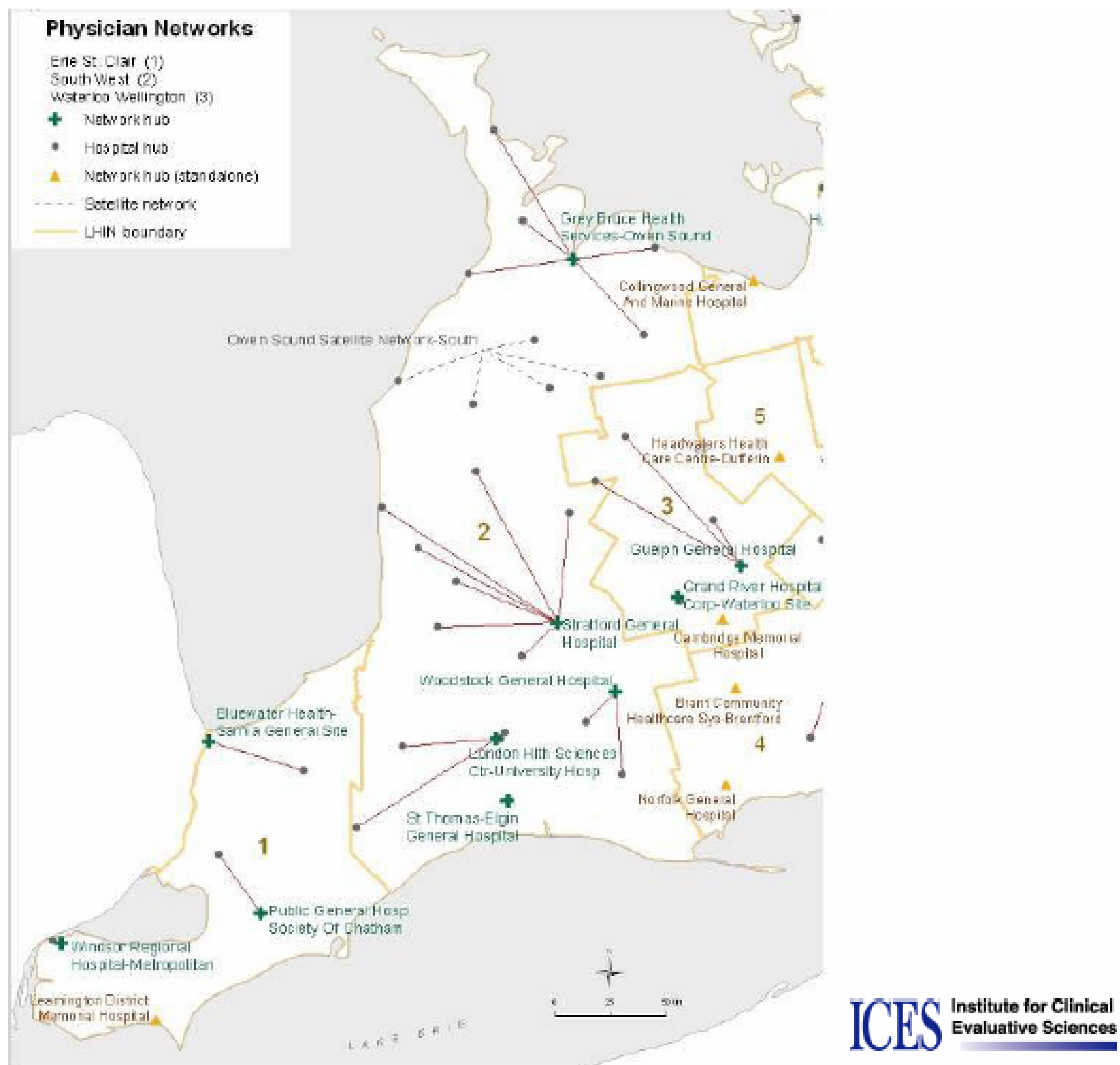
South East LHIN Primary Health Care Council

The South East LHIN Primary Health Care Council was established to provide collaborative leadership for the planning, delivery and evaluation of Primary Care services within the South East Local Health Integration Network (LHIN), creating a forum to address common issues pertaining to primary care across

the continuum of health care. With representation from various sectors and multidisciplinary professions, the council plays an advisory role to the South East LHIN through the chair of the council.

Primary Care Provider Networks

ICES has undertaken research that describes an alternative to intentionally organized systems of care. The so-called “Primary Care Provider Networks” are virtual networks that consist of defined patient and provider populations. The model uses existing patient flow between family physicians, other specialists and the hospitals where their patients are admitted. Through a methodology formulated by ICES, the result shows approximately 70 physician networks with a 65,000+ population per Network, 150+ physicians and 1or more hospital hubs per network.



Appendix C: Scan of Primary Care Organization and Governance in Selected Jurisdictions

Excerpts from "McDonald, J., Cumming, J., Harris, M., Davies, G., and Burns, P. (2006). Systematic review of system-wide models of comprehensive primary health care. Melbourne: Research Centre for Primary Health Care and Equity, School of Public Health and Community Medicine, University of New South Wales":
Link to full article: http://www.anu.edu.au/aphcri/Domain/PHCModels/Final_25_McDonald.pdf

AUSTRALIA

1. Overview of history and context for reforms

The Australian health system is characterized by differing management responsibilities and a mix of private and public provision. The Commonwealth has major responsibility for general practice and the States/Territories have responsibility for hospitals and the network of publicly funded community health services. These characteristics coupled with a predominantly general practice fee-for-service payment system and commitment to ensuring consumer choice, have a significant influence on the reform process and development of system-wide responses. Australia is also characterized by a large land mass and a population that is concentrated along the eastern sea board. This profile has a profound effect on the supply and provision of health services. Despite improvements in material and living conditions and in morbidity and mortality, there are still patterns of health inequalities remain, most pronounced in the Indigenous population.

The General Practice Strategy released in 1992 aimed to "enhance the role of general medical practitioners beyond individual patient care, and to promote better integration of GPs with the rest of the health system" (General Practice Consultative Committee, 1992). The thrust of the Commonwealth reforms since then has been to enhance the capacity of general practice and to strengthen their collaboration with other health service providers. This is especially true in relation to improving the management of chronic disease through a mixture of financial incentives, program funding, grants, and workforce initiatives designed to improve access to GPs and other primary healthcare practitioners, building practice capacity and quality, providing practice support and education (including information management/technology), introducing standards and accreditation and other quality improvement programs, and strengthening research capacity and the evidence-base. Initiatives designed to overcome Commonwealth/State funding fragmentation have also been trialed, but have not been implemented across the system. However, as many commentators have observed, the lack of a national primary healthcare policy or strategic framework continues to impede the development of a national and comprehensive approach to primary health care. Common priority areas for State/Territory-funded community health services have included: improving the integration between primary healthcare and specialist/acute services; reducing avoidable use of hospitals; better management of chronic and complex conditions; and improving service coordination across the range of primary and community health services. There is some evidence that these developments are impacting on workloads and service delivery patterns of community health nurses (Kemp et al., 2002, Kemp et al., 2005).

2. Divisions of General Practice

Divisions of General Practice were established in 1992 as voluntary, GP member based organizations. There are currently 120 across Australia. They aim to support the development of general practice in the following areas: enhancing quality and evidence based care, improving access, encouraging integration and multidisciplinary care, focusing on prevention, early intervention and better management of chronic disease, and ensuring a growing consumer focus (Commonwealth of Australia, 2004). Their focus has shifted over time from GPs to practices. They vary in size and their boundaries are not aligned with other relevant planning or service delivery boundaries, nor are they formally integrated with State-funded health services. In 1998, seven State Based Organizations and a peak national organization were established

as part of the network to provide leadership, representation, advocacy, policy and program support and to liaise with the Commonwealth and State health authorities. In 2005, following a national review of their roles, performance-based contracts and a National Quality & Performance System was introduced (Australian Government Department of Health and Ageing, 2005) which replaced the previous three year outcomes-based funding contracts, introduced in 1998/9. Divisions are funded according to a weighted population formula and in 2002/03 their core allocation was in the vicinity of $125 million (Richardson J et al., 2005). They are also budget holders for some national initiatives, including those that improve the access of GPs to other primary healthcare providers. There were three publications reviewed for this initiative. Whilst annual surveys of Divisions have been undertaken since 1993/94, the national review of the role of Divisions made extensive use of these surveys as an integral part their methodology, hence only the annual surveys after this time were included.

3. Impact on infrastructure

Divisions have been most effective in achieving their core aim of supporting general practice. They have had a strong focus on engagement with GPs as members and in governance arrangements. In 2001/02, 95% of GPs were members of Divisions (Review Panel, 2003). However, there has been considerably less involvement of other health professional groups, consumers or community groups in governance arrangements (Kalucy et al., 2005, Review Panel, 2003) which has, in part, been attributed to less engagement by Divisions in broader primary healthcare reform (Review Panel, 2003). There have been only modest achievements in collaboration with other health services. This has been difficult to achieve and the focus has been mostly on specific initiatives, where there are incentives for GPs to participate (Kalucy et al., 2005). There was little evidence on the extent to which Divisions collaborate with state-funded primary healthcare services to improve access. Non-aligned boundaries with other health services and the size of Divisions have limited collaboration (Review Panel, 2003).

4. Impact on service delivery

Most evidence on the role of Divisions in supporting general practice is related to specific Commonwealth initiatives for which there have been funded programs directed to practices or to Divisions as a vehicle for implementation. Half provide direct patient services in mental health and/or diabetes, and many provide practices and patients with access to allied health professionals, have supported practices to develop chronic disease management programs, and more recently have increased their focus on prevention activities. However, while many are involved in addressing after hours primary medical care access, few have addressed financial and locational barriers to access (Kalucy et al., 2005). Other factors which have influenced the nature and range of Divisional activities include support from GPs (Rogers WA and Veale B, 2000).

5. Impact on access and health outcomes

No evidence was found on the attributable impact of Divisions in improving access to primary health care, improving the health and well being of patients/populations, their impact on other parts of the health system or provider satisfaction. However the findings for GP funding initiatives (see below) do include evidence of improved access to psychologists and practice nurses, most of who are contracted though Divisions.

UNITED KINGDOM

1. Overview of history and context for reforms

Primary care in United Kingdom has been subject to considerable reform in recent years. The focus during the early to mid 1990s was to increase competition within the National Health Service (NHS), predominantly through the creation of an internal market. GP fund-holding and other variations were introduced which enabled GPs to purchase secondary care services (Weller and Maynard, 2004). Whilst fund-holding covered up to 40% of the population by 1995 (Iliffe, 1996b) and had led to reduced waiting times and elective hospital admission rates, it was costly and considered unfair (Chamberlain-Webber, 2005), and was dismantled in 1997. The election of the Labour government in 1997 saw an overhaul of

the NHS and substantial primary healthcare reinvestment to address a number of challenges, including variable quality of care, lengthy waiting times to see a GP and many practices not accepting new patient enrolments. It was during this period that collaboration replaced competition as a significant policy theme (Benson et al., 2001). A major structural reform was the establishment of Primary Care Groups in 1997 which became Primary Care Trusts in 1999 (Department of Health, 1997). This placed primary care at the centre of the NHS and has involved a substantial shift in power. Primary Care Trusts integrate family health services and community healthcare within one organizational structure.

District health nurses and health visitors are sometimes attached to practices and sometimes they are area-based. The former provide a range of home-care type services and the latter provide more public health type functions, including immunization, health education and health promotion services. Practice nurses are also employed by practices, and larger practices have the capacity to employ a broad range of allied health staff. The 1990 General Medical Services contract saw a substantial rise in the numbers of nurses working in practices and an extension of their role to incorporate chronic disease management and some preventive care, Jewell and Turton (cited in Iliffe, 1996a). Workforce modernization and flexibility have been key strategies for addressing a number of challenges. In particular, there has been a focus on extending the roles of nurses (Department of Health, 1999, Avery and Pringle, 2005, Department of Health, 2002a), pharmacists (Avery and Pringle, 2005) and allied health professionals. There has also been a trend towards larger practices of seven or more GPs, although single practices still account for one third of all practices in England (RCGP, 2005). Primary Care Access Targets have been established and this has stimulated the development of a range of primary care nursing developments, including walk-in clinics and a national 24 hour telephone advice line (NHS Direct).

Improving quality of care has been a major policy focus and has included the development of national service frameworks in a number of areas which set minimum standards for the delivery of health services (Department of Health, 2002b). Financial incentives for improved performance have also been introduced as part of the new General Medical Services contract, which incorporates the Quality and Outcomes Framework. Important principles that run through much of the recent reforms include an emphasis on a patient-led and locally driven NHS and patient choice. Despite the considerable upheaval and ongoing primary healthcare reform processes, public confidence in primary health care, including GPs and other health professionals remains high (Healthcare Commission and Picker Institute, 2005).

Following political devolution, the health systems of Northern Ireland, Scotland and Wales have diverged from those in England. In Scotland, although organizations termed Primary Care Trusts were developed, they did not have the same responsibilities (e.g. no commissioning responsibility) as in England (Hopton and Heaney, 1999, Benson et al., 2001), and they were subsequently abolished. The major thrust of Scottish reforms is a focus on partnerships, integration and redesign with the intention that care is delivered locally, access should be improved, inequalities in health tackled, and workforce and facilities are fit for purpose (National Health Service Scotland, 2003).

2. Primary Care Groups/Trusts

Primary Care Groups were established from 1997 as a new structure within the NHS and were originally set up to bring general practice more closely into the NHS. Over time they have evolved into Primary Care Trusts and have assumed greater devolved responsibility for providing community health services, developing primary healthcare services and commissioning secondary health services for their populations. Primary Care Trusts have geographical boundaries, and have managerial responsibility for primary care within those boundaries, including contracting with GPs to provide primary care services. Their other aims were to improve access to primary health care; integrate primary and community healthcare by bringing together GPs and community nurses; to work in partnership with other agencies to promote the health of the local population, reduce health inequalities; and to provide support to practices and clinicians to improve premises, information systems, multidisciplinary education and training and clinical governance. There are now approximately 300 Primary Care Trusts across England. The introduction of practice based commissioning has called into question the role of Primary Care Trusts especially as service providers of community health and public health services (Smith and Mays, 2005a)

There were 19 publications that met the inclusion criteria and none beyond 2003. Twelve of these relate to the three national tracker surveys undertaken between 1999/2000 to 2001/2002.
Impact on infrastructure early on, primary care commissioning was not seen by health authorities as a major driver of change, with the shifts from secondary to primary care perceived as being piecemeal and not underpinned by resource shifts (Craig et al., 2002). Most early progress involved commissioning of community and community health services (Wilkin et al., 2002, Regen and Smith, 2002, Regen et al., 2001), but there was less progress in engagement or developing partnerships with other services or primary care professionals other than GPs or nurses (Wilkin et al., 1999, Regen and Smith, 2002, Glendinning et al., 2001). Relationships between social workers, GPs and community health services improved over time (Glendinning et al., 2001), although barriers for greater intersectoral collaboration included the differing geographical boundaries (Holtom, 2001, Wilkin et al., 2002, Glendinning et al., 2001).

Most Primary Care Groups had mechanisms for consulting with communities and consumers (Alborz et al., 2002), and these developed over time, mainly through Community Health Councils. However, involving lay people, non-government organizations or local authorities in the work of Primary Care Trusts has taken longer to evolve (Wilkin et al., 2001b), and Community Health Councils have now been abolished. Nurses were represented on Primary Care Group/Trust boards from the early days, but they reported that they had not been well prepared for this new role and perceived that their influence on decision making was limited (Dowswell et al., 2002a, Regen and Smith, 2002, Dowswell et al., 2002b). As of 2006, neither GPs nor nurses are entitled to be represented on boards. Primary Care Groups/Primary Care Trusts also made progress in developing capabilities to undertake their role in health improvement, and demonstrated an increasing commitment to addressing poverty/deprivation as priorities, but faced shortages of skilled staff, for example public health staff (Gillam et al., 2001).

Consistent with a strong national focus on clinical governance, from the start Primary Care Groups/Trusts had an emphasis on clinical governance (Wilkin et al., 1999, Regen et al., 2001) and on influencing culture change within practices (Willcocks, 2003) through collecting and sharing information on quality and encouraging practices to participate in learning activities (Wilkin et al., 2001b, Wilkin et al., 2002). While most GPs recognized the centrality of Primary Care Groups/Primary Care Trusts in management and accountability, few believed they would be much affected personally, other than some erosion of autonomy (Dowswell et al., 2002).

3. Impact on service delivery

Over time, Primary Care Groups/Primary Care Trusts played a growing role in improving access to more comprehensive primary healthcare and extending the primary care team. Even by 1999/2000, a number of Primary Care Groups' members reported the development of specific local services that were directly attributable to the work of their Primary Care Groups (Regen and Smith, 2002, Regen et al., 2001), and just under one third had funded health improvement initiatives (Gillam et al., 2001). The National Service Frameworks, especially for coronary heart disease and mental health, were a particular influence on service developments (Regen et al., 2001). There was no evidence that Primary Care Group/Primary Care Trust size was a factor in primary care developments (Wilkin et al., 2003). The integration of practice and community nursing assumed a high priority in primary care development; especially investment in nursing staff (Wilkin et al., 2001b).

A range of initiatives to improve access was introduced, most commonly through reduced waiting times, nurse-led services, extended pharmacist roles, targeting poorly served areas or groups, out-of-hours services, telephone advice lines and information on self care (Audit Commission, 2004, Dowswell et al., 2002b, Wilkin et al., 2001b, Wilkin et al., 2002, Wilkin et al., 2001a, Charles-Jones et al., 2003). There was also a substantial increase in range of services available in primary care including counselling, specialist nurses and GPs and over 80% of Primary Care Trusts had Personal Medical Services schemes in operation (Wilkin et al., 2002); although there was a more limited uptake of complementary and alternative medicines (Thomas et al., 2003). Some practices were introducing nurse triage to manage

patients' requests for same day appointments and GPs were moving from a patient centered approach to a more biomedical role as the consultant in primary care in order to achieve improved accessibility and to better manage resources (Charles-Jones et al., 2003). Impact on access and health outcomes: There were no papers that focused on the impact or effectiveness of Primary Care Groups/Primary Care Trusts on access or health outcomes.

NEW ZEALAND

1. Overview of history and context for reforms

The background and context to the primary healthcare reforms of the 1990s and into the early 2000s included a lack of integration between primary care providers; an uncertain and often confrontational relationship with governments; uncontrolled growth and demand-driven funding, especially for laboratory and pharmaceutical services; a lack of collective accountability for cost and quality of care; underdeveloped and underused information management/technology systems; and little community participation in primary healthcare development (Malcolm et al., 1999). The reforms of 1993 introduced a 'quasi'-market model into health, involving the establishment of a stand-alone purchasing role and increased contracting and competition between providers for contracts. The reforms were very unpopular (Cumming and Salmond, 1998), but in primary healthcare they did result in some positive changes, in particular:

• the shift of primary healthcare providers onto explicit contracts, increasing their accountability;
• the development of networks of primary healthcare providers (especially amongst GPs, but also amongst not-for-profit community-governed primary health organizations); and
• the use of new forms of funding such as capitation, budget-holding and global budget-holding.

Despite these developments, a lack of clear direction for primary healthcare and concerns over poor access to primary healthcare arising from high user charges led to the release of a Primary Health Care Strategy in 2001 (King A, 2001). This Strategy was released not long after the establishment of 21 District Health Boards responsible for planning, providing hospital and community health services and contracting with primary healthcare and community service providers. The Strategy is aimed at developing a strong primary healthcare system, in order to improve health and to reduce inequalities in health.

There are three major organizational and policy changes occurring to implement the Primary Health Care Strategy:

• increased government funding for primary healthcare to reduce fees and increase subsidies;
• the development of Primary Health Organizations as local non-government organizations which serve the needs of an enrolled group of people; and
• introduction of capitation funding for Primary Health Organizations (Cumming et al., 2005).

Two forms of Primary Health Organization funding were initially created – access funding for disadvantaged enrolled populations and interim funding for the remainder. Since 2003, the government has provided further funding; has focused on increasing subsidies for particular age-related population groups in interim-funded PHOs; and has contracted for the majority of the new funding to be passed on in the form of reduced user charges. In addition, a separate funding arrangement has been established for those with chronic illnesses, known as 'Care Plus'. All Primary Health Organizations also receive additional funding for services to improve access, for management costs, and for health promotion.

2. Primary Care Organizations / Independent Practitioner Associations

Independent Practitioner Associations were originally established during the mid 1990s as networks of predominantly GPs, governed by member elected boards. By the late 1990s, Independent Practitioner Association membership covered over two-thirds of all GPs (Malcolm et al., 1999), but few included other professionals or had community/consumer consultation mechanisms (Malcolm et al., 2000). They aimed to strengthen the bargaining position of general practice and reduce transaction costs, and to improve patient and community health outcomes. Since the release of the Primary Health Care Strategy,

Independent Practitioner Associations are now playing a number of new roles. Some are partner organizations in Primary Health Organizations, and some are also providing management support services to Primary Health Organizations.

Not-for-profit community-governed Primary Care Organizations

These are multidisciplinary organizations funded by capitation and providing low cost population focused primary healthcare services to disadvantaged populations. Their development has occurred in three waves from the late 1970's. By 1999 they served a population of approximately 150,000 with about 60 full-time equivalent GPs. They range in: size, primary healthcare services and multidisciplinary staffing mix. In some rural areas with high Māori populations, they include the provision of acute and inpatient care. Leadership, networking and advocacy are provided through a national peak organization, Health Care Aotearoa (HCA), which was formed in 1994 (Crampton et al., 2005a). There were 11 publications reviewed for these models, five for Independent Practitioners Associations and six for not-for-profit community-governed organizations.

3. Impact on infrastructure

The location of these organizations in poor urban or remote, predominantly Māori, areas is governed by their objectives (Crampton et al., 2001). They are more likely than for-profit practices to have a community (as opposed to an individual patient) orientation, as evidenced by their focus on community needs assessment, locality service planning and intersectoral case management (Crampton P et al., 2005b). They also employ more doctors and a broader range of professional groups that then their for-profit practice counterparts (Crampton P et al., 2005b), and have higher patient to doctor ratios; possibly accounted for by the expanded role of nurses, service patterns and the incentive structures inherent in capitation (Crampton P et al., 2000a). Irrespective of ownership and governance arrangements, capitation-funded practices also employed more nurses and community workers and more Māori staff than fee-for-service practices (Crampton et al., 2005a). Information systems have been an area of Development in both not-for-profit and for-profit practices, including computerized age sex registers, patient records, recall systems and disease registers (Crampton P et al., 2005b).

4. Impact on service delivery

There were significant differences in the range of services available in community governed not-for-profit and for-profit practices, with the former providing more group health promotion, community worker, dental health, mental health and ante/post natal and complementary/alternative services. The latter provided more sports medicine, emergency call and specific services for older people (Crampton P et al., 2005b). Furthermore, in keeping with their focus on disadvantaged populations, not-for-profit practices had lower patient charges for all age groups and waived fees for a higher proportion of patients than for-profit practices (Crampton P et al., 2005b).

5. Impact on access/utilization

There is higher utilization by the non-European population, young, elderly and concession card holders than for other groups, but overall utilization rates are lower than for fee-for-service practices (Crampton et al., 2000b, Crampton et al., 2004).