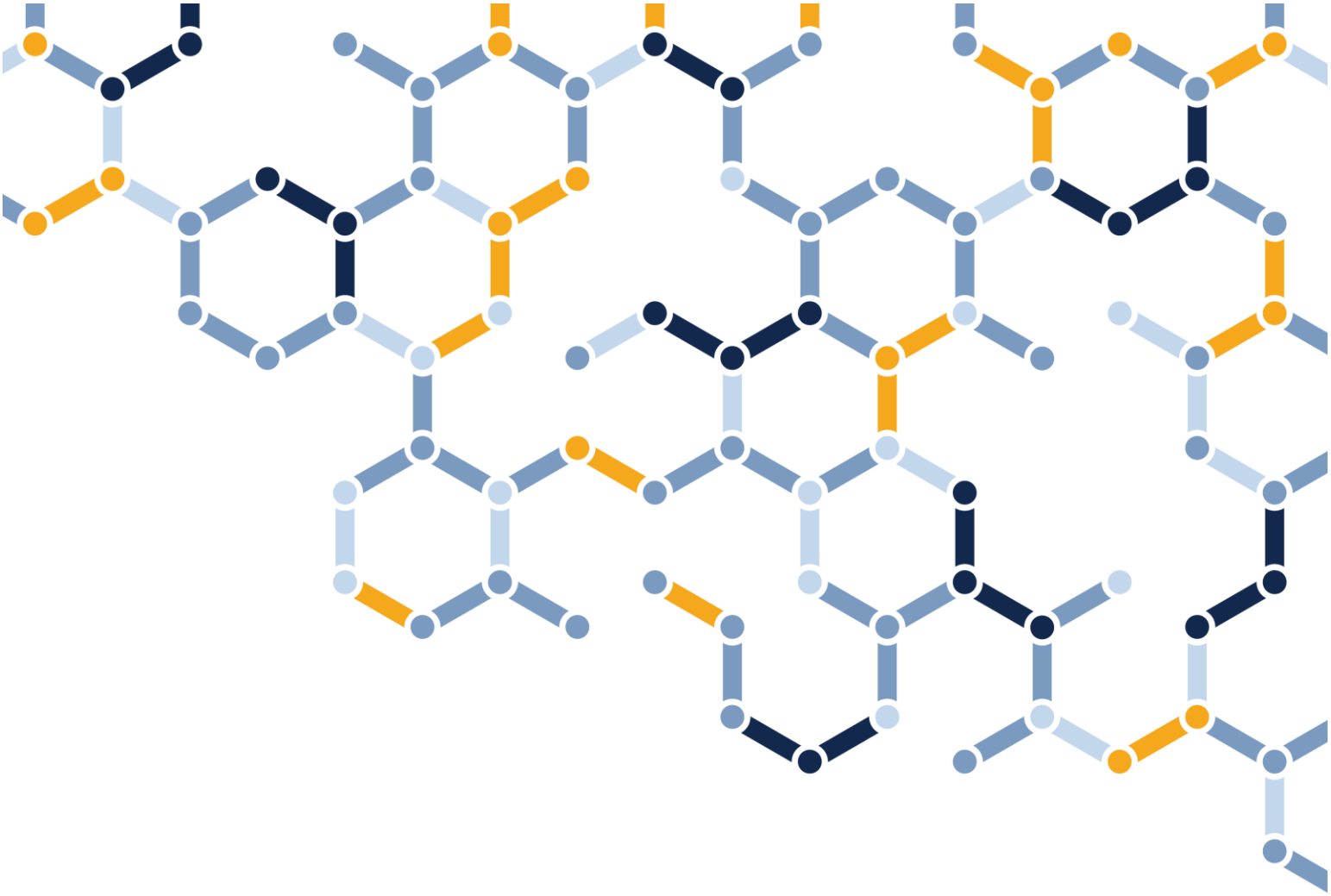

Enabling and enhancing the *People's Health Care Act*

Ontario Medical Association's Submission to the Standing Committee on Social Policy

April 2019

OMA
ONTARIO MEDICAL ASSOCIATION

Executive Summary

The People's Health Care Act (Bill 74) offers significant opportunity to improve patient care and integration, and to prioritize a sustainable and digitally-enabled health care system. The Ontario Medical Association (OMA) strongly supports the intent and key elements of Bill 74.

Experience in other jurisdictions shows that physicians are essential to the success of significant health care transformation, specifically in terms of system design, governance, oversight, and implementation.

This submission captures professional insights and provides key recommendations that the OMA believes will strengthen Bill 74, including emphasizing the importance of voluntary physician involvement in health transformation.

As part of this submission, the OMA strongly recommends that physicians and medical health corporations be explicitly named in the Act as being excluded from the definition of HSP.

Consistent with the government's vision and to further enable the intent of Bill 74, the OMA recommends the following:

1. Amend Section 29 of the Bill to reflect the evidence that Integrated Care Delivery Systems (ICDSs) must be physician-group led, voluntary, and centred around primary care;
2. Recognition of the role of community-based specialists in ICDS / Ontario Health Team (OHT) model is needed;
3. Amend Section 1 of Bill 74 to include an exemption for physicians and medical profession corporations from the definition of Health Service Provider;
4. Clarification is needed about whether amendments are required to the Personal Health Information Protection Act (PHIPA) pertaining to physician accountabilities in an ICDS / OHT. Further, amendments to PHIPA are required to create an enabling information sharing system; and,
5. Amend Section 44 and add new Section 44.1 to Bill 74 to establish formal mechanisms to ensure that Ontario Health collaborates with and seeks advice from physicians and physician leaders.

Introduction

The Ontario Medical Association (OMA) appreciates the Standing Committee on Social Policy's invitation to respond to the *People's Health Care Act* (Bill 74) and looks forward to collaborating with government as the details related to how integration and implementation of the new models of care are developed.

On behalf of Ontario's physicians, the OMA supports the broad changes introduced by this Bill, specifically the focus on improving patient care and integration, and the prioritization of a sustainable and digitally-enabled health care system. The OMA strongly supports the intent and key elements of Bill 74. This submission provides key recommendations that the OMA believes will strengthen the Bill.

Experience in other jurisdictions shows that physicians are essential to the success of significant health care transformation. Specifically, their leadership in terms of system design, governance, oversight, and implementation is vital. As such, we respectfully call on the government to continue to build its partnership with physicians through the OMA. We have appreciated the collaboration thus far and we are committed to working with the government as it implements this new legislation and the new models of care, which the OMA is confident the physicians of this province are best positioned to embrace and lead.

Recommendations and Analysis

Recommendation 1 – Amend Section 29 of the Bill to reflect the evidence that Integrated Care Delivery Systems (ICDSs) must be physician-group led, voluntary, and centred around primary care[1,2]

To best facilitate the successful implementation of Integrated Care Delivery Systems (ICDSs) and physician leadership within them, the OMA has been working with government and other partners in the planning processes to support effective implementation. We are also developing tools and resources for physicians to bolster their participation and promote leadership in ICDSs. The OMA is well informed on other similar ICDS models (e.g., UK, USA), and their implementation and evaluation, including what is working well and what is not.

Primary care is the patient's main point of entry into the health care system. It is where the patient's health care needs or concerns are initially assessed, and where treatment, follow-up, and referrals are provided as needed. Health promotion, disease prevention, and management of chronic diseases are key aspects of primary care. A physician is the most effective leader of primary care.

To help the government achieve its desired intent with Bill 74, the OMA strongly recommends that ICDSs, also known as Ontario Health Teams (OHTs), be physician-group led, centred around primary care, and that physician involvement be voluntary.[3,4,5]

We welcome the opportunity to participate in innovation with respect to the health care system and based on prior experience the role and integration of primary care in the new ICDS / OHT model in Ontario will be most successful with physician groups as leads.

In the US, studies about accountable care organizations (ACOs) (similar to ICDS model) are most successful both in terms of cost-savings as well as quality outcomes, specifically when they are physician-led, voluntary, and primary-care focused.[4,5] For instance, physicians in leadership roles in ICDSs (i.e., as clinical leaders and represented on the governing boards) are positively linked to cost savings.[5] In a recent American study, roughly 30% of physician-led ACOs demonstrated cost savings over corporate or hospital-sponsored organizations.[6] In another study, it was found that after three years of voluntary ACO participation greater shared savings was achieved by physician group ACOs as compared to hospital-integrated ACOs during the same period[7]. These studies further reveal that in the American model, physician-led ACOs have a stronger incentive to find costs savings to lower fee-for-service spending.

Further, higher proportions of primary care physicians in ICDSs models of care lead to higher quality outcomes and shared savings.[5] In addition, voluntary participation and involvement in ICDS models, and building a culture of shared commitment and accountability, lead to improving quality and cost.[5]

Hospitals play an important role in health system integration as they have the infrastructure and possess many of the key characteristics of ICDSs; however, in jurisdictions where independent hospitals have led ICDSs (i.e., without physician governance), results have been mixed.[4] The importance of strong clinical leadership and a willingness to work together and across organizational boundaries and with frontline physicians cannot be understated.[8] The OMA understands and shares the government's intent of health system reform. Successful health system reform must

demonstrate cost savings, efficiencies, and positive outcomes. This is contingent on strong physician leadership.

Physicians must be leaders in ICDS governance, although not be limited to developing local solutions, defining clinical outcomes, and alignment of accountabilities. More specifically, physician leadership in the development as well as implementation of service-accountability agreements and risk-based payment models associated with OHT / ICDS contracts is vital. There is a risk that a wedge may occur within ICDS groups when quality targets are not met. It is important that ICDS models in Ontario not be structured to create this type of friction among service providers and funders should goals not be achieved. Evidence demonstrates that partnerships with funders and better collaboration in decision-making promotes cost savings and better outcomes, which will ultimately support the objectives of Bill 74.[9]

Physicians play a pivotal role in health care transformation. Involving and partnering with physicians rather than coercing participation or forcing integration are essential principles for effective integration to support patients. We have learned through past health reform experiences in Ontario and elsewhere in Canada that physicians must be willing participants and be part of the solution to moving initiatives forward. Physician leadership at the decision-making tables and support for reforms are essential ingredients for success.[10, 11]

The OMA recommends that Section 29 of the Bill be amended to read the following:

Proposed amendment – Add new conditions for ICDS to Section 29:
29 (3) Any integrated care delivery system designated by the Minister must be:

(i) physician group led with voluntary physician involvement; and

(ii) primary-care based.

Recommendation 2 – Recognition of the role of community-based specialists in ICDS / OHT model is needed

In reviewing the definition of ICDS in Bill 74 and the services that are considered for integration, we identify a gap regarding community-based specialty care that may prevent the government from fully achieving the intent of Bill 74 and other health care reform efforts. While most specialty care is delivered in hospitals, there is a significant amount delivered in community practices as well. The definition states that an ICDS can be designated if the group delivering it has the ability to do so in an integrated and coordinated manner and deliver at least three of the services listed in Section 29.

The OMA sees a gap in the listed services which doesn't capture those physicians who provide specialty care to patients outside of the hospital setting, also known as community-based specialists. Without further clarity, community-based specialists may

be inadvertently excluded from ICDSs, and therefore will omit the important role these physicians play in treating and caring for patients with chronic conditions and multi-morbidity. Ontario's health care system has experienced significant increase since the early 2000's in the number of multi-morbidity patients and with that associated high health care use and costs (e.g., high admissions to acute care facilities).[12] As previously mentioned, we are recommending (Recommendation #1) that ICDSs be physician group led, voluntary, and centred around primary care. This leadership should include community-based specialists. The OMA commits to working with all physicians and partnering with the government to help support the successful introduction and implementation of ICDSs.

Recommendation 3 - Amend Section 1 of Bill 74 to include an exemption for physicians and medical profession corporations from the definition of Health Service Provider

The definition for Health Service Provider (HSP) is open-ended, and through regulation may include "any other person or entity or class of persons or entities that is prescribed" [ss.1(2)16]. HSPs are subject to significant controls and compliance requirements related to practice, including directives issued by the Minister and/or Agency (Ontario Health) on policy and operational priorities. In the *Local Health System Integration Act* (LHISIA) ss. 2(3)(1), which will be repealed by this Bill, an explicit exemption is provided for physicians from the definition of HSP. Similarly, an exemption exists for health profession corporations [(ss.2(3)(2)]. These same exclusions are not provided to physicians or medical profession corporations under Bill 74.

The OMA strongly supports the importance of voluntary physician involvement in health transformation. This is strongly backed by evidence that voluntary involvement of physicians, with physician as clinical and governance leads are critical elements for governments to achieve health reform policy goals. The OMA sees significant risk to the Ontario government if physicians are ultimately included as HSPs via regulation. Like ICDS participation, if physicians are named as HSPs, with the accompanying ability to force integration, this will send a strong signal that almost certainly will lead to resistance to fully engage and participate in the transformation process. Achieving quadruple aim outcomes would prove to be difficult (e.g., expected cost savings not achieved, negative physician experience, etc.).

Also and importantly, if physicians were to be designated as HSPs through regulation, it could have implications for current funding agreements. Changes to payment models would violate the Representation Rights Agreement, including the Binding Arbitration Framework.

We appreciate that the government has presumably left the option of including physicians as HSPs to create a mechanism by which to include them as part of the

ICDS. We believe that there are other, much more effective and time-tested ways to ensure physician involvement, namely via the implementation of contracts and governance agreements at various/multiple levels. To compare, current Family Health Organization (FHO) groups contract with Family Health Teams (FHTs) in similar sorts of arrangements. The OMA would be pleased to work alongside government to develop a process for contract development, including templates and boilerplate language.

For the reasons cited above, the OMA strongly recommends that physicians and medical health corporations be explicitly named in the Act as being excluded from the definition of HSP. The suggested amendment is provided below. The OMA will continue to work with the government related to physicians' roles as Bill 74 is operationalized.

Proposed Amendment – Add new subsection to s. 1
Exclusion, physicians:
(4) 1. A member of the College of Physicians and Surgeons of Ontario under the Medicine Act, 1991, is not a health service provider when the member provides, or offers to provide, health services to individuals within the scope of practice of medicine. 2. A medical profession corporation that holds a certificate of authorization issued by the College of Physicians and Surgeons of Ontario under the Regulated Health Professions Act, 1991 or under Schedule 2 to that Act. 2006, c. 4, s. 2 (3).

Recommendation 4 – Clarification is needed about whether amendments are required to the Personal Health Information Protection Act (PHIPA) pertaining to physician accountabilities in an ICDS / OHT. Further, amendments to PHIPA are required to create an enabling information sharing system.
The new integrated care model via Ontario Health Teams raises questions related to data custodianship and data governance. For example, within an Ontario Health Team, who is the custodian? Will it be the Ontario Health Team, or the physician? With multiple providers accessing and contributing personal health information to patient records as part of the ICDS, the roles, responsibilities, and expectations of each participating provider need to be clearly delineated.

As well, section 26 of Bill 74 allows investigators to access records of "any person performing services for the providers, system, person or entity." This would presumably include physicians, even when the physician is the Health Information Custodian and not the FHT or other entity.

While this existed previously (for HSPs) under LHSIA and has not been an authority that has been readily used, depending on physicians' contractual obligations with ICDSs, this authority may apply to physicians in these systems. If physicians' records are accessed without consent, this raises concerns as to whether an investigator might then

report that physician to the CPSO if he or she uncovers something in the record? This may deter physicians from participating in an integrated model if they know their records can be accessed through a FHT or other entity, and raises issues related to procedural fairness. It also raises rationale as to why preserving the HSP exclusion for physicians is of value.

We have begun discussions with government about clinics that are owned and operated by non-health professionals. Under the current language of Personal Health Information Protection Act (PHIPA), these clinics are technically Health Information Custodians. That being said, they are otherwise unregulated, without clear incentive to adhere to the laws, rules, and regulations that otherwise govern health professionals. In our experience, these entities often fail to observe privacy laws, and, in many cases, are not even aware they exist. As unregulated entities operating in a highly regulated space, these clinics pose additional challenges. If a clinic integrated within an OHT that is owned and operated by a non-health professional, how will privacy laws, data sharing, and virtual health be enforced and embraced? Some owners are even located out of province or outside the country. How will these entities be properly managed? This may present obstacles for proper integration and should be explored further.

Further, because these clinics may be well resourced and positioned to step forward and manage and organize, we caution this would not be ideal for the above stated reasons. We have been engaging in discussions with the Ministry's Information Management department to explore options to resolve this issue and would be pleased to be engaged on this issue in the future. Physicians are looking for support from both the Ministry and the Information and Privacy Commissioner to fulfil their obligations, as well as provide innovative uses of virtual health, and as such would be well positioned to offer input.

As such, the OMA advocates that the PHIPA be modernized to facilitate greater information sharing between providers. For an integrated care delivery system to operate effectively, the development of an integrated information sharing system is paramount. Providers must have easy access to and a seamless flow of information across the spectrum of care, to provide for effective care delivery and continuity of care. For an ICDS to operate effectively, it needs to be supported by both access to and exchange of necessary information in the continuum of patient care. From a technology perspective, there are a myriad of ways that information can be integrated (from a single 'system' to the standards-based integration of multiple systems), but it is important to ensure that technology does not create a further barrier by adding considerable complexity, unnecessary variation, or administrative burden for both patients and providers in accessing health information. From a health system perspective, consideration must be given to the acceptable degree of information exchange variation within and across ICDSs, while considering factors such as, but not limited to cost,

implementation, and data exchange. A provincial lens should be applied when considering sectorial integration so that each domain of care does not define their information contribution uniquely within each OHT.

The evolution of a functional and secure information sharing system will be an iterative process. However, providers should be empowered to participate in the information sharing system, as well as the use of digital tools and virtual care. The way to do this will be by the development of functional tools that are well integrated and that do not place further administrative burden on physicians. Many studies have demonstrated that electronic tools are one of the leading contributors to provider burnout.[13,14] Often referred to as 'click fatigue,'[14] such tools have been found to take time away from the physician-patient encounter and direct patient care, with findings that "physicians typically spend two hours doing computer work for every hour spent face to face with a patient" including after-hours work.[13] This is largely in part due to the poor usability and inefficient data input requirements of the digital tools.[14] As such, physicians and other users must be involved in their design and development, to ensure the digital tools are functional for providers in daily clinical practice. As users, providers are best-positioned to identify challenges and opportunities for improvement. We must, as a system, look for all ways to mitigate and reduce provider burnout, as this will improve quality of care and ensure sustainability of the health care system at large."

In addition, with respect to telemedicine, virtual care, and electronic transfer of information, clarity must be provided with respect to what is permissible by law. Privacy controls should remain one of many important considerations in developing an enabling eHealth system; however, privacy must not act as a barrier to effective care delivery. We encourage the government to work with the Information and Privacy Commissioner to ensure the guidance provided to physicians and other providers is aligned with the actual intent of PHIPA and the notion of information sharing within the circle of care.

As the legal custodians and stewards of patients' personal health information, providers are best positioned to advise on how information should flow. As such, physicians should be partners in decision-making processes surrounding eHealth governance and the development of an information sharing system.

Recommendation 5 – Amend Section 44 and add new Section 44.1 to Bill 74 to establish formal mechanisms to ensure that Ontario Health collaborates with and seeks advice from physicians and physician leaders

While the Bill sets out the important requirement for Ontario Health to engage in its operational planning processes with the Minister's Patient and Family Advisory Council established under the *Ministry of Health and Long-Term Care Act* [S. 44(2)], there is no similar requirement for formal engagement and consultation with physicians and other providers. While LHSIA provided local health integration networks with the authority to

establish health professional advisory committees with prescribed duties and role, it was not mandatory [(S. 16(5)].

Given Ontario Health's significant mandate, and the vital role physicians have in the successful planning and implementation of ICDSs (See Recommendation #1), the OMA recommends that formal mechanisms be enshrined in legislation to ensure physician input and advice is sought and considered by Ontario Health in exercising its mandate through the following amendments to the Bill:

A. First, the OMA recommends that a 'Health Provider Council' be established in legislation to advise and work with Ontario Health on matters related to its objects. The OMA also recommends that the Council have mandatory physician membership via the OMA as its representative body. Specific details regarding mandate (e.g., roles and duties could include advising in the development of clinical outcome measurement, on health care integration and delivery, etc.), membership (e.g., numbers, types of providers, qualifications, etc.) and reports (e.g., annual report) of the Council should be established through regulation and/or through the Agency's accountability agreement to the Minister [(ss.19(2)(f)].

Proposed Amendment – Amend Bill 74 by adding new section 44.1 to establish "Health provider council'
44.1 The Board of Ontario Health must establish a health provider council that includes physicians to provide advice and perform other duties as prescribed

B. Second, Ontario Health is required to engage the community such as patients, families, caregivers, health sector employees in their operational planning processes [S. 44(1)]). Physicians in general are not captured by this definition as the majority would not be categorized as health sector employees. Because of the leadership role of physicians in delivering health care in Ontario, the OMA recommends that this section be amended as outlined below (see suggested wording in bold).

Proposed Amendment – Amend Bill 74 Section 44 (1) to add physicians to the list of those that must be engaged
Community engagement
44 (1) The Agency, integrated care delivery systems and health service providers shall establish mechanisms for engaging with patients, families, caregivers, health sector employees, ***physicians*** *and others as part of their operational planning processes in accordance with the regulations, if any.*

Finally, the OMA notes that the Board may establish committees of the Board that the Minister specifies and appoint members who meet qualifications if any, as prescribed [(s.13(3)]. By-laws approved by the Minister will establish committees, but it is not clear

if committees of the board may include non-board members. Depending on the nature of the committee, as per the Agency's objects, partnership with the physicians via the OMA is essential. We look forward to further discussions with the government on the development and implementation of these formal mechanisms. This collaboration with physicians is critical for success.

Conclusion

The OMA is pleased to see the government's commitment to support integrated care in Ontario, with a focus on a digital system. The OMA has long supported the notion that a truly effective, high quality health care system must be coordinated and integrated, enabled by a seamless health information system, and be centred around the patient. This is what Bill 74 intends to do and we are very encouraged and strongly support the intent and key elements set out in Bill 74 as a result.

This submission provides five key recommendations that OMA believes will strengthen the Bill and help the government achieve the desired outcomes. Amendments to the Bill and further areas discussed elaborate on where additional clarification is needed.

Our recommendations are:

1. Amend Section 29 of the Bill to reflect the evidence that Integrated Care Delivery Systems (ICDSs) must be physician-group led, voluntary, and centred around primary care
2. Recognition of the role of community-based specialists in ICDS / OHT model is needed
3. Amend Section 1 of Bill 74 to include an exemption for physicians and medical profession corporations from the definition of Health Service Provider
4. Clarification is needed about whether amendments are required to the Personal Health Information Protection Act (PHIPA) pertaining to physician accountabilities in an ICDS / OHT. Further, amendments to PHIPA are required to create an enabling information sharing system
5. Amend *Section 44 and add new Section 44.1 to* Bill 74 to establish formal mechanisms to ensure that Ontario Health collaborates with and seeks advice from physicians and physician leaders

Effective partnerships and physician involvement via the OMA are critical to the success of this Bill. As noted in the recommendations, more details related to how the new models of care will be operationalized is needed. We would like to reiterate our appreciation for the open discussions we have with government to date given the significant and broad sweeping changes to our health care system ahead. The OMA

and our physician members look forward to ongoing collaboration and in partnership with government in this process, taking an active role in leading future initiatives.

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