OMA
ONTARIO MEDICAL ASSOCIATION

An Integrated Health Network Approach to Address Priority Populations in Family Practice in Ontario

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Background

Historically, with the exception of those physicians and patients receiving care through formally integrated and collaborative practice environments like Community Health Centres (CHC) and Health Service Organizations (HSO), Ontario's primary care services were delivered by family physicians that operated in small informal groups, alone or with the support of an office practice nurse. Their work and relationships with primary care providers and community partners were typically informal and built on relationships established over time. It wasn't until the late 1990's that the Ontario government and the Ontario Medical Association (OMA) partnered with physicians to begin approaching primary care delivery in a more organized and systematic way.

The introduction of Patient Enrolment Models (PEM), including, Family Health Networks (FHN) in 2001, Family Health Groups (FHG) in 2003, the Rural Northern Physician Group Agreement (RNPGA) in 2005 and Family Health Organizations (FHO) in 2006 shifted family physicians into formal groups and introduced shared responsibilities for providing access to care after hours and incentives to perform key services for targeted patient populations. Payment options were expanded; with physicians being able to choose between the traditional fee-for-service and incentive based fee-for-service group practice model and one that blended an age-sex adjusted capitation payment with fee-for-service. Currently nearly 8,500 family physicians provide comprehensive care to over 10 million patients as part of a PEM, with over sixty per cent of family physicians providing care through the blended capitation based FHO model.

To move the health system forward and to meet the evolving needs of the population the government has expanded access to publicly funded interdisciplinary health care providers in community based organizations and programs. Comprehensive continuing care, including family physician services is available at 75 Community Health Centres (CHC) which provide service to over 250,000 patients. In 2005 the government introduced Family Health Teams (FHTs). FHTs are a multi-disciplinary formalized team model of interdisciplinary health professionals that work collaboratively with family physicians in FHO, FHN, RNPGA and Blended Salary models. There are now 186 FHTs which establish program and services to meet the needs of patients enrolled to the physicians who are formally affiliated with the FHT.

Formal collaborative interdisciplinary family health care services now provide care to over 3 million patients. Patients have access to varying levels of expanded service based on where they live in the case of CHCs or based on the patient enrolment relationship with one of the approximately 2700 family physicians currently affiliated with a FHT. With over 250 formal collaborative interdisciplinary family health care organizations (CHCs and FHTs) in Ontario, it is time to consider what can be done to begin to provide access to collaborative interdisciplinary team based programs and services to the nearly 10 million patients and approximately 5800 family physicians that are not affiliated with a FHT or employed by a CHC.

In addition to FHTs and CHCs, Ontario has expanded into nurse led care models. Nurse Practitioner Led Clinics are supporting patient care using a formal interdisciplinary approach. While not within the scope of this paper, it is important to recognize the role these practice models are playing in supporting patient care and to acknowledge that this model may also gain benefits to patient care from access to program and services delivered through the FHT and CHC investment. Additionally, many community based hospitals have been integrated with primary care to support a local shared care approach to patient care. While this approach plays an

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important role in many communities, it is less clear how community hospital services would be connected to FHT and CHC resources and therefore is not addressed within this paper.

Integrated Health Network

Ontario requires a supportive policy environment that values the ability to connect patients to services locally while maximizing access, quality and patient experience. The goal of this paper is to present a new clinical network model of collaboration and shared care through an approach to horizontal integration in primary care. The integrated health network model works by linking family physicians with existing FHTs and CHCs as part of an integrated team of providers to care for patients with complex needs within primary care. It does not propose a referral or consultation model but rather has at its foundation a goal of shared care and coordination. It requires that physicians and primary care providers lead care coordination and provide access to appropriate programs or services. The desired outcome is for an individual to receive care that is shared, seamless and transitions effectively.

When compared internationally Canada consistently ranks highest in emergency department use and most measures of timeliness of care, and second to last in patients' ability to get a same-day or next day appointment with a family doctor or nurse. These results reflect on areas that require focussed improvements and where leveraged investment will yield a high degree of benefit to patient care and provider performance. Despite Canada's international ranking on key indicators, patient experience surveys tell us that we are well positioned to improve our system. Nine percent of Ontarians do not have a regular place to obtain primary health care and thirty five per cent of patients feel they do not have enough time to discuss concerns with their doctor. Currently thirteen per cent of patients report difficulty with access and fifteen per cent report that their wait time for health care is unacceptable[1]; an integrated health network model approach would add key resources necessary to improve upon these measures through the addition of patient care options for all patients who require them, regardless of their physicians affiliation with a formalized program and service delivery model for interdisciplinary care.

To better leverage our existing collaborative interdisciplinary care investment the OMA is proposing that Ontario adopt an integrated health network model in primary care that will build on what has been learned about delivering programs, services, sessional specialty care, case management and care coordination in CHCs and FHTs. By establishing a horizontal level of integration between FHTs and CHCs with all family physicians, Ontario will be better able to provide coordinated care and supports for patients whose health status requires a higher degree of interdisciplinary support. By using a population approach, family physicians, FHTs, CHCs and community providers can be linked around the patient and provide coordinated care locally.

Priority populations who gain the greatest benefit from coordinated and collaborative interdisciplinary care typically include patients with mental health disorders, cardiovascular

[1] Karen Davis; Kristof Stremikis; David Squires and Cathy Schoen. *Update 2014 Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally*. The Commonwealth Fund, 2014 accessed November 12, 2014 http://www.commonwealthfund.org/~/media/files/publications/fund-report/2014/jun/1755_davis_mirror_mirror_2014.pdf

disease, cancer, diabetes, asthma, and chronic obstructive pulmonary disease as well as paediatric patients and those requiring palliative care services. Additionally those patients who face social issues, including housing, food and income security will also benefit from the formal community linkages, case management and system navigation capacity in an integrated health network model. Through a focus on differences in health within major population subgroups, and by using a coordinated, collaborative system redesign, Ontario has the potential to realize a high impact on the health status and capacity to provide appropriate care to the whole population.

By focussing on high impact system-wide initiatives that improve access to a team of providers, enhanced management of chronic disease and improved coordination and management of co-morbidities, Ontario will improve health and wellness, provide high quality care and move towards a more sustainable, accessible and affordable health care delivery model.

Policy Environment

Ontario's Action Plan for Health commits to providing patients with "faster access to family health care that serves as the hub of our health care system, they stay healthier, get connected to the right care and are less likely to require treatment in hospital. This is especially true for our seniors, who need a coordinated plan in place to receive the care they need, with help navigating the various parts of our system"[2]. Ontario's doctors share this vision and support the role of primary care in delivering on this commitment. The Action Plan rightly identifies family physicians and other primary care providers as "a natural anchor for patients in our health care system….well positioned to help patients navigate the system, particularly patients with multiple complex conditions."[3]

Achieving this goal will require both a top-down and most importantly bottom-up approach whereby patients, family physicians, CHCs, FHTs, public health, and community providers work collaboratively with the Ministry of Health and Long-Term Care and the Local Health Integration Networks to focus on design of a coordinated system that includes the necessary health professionals and services. The integrated health network permits identification of priority populations and patients, the implementation of effective clinical practice changes, and access to a family physician and interdisciplinary providers for comprehensive, continuous care.[4] Using a staged approach that is dynamic and flexible, Ontario needs to begin to establish more formal alignment for all patients and their family physicians with health and community resources that are part of an integrated team of providers. This will require a supportive and flexible policy environment that allows providers to create local changes, realign services or establish partnerships that improves service distribution, coordination of care and outcomes for patients.

[2] Ontario. Ministry of Health and Long-Term Care. Ontario's action plan for healthcare: better patient care through better value from our health care dollars: let's make healthy change happen. Toronto, ON: Queen's Printer for Ontario; 2012.
[3] Ibid
[4] British Columbia, Ministry of Health, *Primary Health Care Charter: A Collaborative Approach*, 2007 accessed November 12, 2014 http://www.health.gov.bc.ca/library/publications/year/2007/phc_charter.pdf

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Fiscal Environment

Ontario is currently faced with limited fiscal resources and rising costs of health care that provide an opportunity for the system and providers within it to look for innovative solutions and investments that will bring value to patients and redistribute costs. Focussing attention on primary care services has the greatest potential for reducing more upstream costs like hospital, drug and diagnostic services. The reallocation of spending among types of services and a better use of capacity, shortening the cycle time and provision of services in the appropriate setting has the potential to improve the health outcomes of patients and achieve structured cost-reduction.[5]

Successful implementation of the integrated health network model will require a partnership approach between all providers and the Ministry to address barriers in the prevailing cultures within provider groups and an active support of excellence in the delivery of accessible, high-quality, cost-effective patient-centred care.[6] Physicians are committed to working with all providers and the Ministry to focus further work on establishing role clarity, tools for communication, monitoring and evaluation, population needs-based services, timeliness of care across the continuum and care coordination.[7]

Efficiency and Equity

Two keys to the success of a high performing health care system are efficiency and equity in primary care. An efficient, high-value health system seeks to maximize the quality of care and outcomes given the resources committed, while ensuring that additional investments yield net value over time.[8] Ontario's FHT and CHC investment has provided an important foundation for building an efficient, high-value health system. Maximizing this investment, by extending access to the programs and services they offer to targeted patient populations who currently receive care outside these models has great potential to improve upon the care provided to all Ontarians. This equity based approach will build a primary care system in Ontario that doesn't vary in quality because of policy, patient socioeconomic status, and family practice location or remuneration preference.

At present Ontario offers uneven care through an inequitable approach to organizing primary care services. Patients connected to FHTs and CHCs receive facilitated access to the programs, services and supports they require, with little or no cost to the patient, by virtue of their proximity to a CHC or their physician's practice arrangement. Patients who are not affiliated with a FHT or CHC still typically receive necessary primary care services, but have variable access, may receive less navigation and care coordination and may have to pay for services out of pocket. With increasing rates of chronic diseases, multiple co-morbidities within patients, an aging population

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[5] Porter, ME. *What is Value in Health Care?* The New England Journal of Medicine, 363;26, December 23, 2010
[6] Thy Dinh, Carole Stonebridge, and Louis Theriault. *Getting the Most out of Health Care Teams: Recommendations for Action*. Ottawa: The Conference Board of Canada, 2014
[7] Ibid
[8] Karen Davis; Kristof Stremikis; David Squires and Cathy Schoen. *Update 2014 Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally*. The Commonwealth Fund, 2014 accessed November 12, 2014 http://www.commonwealthfund.org/~/media/files/publications/fund-report/2014/jun/1755_davis_mirror_mirror_2014.pdf

and growing workplace, social and economic pressures Ontario's inequitable delivery of primary care services has the potential to unfairly and unnecessarily lead to inequitable health outcomes.

Health Links as a new and emerging initiative in Ontario has demonstrated some early successes, but unlike Health Links which are focussed only on the highest users of the health care system, integrated health networks include those patients who are not currently captured within the Health Links model. Similar to Health Links, the integrated health network model will match patient need with service availability and accessibility. Supports in an integrated health network have the potential to prevent many patients from moving into the higher needs or high user category and provides appropriate coordinated care for those that have improved as a result of Health Links. It also recognizes and responds to patients with few health care needs without 'over-serving'.

Value

Sustainability of the health system requires a focus on offering value to patients rather than maximizing cost benefits of a single episode or intervention. Porter defines value as health outcomes achieved per dollar spent that requires a focus on results not inputs.[92] A focus on value rather than cost allows for the health system to focus its limited resources on investing in services that will reduce the need for other services. In our integrated health network model an investment to expand access to CHC and FHT based providers, programs and services for specific patient populations has the potential to realize improved access to the necessary chronic disease and social supports that will reduce demand and costs associated with hospital in-patient and emergency room services, long-term care and diagnostics.

Barriers

A team approach in primary care has been shown to be successful in the prevention and management of mental health conditions and chronic diseases and also contributes to improvements in health status and quality of life. However, barriers and organizational capacity issues do exist that significantly impair our ability to provide effective, equitable, efficient primary care services.

Shifting to a shared-care approach will take careful planning and a strong governance framework that establishes an accountable and sustained relationship between physicians, patients and interdisciplinary service providers. Resources that support collaboration, including continued provider and patient education, effective administrative support, practice agreements, protocols , care planning and service provisions will be required and should be focused on adding value to the physician and patient experience. Contradictory financial incentives, the lack of interoperable electronic medical records and issues with respect to professional roles and sharing responsibilities between different providers[10] and care sites won't be easily overcome.

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[9] Huynh, Tai M; G. Ross Baker; Arlene Bierman; David Klein; David Rudoler; Gilbert Sharpe; Therese Stukel; Theresa Tang; Hannah J. Wong; Adalsteinn D. Brown. *Exploring Accountable Care in Canada: Integrating Financial and Quality Incentives for Physicians and Hospitals*, 2014 Canadian Foundation for Healthcare Improvement

Many will argue that capacity within Ontario's FHTs and CHCs is limited. Funding for interdisciplinary services is currently limited and Ontario's fiscal situation is restricted by budget deficits. FHTs and CHCs will face challenges absorbing new patient demands within existing budgets. To be successful, Ontario will need to see the addition of new resources and providers within the FHTs and CHCs, they will need to apply a population approach to planning and evolve program models and service delivery. This will have to be done collaboratively and include physician leadership from inside and outside the FHTs and CHCs working alongside other providers to ensure that this model has the potential to improve patient outcomes by increasing the availability of a diverse group of professional expertise in patient care. Ontario needs to ensure that funding restrictions don't limit the health care system from better addressing the needs of patients and meeting the growing demand for patient care.

Next Steps

Ontario is poised to realize enhanced collaborative interdisciplinary care for targeted patient populations by deploying a change management approach that facilitates providers working together and increases the role and understanding of each provider within the system. This will require physician leadership, training and continuing education in collaboration and shared care along with the establishment of formal and functional communication processes, the building of trust and respect between all providers, the identification of shared goals for the patient and the system, and the utilization of supportive clinical and administrative systems.

Adopting an integrated health network model in primary care will improve equity by providing appropriate access for patients to publicly funded interdisciplinary health services. This access to the community based programs and services for patients that need it most will make significant progress in putting patients at the centre of care while achieving a more sustainable health care system by providing the right care, at the right time in the right place.

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