

JUNE 2009

First Things First: Fostering Accountable, Connected, Quality Primary Health Care

Framing paper for Meeting of the Minds 2009, June 16–17



H E A L T H C A R E D E S E R V E S O U R F I N E S T T H O U G H T



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First Things First: Fostering Accountable, Connected, Quality Primary Health Care

JUNE, 2009
The Change Foundation
www.changefoundation.com

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About The Change Foundation

The Change Foundation is an independent health policy think tank that generates research, analysis and informed discussion on health system integration and quality improvement in home and community care in Ontario. Located in Toronto, The Change Foundation is governed by a 12-member board of directors, led by President and CEO Cathy Fooks and supported by a small professional staff.

Established in 1996 through an endowment by the Ontario Hospital Association, The Change Foundation is an independent charitable foundation with a mandate to promote, support and improve health and the delivery of health care in Ontario.

For more information, visit www.changefoundation.com

Acknowledgements

This framing paper was prepared by The Change Foundation's president and chief executive officer, Cathy Fooks, based on an outline provided by the Foundation's research advisor, Steven Lewis, with contributions from *Meeting of the Minds* facilitator and health policy consultant Lillian Bayne.

Voices Over the Years

Provider attitudes and beliefs, lack of government support, lack of enabling legislation, lack of capital and start-up funding especially for consumer-sponsored programs, and cost constraints associated with an ailing economy – all of these have contributed to the lack of growth of comprehensive community based programs on Canada.

Hastings and Vayda, 1986

The solo doctor who embodies every process needed to ensure highest-quality health care is now nearly a myth. All physicians depend on systems, from the local ones in their private offices to the gargantuan ones of national health care.

Don Berwick, 1989

The HSRC believes that an effective primary health care system does not exist in Ontario today. Although there are many dedicated primary care providers who serve the population, health care is fragmented, unstructured, and not part of an integrated and coordinated health care system. Serious access problems exist in a number of areas in the province, especially in rural and remote areas. Much of the activity to date aimed at improving the health system has related to hospital services. Attention is badly needed to improve primary care now.

Health Services Restructuring Commission, 1999

The primary care sector is structured like a 19th century cottage industry rather than a 21st century service industry, consisting as it does largely of individual physician practices which are not clustered together, making 7/24 service impossible. The first and essential step in organizational change must be primary care reform. This has been recognized by the Sinclair Commission in Ontario, the Clair Commission in Quebec and the Fyke Commission in Saskatchewan. It is why the federal government agreed to contribute \$800 million to primary care reform following the F/P/T agreement on September 2000.

Standing Senate Committee on Social Affairs, Science and Technology, 2001

Saskatchewan has skilled and caring professionals who can provide good quality care in communities large and small. But these skills are not employed as effectively as they could be. Physicians, in today's model, are isolated from the rest of the health system. Working in independent practice, and paid a fee for each service, doctors cannot easily share work with nurses, nutritionists, mental health counselors or other professionals.

Saskatchewan Commission on Medicare, 2001

Every report reviewed identified the need to restructure the way we deliver primary care. Without reforming primary care, we cannot do much about other important parts of the system.

Fooks and Lewis, 2002

Primary health care is about fundamental change across the entire health care system. It is about transforming the way the health care system works today – taking away the almost overwhelming focus on hospitals and medical treatments, breaking down the barriers that too frequently exist between health care providers, and putting the focus on consistent efforts to prevent illness and injury, and improve health. In fact, no other initiative holds as much potential for improving health and sustaining our health care system.

Roy Romanow, 2002

Despite the broad consensus on the importance of primary care reform in theory, achieving such reform is proving difficult in practice. In Canada, all provinces and territories have been designing and implementing reforms in primary care. Their approaches to program design, implementation and pace differ, but nowhere is the process proving to be speedy.

Ruth Wilson et al, 2004

In short, the implementation of primary care reforms must be the central issue to be solved in Canadian health care in this decade. New models or new studies are not the solution, nor will rehashing old debates solve the problem: what is needed to meet the challenge is a lot of energy devoted to issues of implementation.

Michael Decter, 2004

The current political debate with respect to medicare is focused on wait times and sustainability. Unfortunately, neither of these two issues has a clear direct connection to primary care renewal, which places future ongoing investment in primary care at risk.

Alan Katz, 2008

Unless measures are taken to rebalance the system in favour of primary care and to align secondary and tertiary care in support of primary care, the performance of the Canadian health care system could even fall behind the US system in future international comparisons.

Paul Lamarche, 2008

Primary care reform (and Family Health Teams in particular) hold a lot of potential to help LHINS achieve the goals of better health care and a better health system. Many physicians and other health professionals want to practice within a model of health care similar to family health teams.

Meeting of the Minds participant, 2008

Primary care physicians are a huge issue, because they tend to be the most isolated in the system, particularly if they are not involved in hospital work, which in the most populated parts of our country, they're not. They often experience the interface with many parts of the system as an added burden versus something that should enable them to do a better job. To me, the first job of any health region should be to bring its primary care physicians into a more integrated role in the region, recognizing that they are a critical part of a high-quality health care system.

Penny Ballem, Former Deputy Minister of Health for BC and Clinical Professor of Medicine at UBC, 2009

Introduction

This is not a literature review nor a position paper. They can be found elsewhere. The purpose of this background document is to amplify the thinking behind The Change Foundation's 2009 *Meeting of the Minds*, *First Things First: Fostering Accountable, Connected, Quality Primary Health Care* and to stimulate discussion and debate.

The way in which a health system organizes, funds, incents and rewards its primary health care sector has a lot to do with how effective, efficient and high performing that health system becomes. Primary health care in Ontario has historically experienced waves of intense attention and absolute neglect. It is not currently a major policy priority, overshadowed by wait times (surgical, diagnostic and emergency department stays), efforts to reduce the number of alternate levels of care patients, and institutional budget shortfalls. Yet, some of the long-term fix for these issues lies in a primary health-care sector integrated into the rest of the health-care system. So where to begin?

What is it?

Generally, there is little disagreement over what it is.

- The National Forum described primary health care as the care provided at the first level of contact with the health-care system – the point at which health-care services are mobilized and coordinated to promote health, prevent illness, care for common illness, and manage ongoing health problems. (1997)
- The Ontario Health Services Restructuring Commission followed suit: Primary health care is the first level of care, and usually the first point of contact, that people have with the health-care system. Primary health care supports individuals and families to make the best decisions for their health. It includes advice on health promotion and disease prevention, health assessments of one's health, diagnosis and treatment of episodic and chronic conditions, and supportive and rehabilitative care. (1999)
- And, the Federal/Provincial/Territorial First Ministers agreements recognized the foundational importance of primary health care:
- First Ministers agree that improvements to primary health care are crucial to the renewal of health services. Governments are committed to ensuring that Canadians receive the most appropriate care, by the most appropriate providers, in the most appropriate settings. First Ministers will continue to make primary health-care reform a priority. First Ministers agree that their governments will work together, in concert with health professionals, on improving primary health care and its integration with other components of the health-care system. (2000)

- The key to efficient, timely, quality care is primary health-care reform. First Ministers agree that the core building blocks of an effective primary care system are improved continuity and coordination of care, early detection and action, better information needs and outcomes and new and stronger incentives to ensure that new approaches to care are swiftly adopted and here to stay. (2003)
- Timely access to family and community care through primary health-care reform is a high priority for all jurisdictions. (2004)

Key Attributes

Again, there is little disagreement over the key attributes of a high performing primary health-care sector.

The Ontario Health Services Restructuring Commission in Ontario recommended five essential elements:

- Access to a comprehensive selection of primary health-care services;
- Services accessible 24/7;
- Group practices;
- Enrolment of patients;
- Interprofessional primary health-care provider teams.

The Standing Senate Committee outlined their basic premise for primary health care groups as groups that:

- Are working to provide a broad range of services, 24/7;
- Strive to ensure that services are delivered by the most appropriately qualified health-care professional;
- Utilize to the fullest the skills and competencies of a diversity of health-care professionals;
- Seek to integrate health promotion and illness prevention strategies in their day-to-day work;
- Fully integrate electronic patient health records into the delivery of care;
- Progressively assume a greater degree of responsibility for all the health and wellness needs of the population they serve.

The Ontario Ministry of Health and Long-Term Care has identified the following as core elements of primary health care (www.healthforceontario.ca):

- A common basket of services
- Access through a telephone health advisory service
- Voluntary patient enrolment with a physician

- Patient-based funding
- Inter-disciplinary care
- Grouped or networked practices
- Extended hours of access
- Access to preventive care and comprehensiveness incentives

Why Does it Matter?

1) Primary Health Care is Essential to a High Performing Health System

- Countries with a stronger primary health-care system generally have healthier populations. An emphasis on primary health care can be expected to improve health outcomes through improved access to appropriate services, reduced inequities in the population's health and lower costs of care. (Starfield 2008)
- Countries with weaker primary health-care systems have significantly higher costs (Starfield 2005).

A recent review of the literature on the attributes and benefits of a high quality primary health-care system identified the following key characteristics: (McMurphy forthcoming 2009):

- Comprehensiveness of care
- Family orientation
- Equitable resource distribution
- Government or government-related universal coverage
- Low or no patient user fees

2) Well Organized Primary Health Care Can Achieve Health, Service and System Goals Simultaneously

HEALTH GOALS WOULD INCLUDE:

- a focus on health promotion and prevention
- effective chronic disease management
- holistic treatment and cure

SERVICE GOALS WOULD INCLUDE:

- evidence based quality
- timeliness/access
- comprehensiveness of service
- excellent communication with patients and provider

SYSTEM GOALS WOULD INCLUDE:

- coordinated care
- ease of patient navigation
- interprofessional collaboration
- enhanced patient safety
- Optimal scope of practice

Where Are We in Ontario?

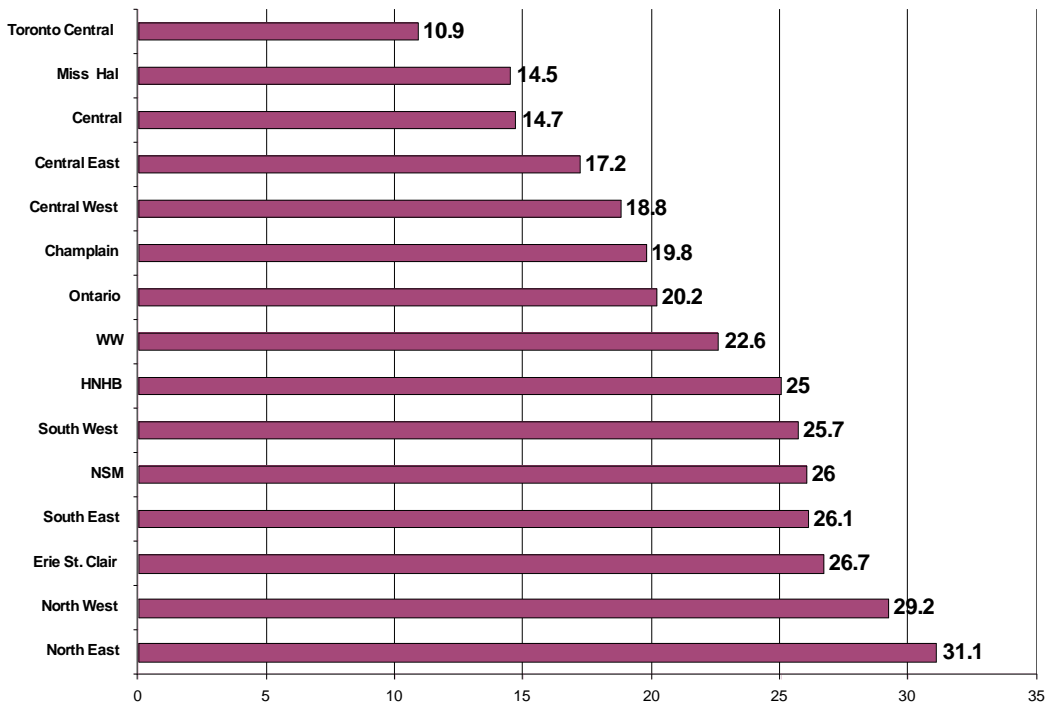
- Despite government investment and plenty of evidence supporting the benefits of a well organized primary care system, Canada is behind others with similar resources – particularly in access to after-hours care, wait times, chronic disease management, quality improvement foci and electronic health records. (Schoen 2006, 2007; Starfield 2005, 2008a)
- Canada's primary health-care sector is characterized by fragmentation, inefficient use of providers and resources, lack of health promotion, poor information sharing and misaligned incentives. (Deber 2006)
- Quite simply, Ontario is failing to meet the challenge of chronic disease. Close to 8000 lives could be saved annually – and the quality of life improved for many more people – if we did a better job of delivering the all-important regular care and monitoring that prevents the chronically ill from falling into severe bouts of illness. (OHQC, 2008)
- A number of different primary health-care models have been or are being implemented in Ontario as outlined in Appendix A. The current focus in Ontario is on Family Health Teams and Nurse Practitioner-led clinics and increasing the number of Community Health Centres.
- Contractual accountabilities and reporting requirements vary within these models as does the existence of community board oversight.
- Current provincial ehealth strategy is targeted to have 100% of physician practices using electronic health records by 2015.
- Funding and to some extent non-clinical primary health-care policy is negotiated between the provincial government and the Ontario Medical Association – other groups are not at the table or able to influence the outcome.
- LHINs do not fund or have authority over physicians and other independent health care professionals.

Some Quick Stats On Achieving Health Goals

1) Focus on health promotion and prevention

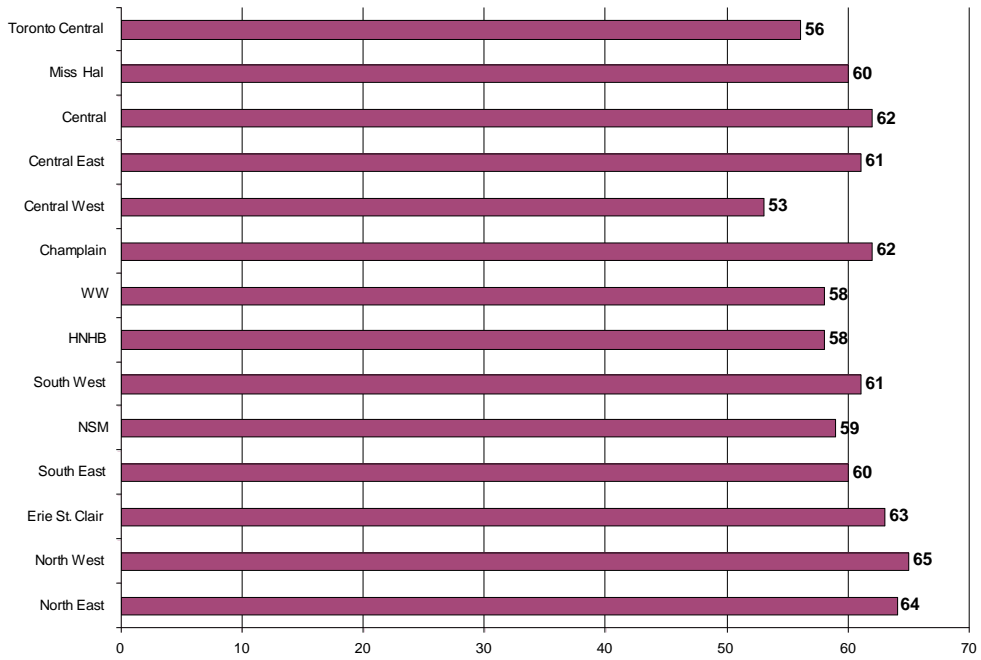
The following graph shows the percentage of the population by LHIN that indicated they had not had a pap smear within the last three years by LHIN. The variability could be due to many factors including the organization of primary care services, the availability of health professionals, and the lack of electronic information systems

% OF POPULATION WITH NO PAP SMEAR FOR AT LEAST THREE YEARS, BY LHIN, 2007



Source: Ontario Hospital Association, Health System Facts & Figures & Statistics Canada, 2007.

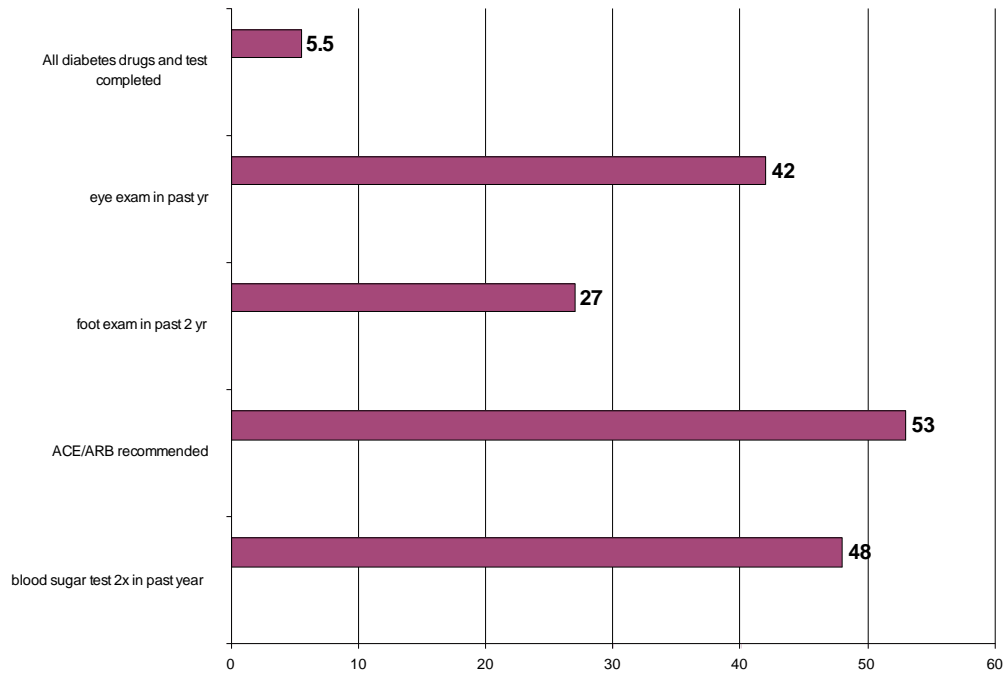
**% ELIGIBLE WOMEN (AGED 50-69) WHO HAD A MAMMOGRAM
BY LHIN, 2004/05**



Source: Cancer System Quality Index, CCO, 2007

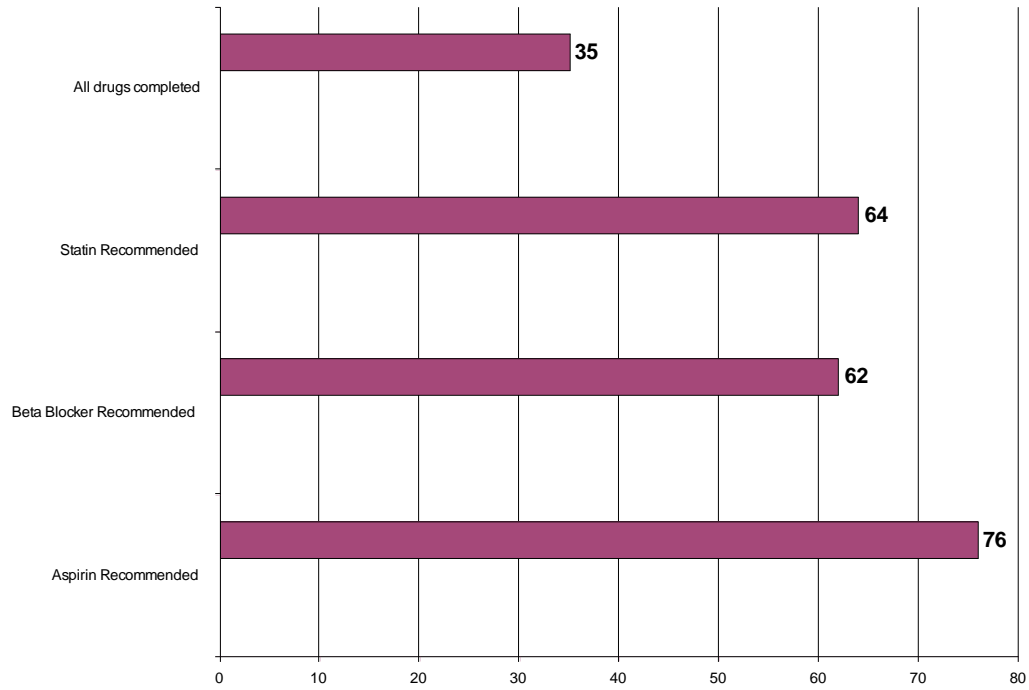
2) Effective Chronic Disease Management and Evidence Based Quality

% OF ONTARIO DIABETES PATIENTS RECEIVING RECOMMENDED DRUGS AND TESTS, 2007



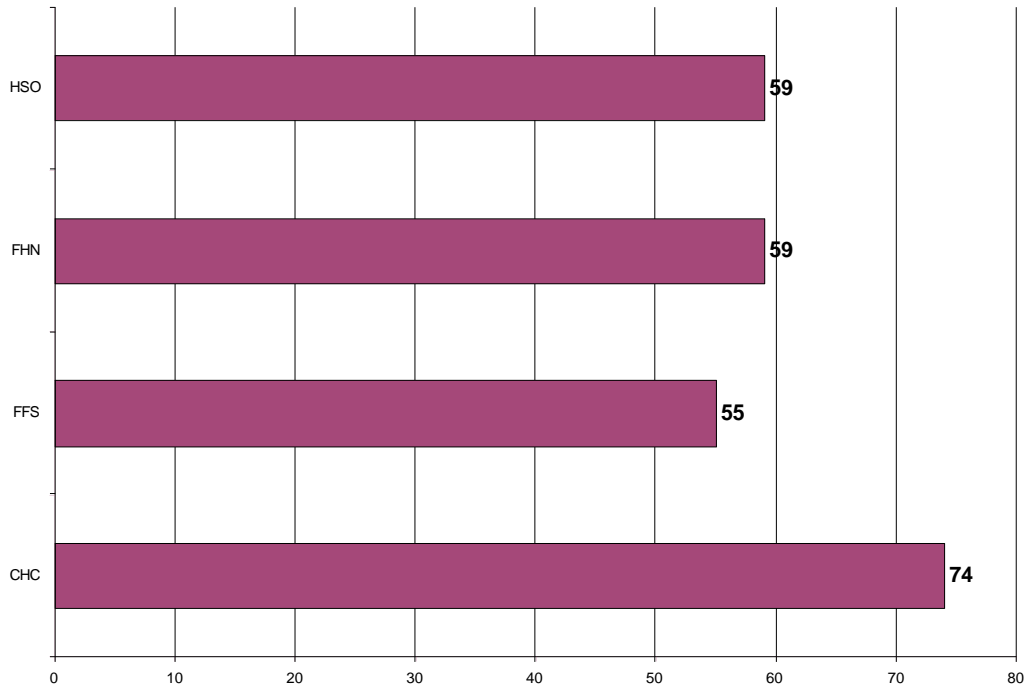
Source: Ontario Health Quality Council, Q Monitor, 2008

**% OF ONTARIO HEART DISEASE PATIENTS RECEIVING
RECOMMENDED DRUGS AND TESTS, 2007**



Source: Ontario Health Quality Council, Q Monitor, 2008

**% OF RECOMMENDED DRUGS AND TEST DELIVERED TO ONTARIO'S
DIABETES AND HEART DISEASE PATIENTS BY MODEL OF CARE, 2007**

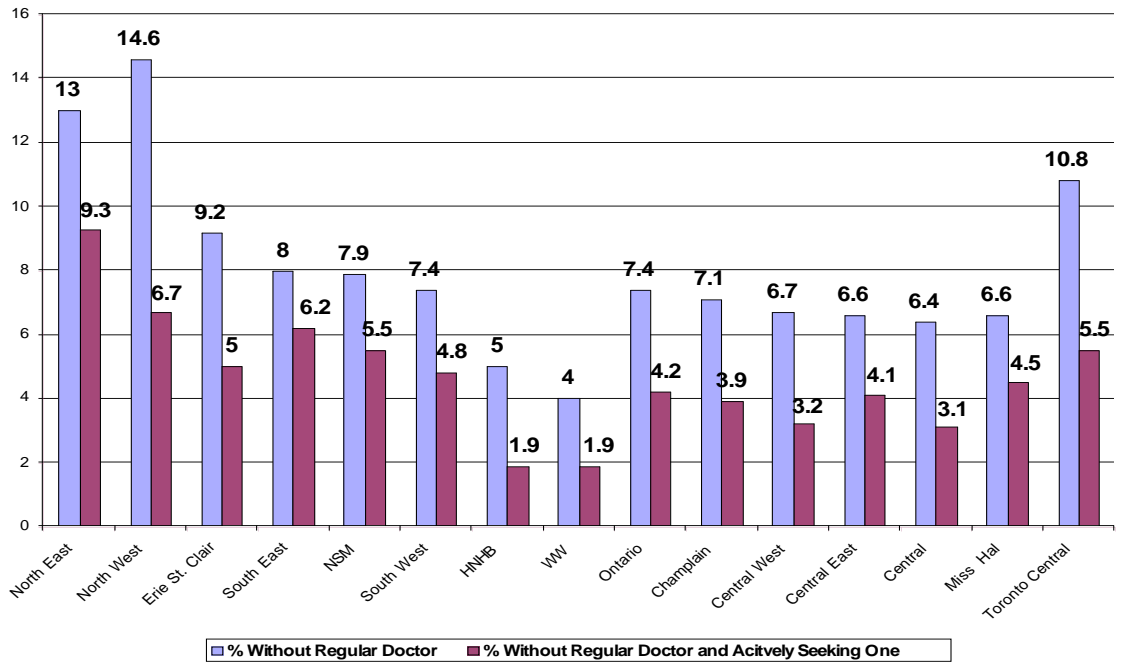


Source: Ontario Health Quality Council, Q Monitor, 2008.

Quick Stats on Services Goals

1) Timeliness / Access

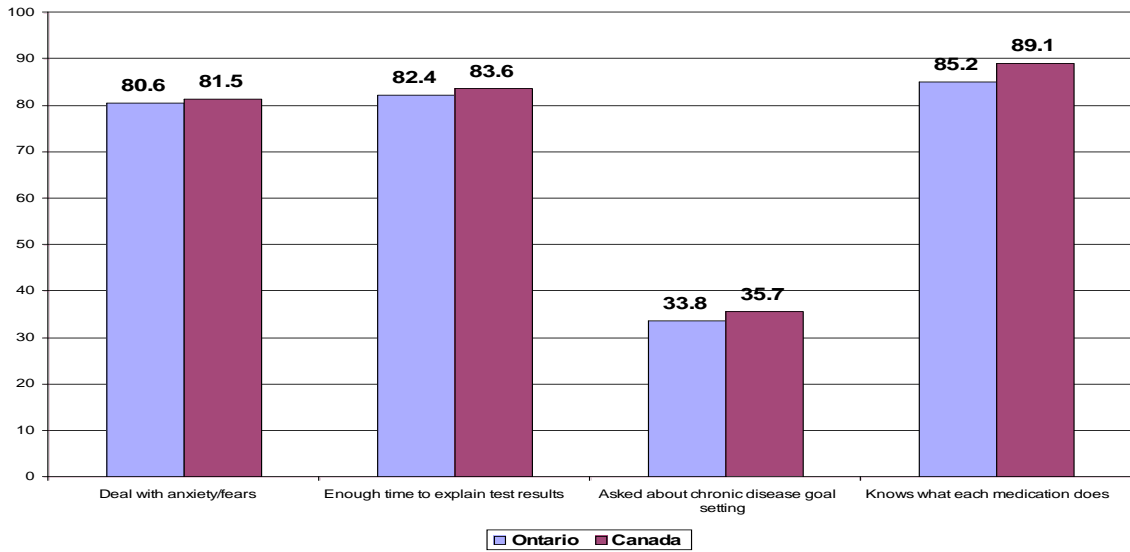
% ADULTS (18+) WITHOUT A REGULAR DOCTOR AND % WITHOUT A REGULAR DOCTOR AND ACTIVELY SEEKING ONE, BY LHIN, 2007/08



Source: Ontario Health Quality Council. Q Monitor, 2009

2) Excellent Communication with Patients and Providers

**% WHO FEEL THEIR PRIMARY CARE PROVIDER WAS PATIENT CENTRED,
ONTARIO AND CANADA, 2007**

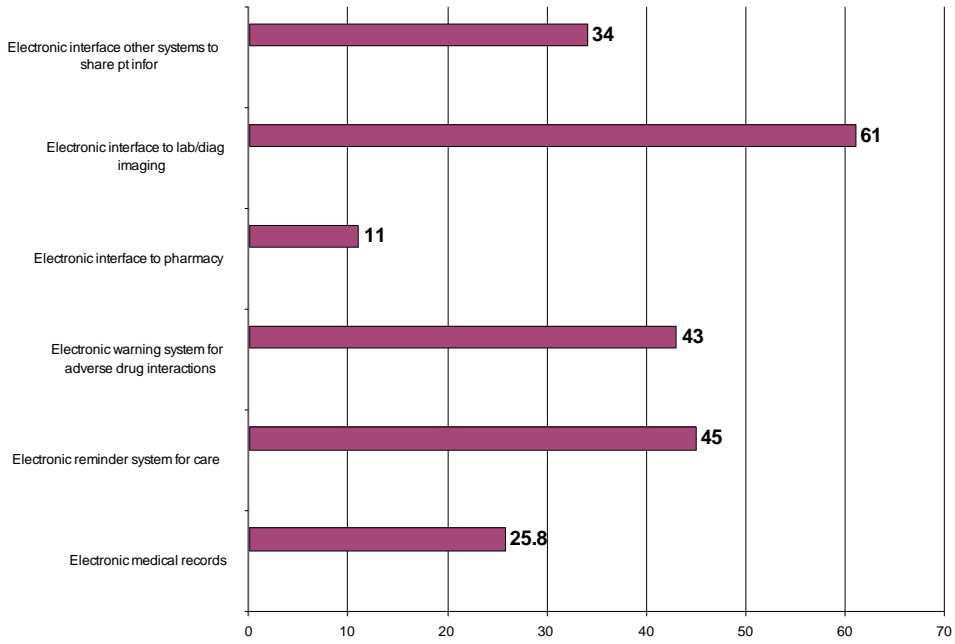


Source: Statistics Canada, Canadian Survey of Experiences with Primary Health Care, 2008

Quick Stats on System Goals

1) Coordinated Care and Patient Safety

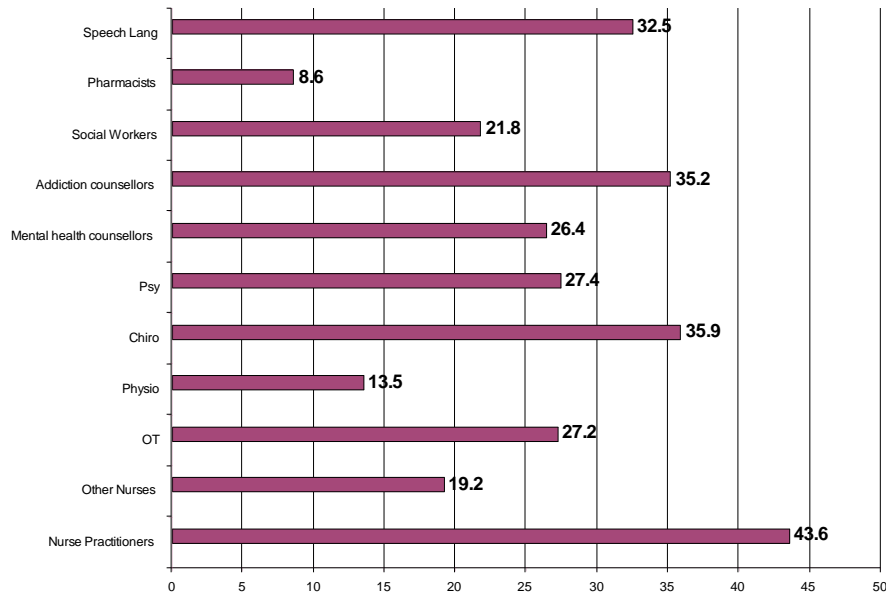
% OF FAMILY PHYSICIANS WHO USE ELECTRONIC INFORMATION MANAGEMENT SYSTEMS, ONTARIO, 2007



Source: CFPC, CMA, RCPSC, National Physician Survey, 2007

2) Interprofessional Collaboration

% FAMILY PHYSICIANS WHO REPORT THEY DO NOT COLLABORATE WITH OTHER HEALTH PROFESSIONALS, ONTARIO, 2007



Source: CFPC, CMA, RCPSC, National Physician Survey, 2007

Ontario's History of Policy Development

Since Ontario entered medicare in the early 1970s, there have been essentially four waves of effort to provide primary-care services to residents:

- Focus on physician services (1970s)
- Focus on other providers like Nurse Practitioners and Community Health Centres (1980s)
- Incent interprofessional collaboration and teams (largely physician led) (1990s – 2000s)
- Incent better Chronic Disease Management (now)

Hutchison has characterized the earlier efforts as “policy gridlock, resulting in myriad small-scale innovations but not system-level change.” (2008) All these efforts were focused on funding to professionals, not on achieving a set of goals linked to the health system. And now as Ontario develops a chronic disease management focus, the role of primary health care becomes paramount. It is unlikely that Ontario can change its disease burden without an organized approach to the role of primary health care and its connectedness to the rest of the health-care system.

Previous analysis of primary health-care reform efforts provide sound advice (Hutchison 2004):

- Policy legacies limit the possibilities for change;
- There is no single “right” primary health-care model – pluralism is unavoidable and even desirable;
- Funding and payment models are no panacea for the ills of primary health care;
- Renewal requires major investment in infrastructure – tools to support quality improvement and coordination, information management systems, team staffing models etc.

So in 2009 – where to begin? Are we at the point where an expectation of a high performing primary health-care sector is directly linked to and supported by other levels of care with explicit accountabilities for improved patient outcomes? And if so, who does what?

Where do planning structures (LHINs) and case management structures (CCACs) fit? If primary care and home care were to be more integrated with specialty care, how would the money flow? Could/would/should Community Care Access Centres or LHINs fund physicians? About one third of Ontario's physicians are still working in solo practice – should we reduce that percentage, and if so, how? How do we direct scarce resources to where we know the greatest effect will ensue?

Perfect questions for a meeting of the minds.

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Appendix A. Primary Care Models in Ontario

(Extracted from www.healthforontario.ca, June 8, 2009)

Family Health Teams (FHTs): 150 established with a promise of another 50 to be developed. Family Health Teams are groups of health care professionals who work together to provide primary health care for a group of patients. They provide a wide range of services including health promotion, treatment services, chronic disease management and prevention, rehabilitation and palliative care. Funding flows through one of three models:

- blended salary model – base salary linked to patient enrolment, benefits and locum coverage and physicians can bill fee for service for non-enrolled patients up to a maximum and for services outside the blended salary basket;
- blended capitation model – a per capita payment for each enrollee and physicians can bill fee for service for non enrolled patients. Services provided outside the capitation basket of services are also eligible for fee for service billing;
- blended complement model – a combination of base salary dependent upon complement and geography and incentives for things like hospital emergency room coverage and preventative care.

Community Health Centres (CHCs): approximately 60 CHCs in Ontario. CHCs employ a team of health professionals that serve high risk communities and populations who may have trouble accessing health services because of language, culture, physical disabilities, socioeconomic status or geographic isolation. They focus on addressing the underlying conditions that affect people's health such as poor diet, poverty, housing problems, violence and lack of education. Funding is a global budget for the centre with all health professionals, including physicians, on salary.

Family Health Networks (FHNs): Family health networks are groups of physicians who work as a network along with nurse-staffed after hours telephone advisory service to provide primary health care to their patients 24 hours a day, seven days a week. The networks emphasize illness prevention and comprehensive care for patients. Physicians are paid on a blended capitation model. A minimum of three physicians is required.

Family Health Groups (FHGs): Family health groups offer comprehensive primary health care services for their enrolled patients. They offer regular office hours plus extra after hours block of time. The FHG physicians are also on call to a Ministry funded telephone advisory service outside of regular office hours that takes phone calls from their enrolled patients. Physicians are paid on a fee for service basis.

Comprehensive Care Model (CCM): this is specifically designed for solo primary care physicians. These physicians offer comprehensive primary health care services to their enrolled patients including regular office hours plus one 3-hour block of after hours service per week. Physicians are paid on a fee for service basis.

Family Health Organization (FHO): FHOs are groups of physicians who provide comprehensive primary health care services to their patients with a focus on illness prevention. They provide care during regular and extended office hours and patients have access to a nurse-staffed telephone advisory service. Physicians are paid on a blended capitation model. A minimum of three physicians is required.

Rural-Northern Physician Group Agreement (RNPGA): the group of physicians provide comprehensive primary health care services during regular and extended office hours. Emergency services are provided 24/7 and patients have access to a nurse staffed telephone advisory services. Physicians are paid a combination of base salary and incentives for things like hospital emergency room coverage, preventative care and a rurality incentive payment.

Nurse Practitioner Led Clinics: 25 to be developed over four years. This new model of care will see nurse practitioners working in collaboration with doctors to provide health care to many Ontarians who previously did not have a primary health care provider. These clinics will not only focus on providing better care to patients, but also will work with patients to educate them about disease prevention and health promotion. The clinics will also help patients navigate the health system – connecting them, if needed, with other service providers and with community-based programs and services. Funding will be a global budget for the clinic,