Breakfast with the Chiefs

Ontario's Transformation Agenda: Integrating Primary Care

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The Commitment

"We will integrate family health care into the LHINs"

"We will strengthen the role of family health care in our system"

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The Goal

1. Improve health outcomes
2. Improve system efficiency
3. Improve patient experience

The Goal

TODAY

- 54 yr old
- Overweight
- Diagnosed with diabetes

20 years

- Higher quality of life
- Lower costs

- Lower quality of life
- Higher costs

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The time may be right

Ontario's Action Plan For Health Care

Better patient care through better value from our health care dollars

COMMISSION ON THE REFORM OF ONTARIO'S PUBLIC SERVICES

afhto association of family health teams of ontario

ONTARIO COLLEGE OF FAMILY PHYSICIANS

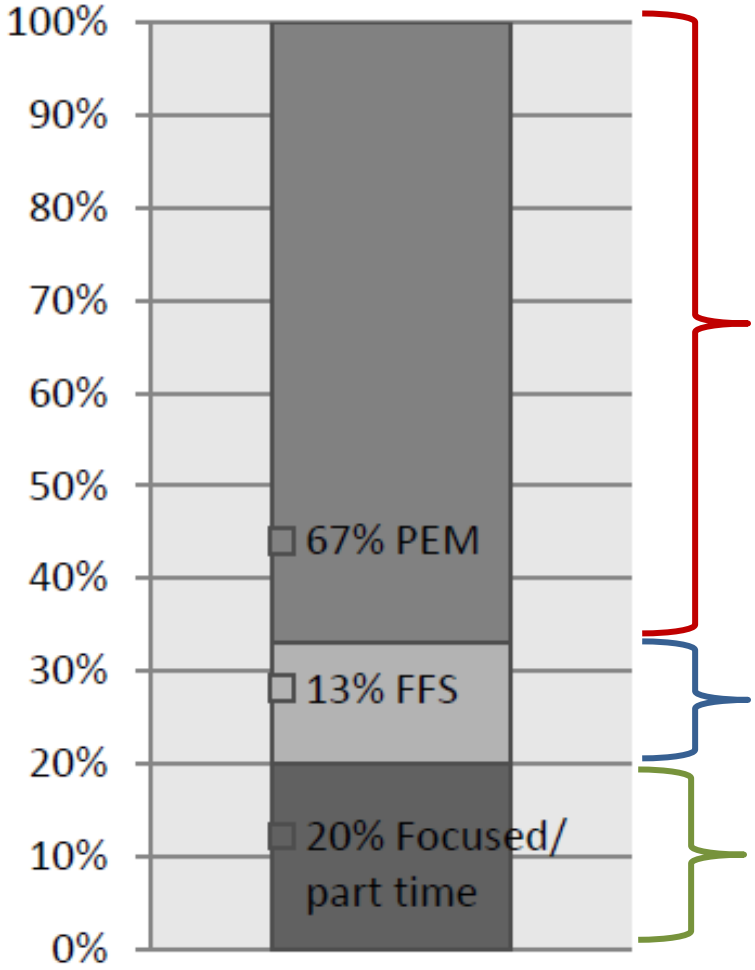
oaccac acasco

The Question

How can Ontario better integrate primary care into local health systems?

The Context: Primary care in Ontario

TOTAL: 11,500 Family Physicians



Funding Models:

- 7,700 physicians funded through an alternate funding arrangement
- 90% through FHN, FHG or FHO
- 9.5 million patients enrolled
- 1,500 funded through FFS
- 2,300 specialty/part-time practice

Source: 2011 Annual Report, Office of the Auditor General of Ontario, Section 3.06

The Context: Primary care in Ontario

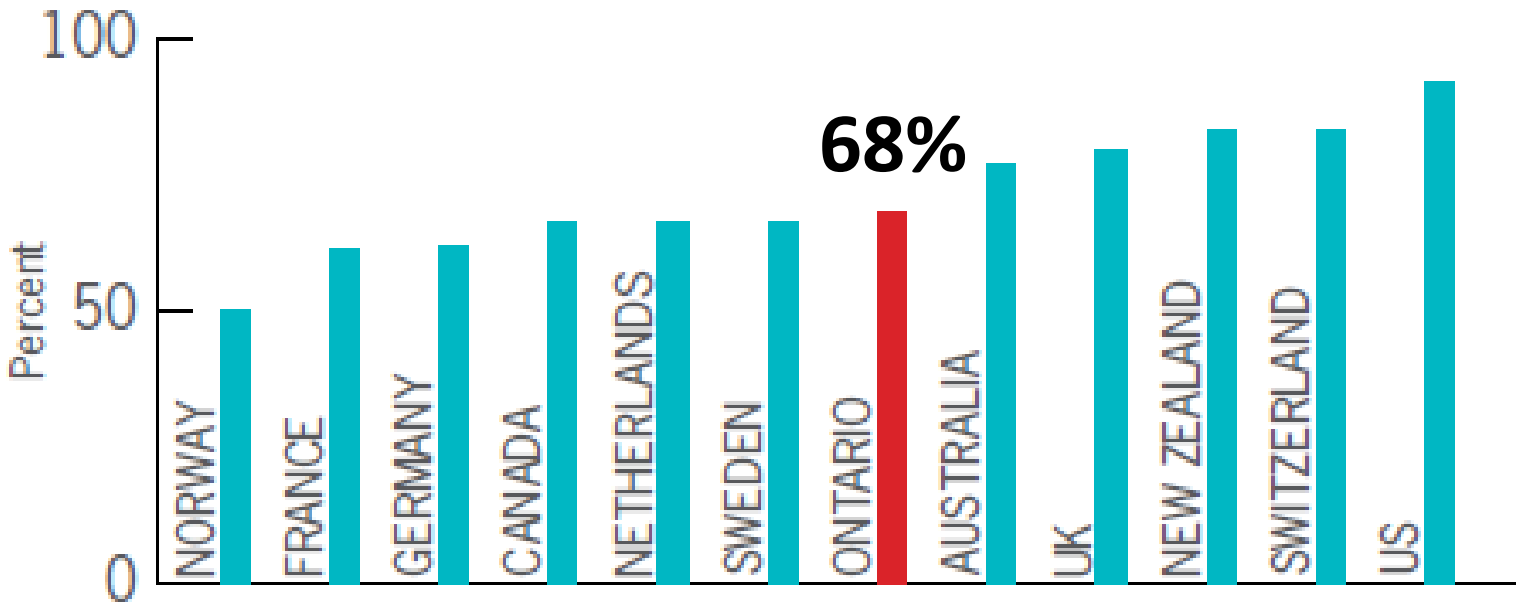
Practice Models:

- **186** Family Health Teams → Care for **20%** of Ontarians
- **73** Community Health Centres
- **10** Aboriginal Health Centres
- **26** NP Led Clinics
- Physician led group practices
- Individual physician practices
- Walk-in clinics
- Others?

Source: Association of FHTS of Ontario

The Context
How integrated is primary care today?

Percentage of adults who report their family physician seems informed about the care they received in hospital, including any new prescription medications



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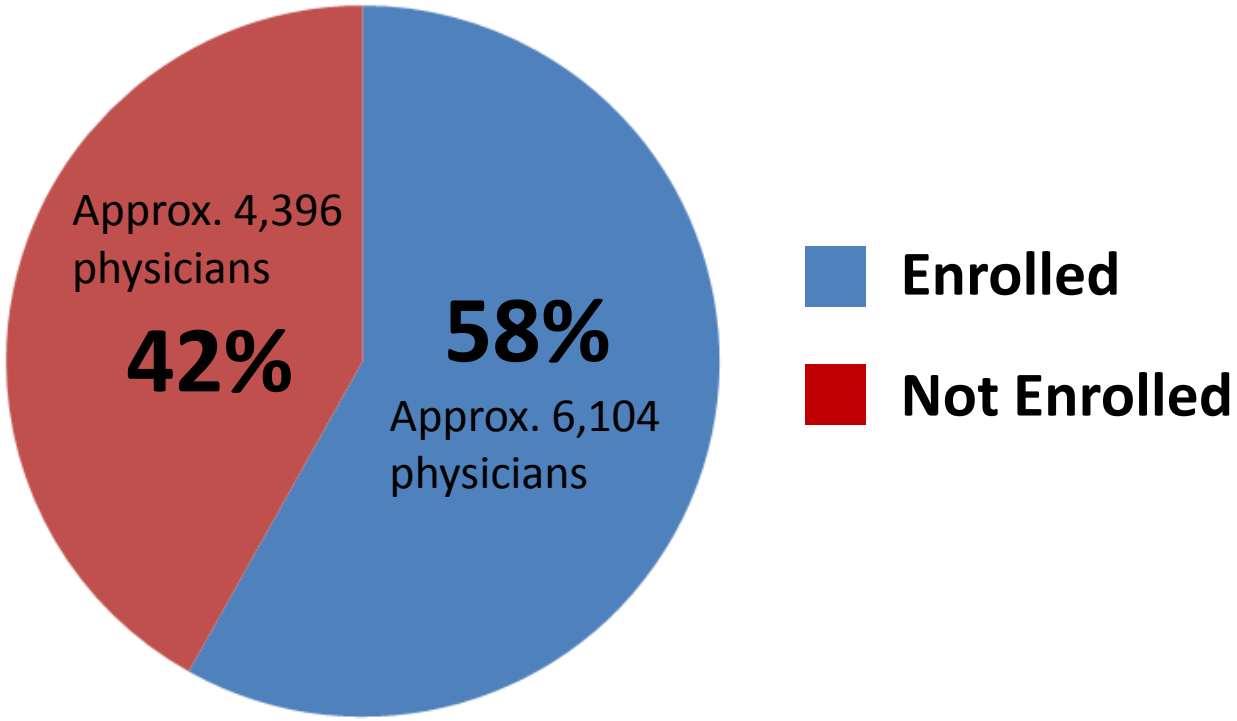
Source: HQO, 2011 Quality Monitor Report

The Context
How integrated is primary care today?

Physician Enrolment in an EMR Adoption Program in Ontario



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Source: eHealth Ontario, December 2011

The Context
How integrated is primary care today?

Example: good integration

Osler inpatient programs

Bridging the Gap

Community Family Physicians

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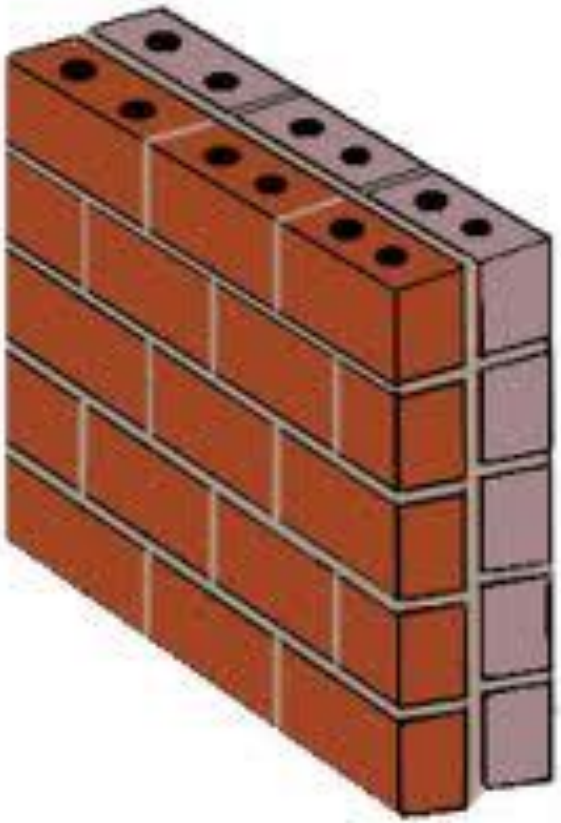
The Context
How integrated is primary care today?

Example: poor integration

Primary Care

- Delayed/absent communication of acute episodes
- Patient confusion post-discharge



Hospitals

- Duplicate testing
- Unknown medical history
- Unknown social history
- Difficulties personalizing care

What not to do…

DON'T:

- Provide incremental incentive payments for physicians
- Focus on creating additional structures and legal entities
- Create more pilot projects
- Dictate the form integration takes locally

Ingredients for success

DO:

- Create shared objectives and accountability amongst providers
- Establish shared pools of resources with flexibility to shift money where it is needed locally
- Involve local primary care leaders at regional planning tables
- Ensure efficiency gains are reinvested into the system

The Recommendations

1. Define provincial goals for improved outcomes
2. Create a shared pool of resources locally
3. Establish criteria for acceptable regional delivery
4. Empower regions to design local solutions
5. Monitor progress, locally and provincially

The Recommendations

1

Define provincial goals for improved outcomes

Examples

1. Improve the continuity of care for patients during transitions into and out of hospital
2. Improve timely access to specialist care
3. Reduce ED visits for primary care related issues (i.e. CTAS 3/4/5 patients)

RECOMMENDATION

1 Define provincial goals for improved outcomes

Goal: Reduce the rate of CTAS 3,4,5 ED visits

- Focuses on high volume users of the system
- Many CTAS 3,4,5 ED visits are a symptom of poor access to primary care in the community
- Also impacts other areas of the system (eg. paramedic services)
- Solution requires joint participation of acute and primary care
- Alignment with existing provincial priorities

The Recommendations

2

Create a shared pool of resources locally

- Allow organizations in regions to collectively determine best use of funds to achieve set objectives
- Initially leverage existing incentive funds available for family physicians
- LHINs oversee allocation of incentive pool + non-physicians funding

RECOMMENDATION

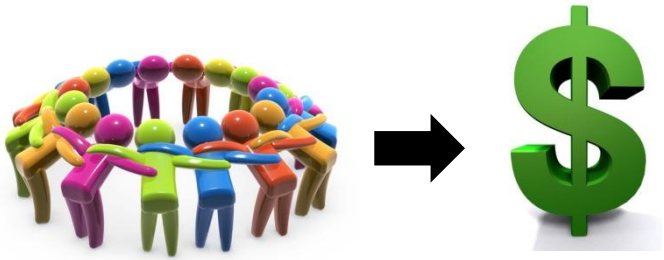
2 Create a shared pool of resources

Goal: Reduce the rate of CTAS 3,4,5 ED visits

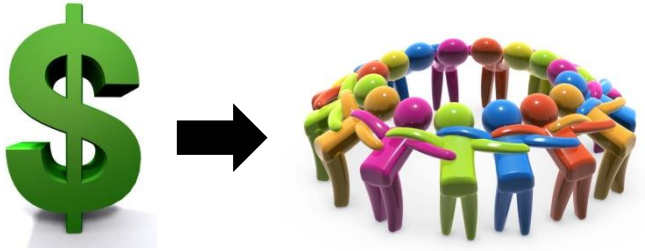
Shared pool of resources:

- Portion of hospital ED wait times funding
- Portion of existing primary care incentive funds
- Portion of OHIP funding

Option: Funds distributed once targets are met



Option: Funds distributed upfront w/ potential claw back



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The Recommendations

3

Establish criteria for acceptable regional delivery

- Set the requirements regions must satisfy to access funds
- Require patient engagement
- Include governance framework to define and uphold accountabilities

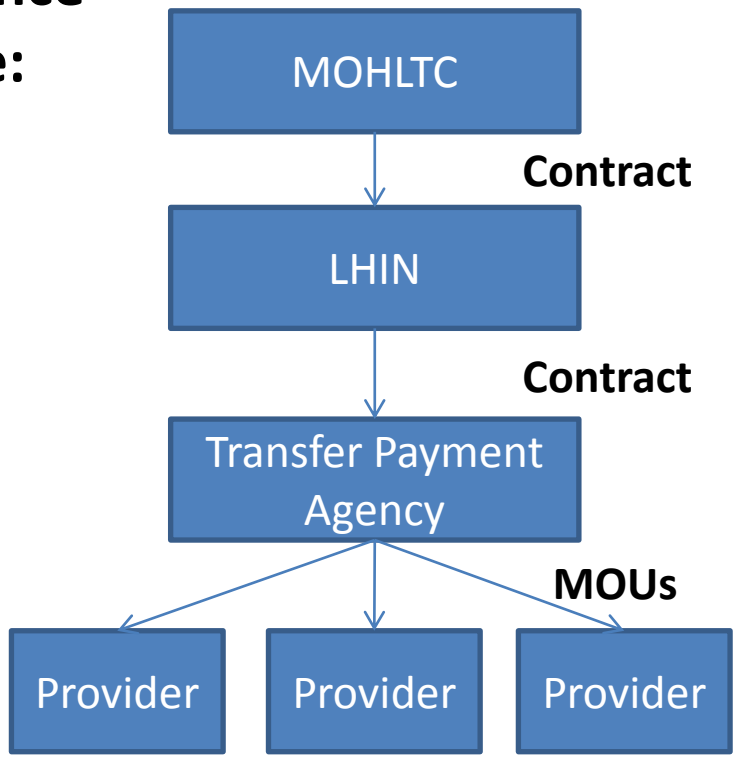
The Recommendations

3 Establish criteria for acceptable regional delivery

RECOMMENDATION

3 Establish criteria for acceptable regional delivery

Governance structure:



- Local governance committee would be established to oversee initiative
- Leverage Board members from participating organizations

The Recommendations

4

Empower regions to design local solutions

Examples:

1. Implementation of advanced access to reduce waits for primary care appts
2. Centralizing referral processes to improve access to specialist care
3. Online speciality referral/appointment scheduling
4. Improved access to advanced diagnostics

RECOMMENDATION

4 Empower regions to design local solutions

Goal: Reduce the rate of CTAS 3,4,5 ED visits

Local Solution: Focus on complex seniors

Increase supply

Expand community UCC capacity

+

Targeted advertisement & education campaign channelled through family physicians

Reduce demand

+

Proactive follow-up care program for ED patients likely to re-present

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The Recommendations

5

Monitor progress, locally and provincially

- Metrics tied to accountability agreements
- Leverage existing data analytics capacity

RECOMMENDATION

5 Monitor progress, locally and provincially

Goal: Reduce the rate of CTAS 3,4,5 ED visits

Reporting to LHIN/MOHLTC

- Leverage existing Stocktake Report
- Metric: Number of CTAS 3/4/5 65yrs+ per 1000 population 65yrs+

Local reporting

Metrics:

- Number of CTAS 3/4/5 65yrs+ per 1000 population 65yrs+
- Number of UCC visits by patients 65+yrs
- Additional process metrics to ensure all participants uphold their responsibilities

Conclusion

Question:

How can Ontario better integrate primary care into local health systems?

Recommendations:

1. Define provincial goals for improved outcomes
2. Create a shared pool of resources locally
3. Establish criteria for acceptable regional delivery
4. Empower regions to design local solutions
5. Monitor progress, locally and provincially

Questions?