Engaging PHC Providers in Local/Regional Governance

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ICES Institute for Clinical Evaluative Sciences

Local/Regional Governance in Ontario

- Regional governance through LHINs
  - large (almost 1 million pop), heterogeneous
  - each has a primary care lead

- Practice-based governance
  - Community Health Centres (CHCs), Aboriginal Health Access Centres (AHACs), Family Health Teams (FHTs), Nurse Practitioner-Led Clinics (NPLCs)

- Organizational support
  - Association of Ontario Health Centres (AOHC), Association of Family Health Teams of Ontario (AFHTO), Nurse Practitioners' Association of Ontario (NPAO), Ontario College of Family Physicians (OCFP), Ontario Medical Association (OMA), Ontario Pharmacists' Association (OPA), Ontario MD, eHealth Ontario, Health Quality Ontario (HQO), Cancer Care Ontario (CCO), others

- No previous form of local governance

Making Healthy Change Happen
– by the Numbers

Increased investments in home care and community services by 4 per cent means **90,000** more seniors receiving care at home

Additional funding means **3 million** more personal support worker hours over the next 3 years

19 early-adopter Health Links providing care to almost one million people, through the co-operation of 18 hospitals, 42 primary care groups and over 60 community service providers

Since 2005, Ontario has led all provinces and territories by having the **lowest surgical wait times**

As of January 2013, **619** pharmacies are participating in the Universal Influenza Immunization Program

More than **9,800** community-based clinicians implementing Electronic Medical Records – represents 9 million Ontarians

4,000 more doctors practicing in Ontario today than 9 years ago

26 Nurse Practitioner-Led Clinics serving over 27,000 patients and growing

200 Family Health Teams in operation, serving nearly 3 million Ontarians and growing

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http://www.health.gov.on.ca/en/ms/ecfa/healthy_change/docs/progress_healthychange_en.pdf

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Health Links

- Announced December 2012
- 60 in development with plan to cover the province
- Aim is to
  - "improve the delivery and co-ordination of care for a defined patient population while reducing costs"
- Focus is on seniors and the complex patient cohort
- Resources devoted to:
  - strengthening partnerships and data-sharing capacity
  - co-ordinated care plans, tools and resources
- Operational, results-based and evaluation-based indicators

“Community Health Links provide coordinated, efficient and effective care to patients with complex needs

Five per cent of patients account for two-thirds of health care costs. These are most often patients with multiple, complex conditions. When the hospital, the family doctor, the long-term care home, community organizations and others work as a team, the patient receives better, more coordinated care. Providers will design a care plan for each patient and work together with patients and their families to ensure they receive the care they need. For the patient it means they will :

- Have an individualized, coordinated plan
- Have care providers who ensure the plan is being followed
- Have support to ensure they are taking the right medications
- Have a care provider they can call who knows them, is familiar with their situation and can help.”

http://www.health.gov.on.ca/en/pro/programs/transformation/community.aspx

Why Providers Might Engage

- Provider perspective
  - find out when my patient is admitted, discharged
  - discharging doctor will call me
  - homecare will communicate with me
  - my records will be linked with local hospitals, labs, pharmacies, homecare, specialists
  - we will share resources across practices, groups, models
  - I will have more organized specialist referrals, imaging tests
  - my isolated poorly supported patients will get additional support
  - my complex patients will get better, more coordinated and more appropriate care

“Five per cent of patients account for two-thirds of health care costs”

- Attractive target for saving money or reducing growth in costs
- Challenges
  - who are these patients?
  - what are the interventions?
  - evidence of effectiveness?
  - possible to scale up small successful pilots?
- Barriers
  - many are in the last year of life, so there is substantial turnover
  - predicting next year’s 5% will be difficult
  - many have mental health and substance use problems
  - many are isolated, lonely, few supports

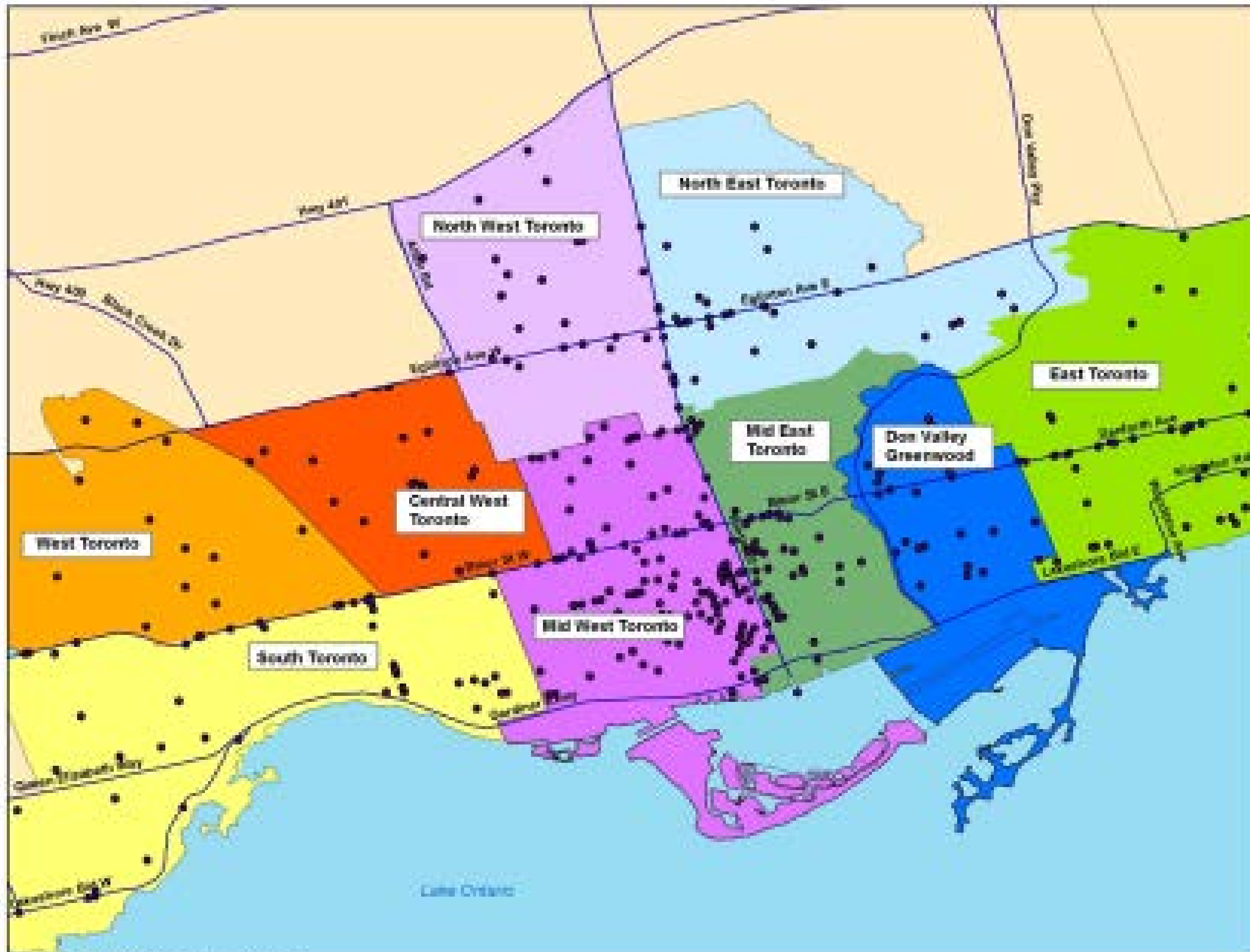
The Problem of Geography

- Large urban centres establishing Health Links within geographic boundaries
  - most health care costs may be generated outside the Health Link
  - limits ability of the Health Link to impact costs

- May need to take into account natural networks, distributions of doctors and hospitals

Stukel T et al. Multispecialty physician networks in Ontario. Open Medicine 2013; 7(2):.40-55

Location of Primary Care Physicians by Health Link (updated)



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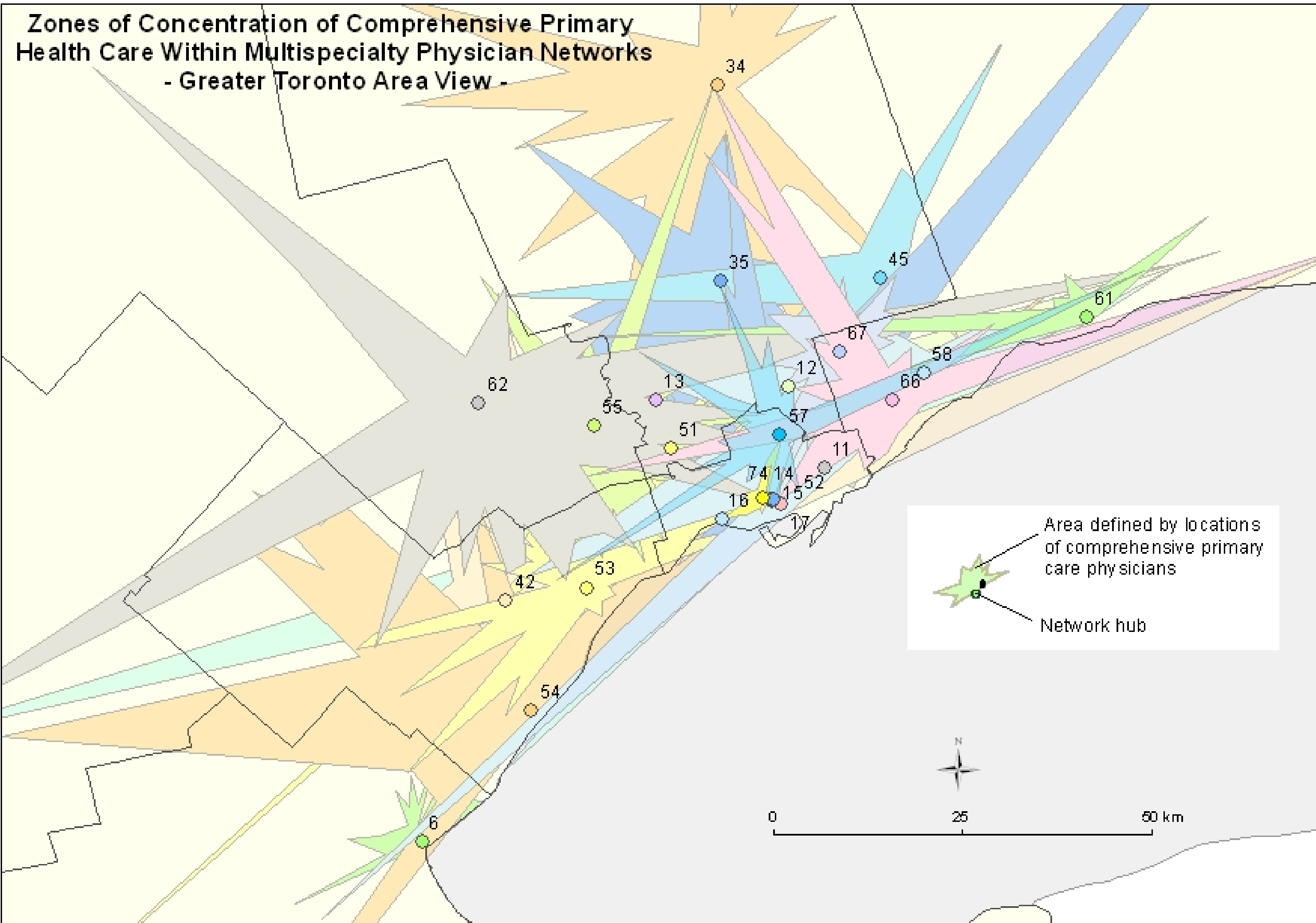

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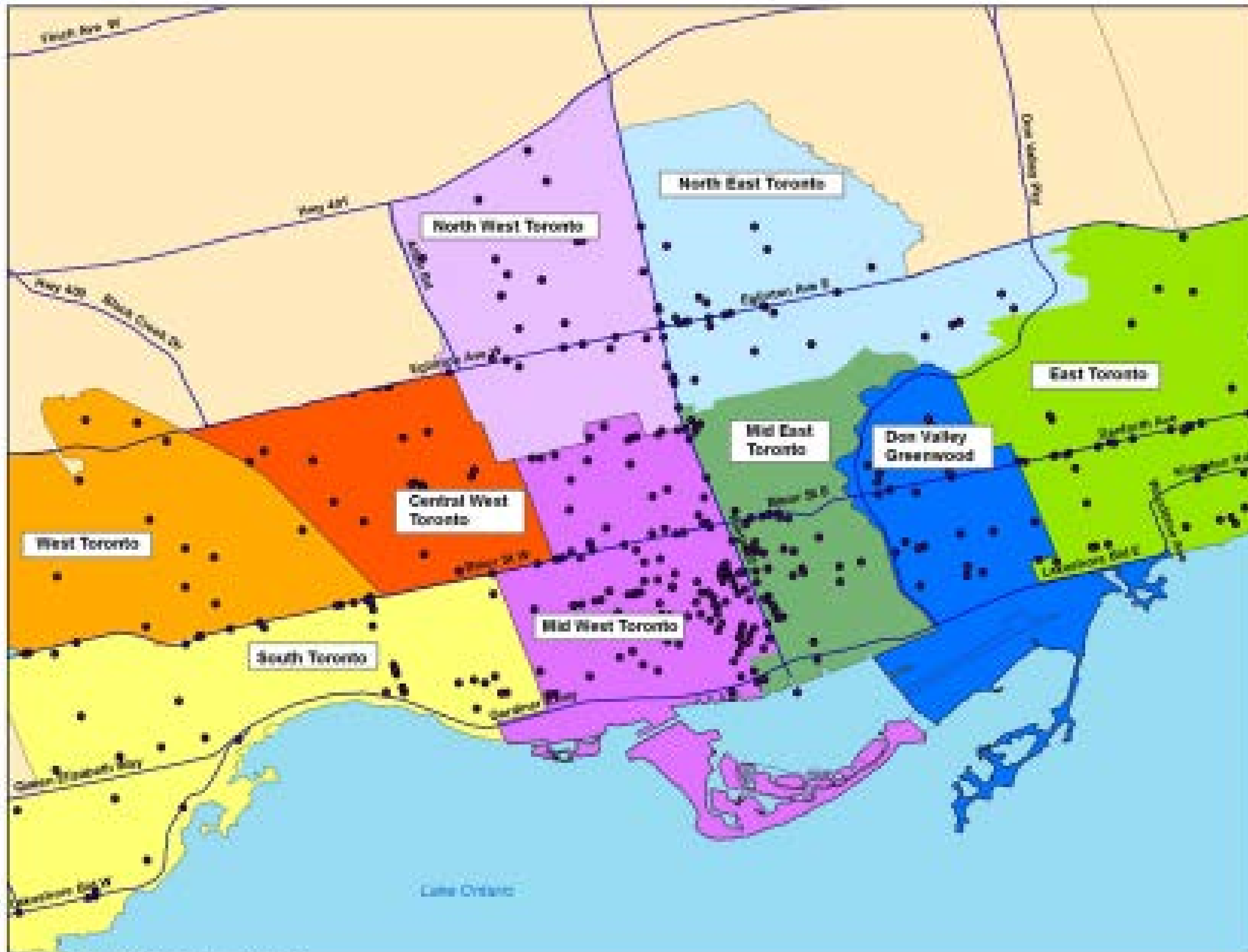

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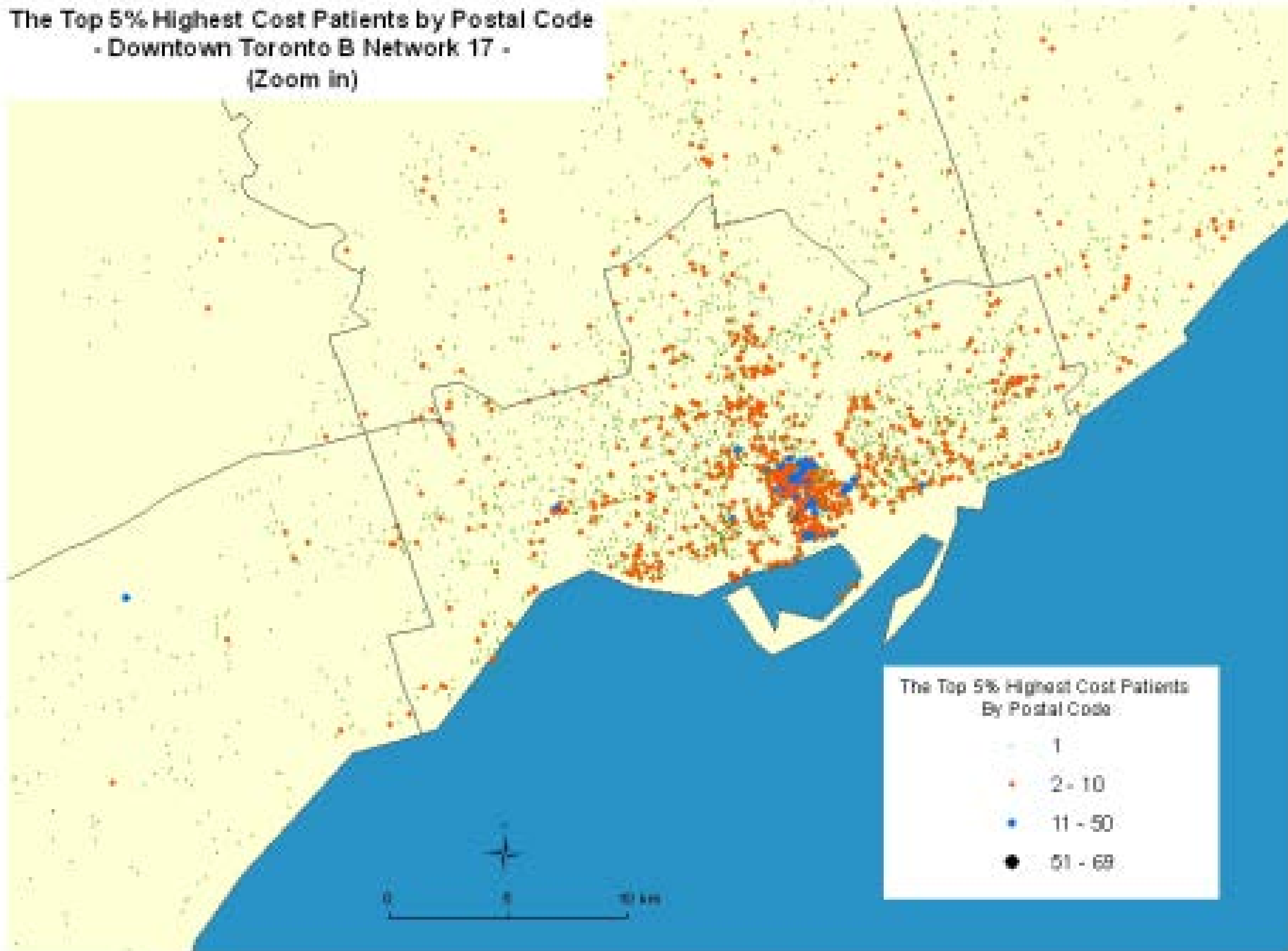

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Three More System Challenges

1. Lack of horizontal PC integration
   - PC models don't collaborate, don't share resources
   - financial penalty for cross-referrals, cross-coverage
   - no history of local leadership across groups, models
2. Unequal power relationships between sectors
   - hospitals, homecare, long-term care have administrators, governance, resources, measurements, accountability, none of which exist in most of PC
3. Increasing inequity
   - close to 3 million Ontarians in an inter-professional model, similar number in no model at all
   - will Health Links make inter-professional teams even better, leave others in the cold?

Questions, Discussion