PRIMARY HEALTH CARE STRATEGY

HEALTH SERVICES RESTRUCTURING COMMISSION

Advice and Recommendations to the Honourable Elizabeth Witmer
Minister of Health

December 1999
# TABLE OF CONTENTS

**EXECUTIVE SUMMARY** .......................................................................................................................... 1

**INTRODUCTION** ........................................................................................................................................... 1

- What is Primary Health Care .................................................................................................................. 1
- Primary Health Care in Ontario .................................................................................................................. 2
- The HSRC’s Approach to Developing a Primary Health Care Strategy ..................................................... 7
- Overview of the Report ............................................................................................................................. 9

**THE HSRC’S STRATEGY FOR PRIMARY HEALTH CARE IN ONTARIO** ............................................. 11

- The HSRC’s Vision and Goals for Primary Health Care .......................................................................... 13
- Essential Features and Supporting Mechanisms of the HSRC’s Strategy ............................................... 14
- Essential Features of the HSRC’s Strategy for Primary Health Care ...................................................... 18
  1. Access to a Defined Range of Comprehensive Primary Health Care Services .................................. 18
  2. Services Accessible 24-Hours-a-Day, 7-Days-a-Week (24-7) .............................................................. 20
  3. Primary Health Care Group Practices .................................................................................................. 23
  4. Consumers Enroll With Their Provider of Choice .............................................................................. 25
  5. Inter-Professional Provider Team ......................................................................................................... 29
- Supporting Mechanisms ............................................................................................................................ 38
  1. Population-Based Group Funding ......................................................................................................... 38
  2. Education ................................................................................................................................................ 42
  3. Information Management ....................................................................................................................... 47
  4. Mechanisms To Coordinate Care ........................................................................................................... 50
  5. Mechanisms To Ensure Accountability .................................................................................................. 55

**ESTABLISHING THE PRIMARY HEALTH CARE GROUP** ........................................................................... 64

- Configuration of Providers and Supporting Functions in PCGs ............................................................... 64
- Size of the Enrolled Population in PCGs .................................................................................................... 72
- Funding Components ...................................................................................................................................... 76

**CRITICAL SUCCESS FACTORS FOR IMPLEMENTING THE HSRC’S STRATEGY FOR PRIMARY HEALTH CARE** .......................................................................................................................... 79

- Identifying One or More Champions To Provide Leadership .................................................................... 79
- Investing In A Structure To Implement, Monitor and Support Change .................................................... 80
- Implementing the Strategy Provincially, In a Planned and Comprehensive Manner, Over the Next Six Years .................................................................................................................................................. 81

**CONCLUDING REMARKS** ......................................................................................................................... 83

**PROPOSED IMPLEMENTATION PLAN** ........................................................................................................ 86

**SUMMARY OF RECOMMENDATIONS** ......................................................................................................... 95

**APPENDIX A: PRIMARY HEALTH CARE IN ONTARIO** ............................................................................. 105

**APPENDIX B: COMPARISON OF PRIMARY CARE REFORM MODELS AND ESSENTIAL ELEMENTS** ........................................................................................................................................................................ 117

**APPENDIX C: DEFINITION OF PRIMARY HEALTH CARE SERVICES** ....................................................... 126

**APPENDIX D: IMPLEMENTATION AND MONITORING COMMITTEE** ......................................................... 138
APPENDIX E: COMPARISON OF PRIMARY HEALTH CARE DELIVERY SYSTEMS AND STRATEGIES ...............................................................................................................................................................141

EXECUTIVE SUMMARY

Ontario’s Primary Health Care Can Work Better

The Health Services Restructuring Commission believes that primary health care in Ontario can be improved. Enhancements can be made that will benefit both consumers and health professionals. We can create a better overall health system for the 21st century.

This paper outlines a detailed action plan to create a true system of primary health care in Ontario. After years of study and numerous reports, there is a need and a consensus to act now.

The plan is the result of extensive consultation and roundtable discussions. Over the past six months, the HSRC has brought together health care providers and other groups to consult and listen to their ideas and concerns. Leading professional organizations representing family doctors and nurses are ready to work with the government to build a better system. They support the changes being proposed.

Enhanced Quality, Accessibility and Affordability

This plan identifies the resources and professional teams needed to serve patients in a reorganized primary health care system. It provides the framework to deliver improved quality care and establishes accountability for outcomes. It solves accessibility problems by providing 24-hour, 7-day-per-week coverage in urban, rural and remote areas. And, it addresses affordability issues by creating teams and links service delivery to the professional best suited for the task. In sum, the HSRC vision for primary care is the following:

All Ontarians will have access to comprehensive primary care services. Primary care will be the first point of access and the connector to the rest of the system.

Primary Health Care is Important to Ontarians

Primary health care is usually the first point of contact Ontarians have with the health care system. Public research also shows that 92 per cent of the population report having a family physician with whom they have had a long-term relationship.

The HSRC believes that primary health care is the foundation of a genuinely integrated system of health care services. It is the most essential component for improving continuity of care.

In many cases, the people who deliver primary care represent the part of the health care system most trusted by patients. Effective primary health care should play a pivotal role in
helping people to stay healthy. In addition, it should connect patients to the rest of the health care system when they need various services.

**Today’s Primary Health Care Has Limitations**

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.

**The Urgency is Growing**

A series of pressures is mounting on primary care givers, and the failure to improve the way they work will continue to cause compounding problems in the very near future. Specific examples of the need to change include: shortages of services in rural and northern regions are threatening access to primary care; diminished quality of life for physicians and nurses is causing low morale and burnout; many health care providers are working below their potential; the shortage of nurse practitioners will continue without meaningful change; and the inappropriate use of emergency departments for primary care is taxing hospital resources.

These limitations are making it difficult for primary health care to manage increasing demands in the future. Factors such as an aging population, the changing health care consumer and hospital restructuring are highlighting the need to have a comprehensive system of primary health care to meet the needs of Ontarians.

One major focus of primary care reform in recent years has been the Ministry of Health and the Ontario Medical Association primary care reform pilots. In addition to announcing pilot sites, a tremendous amount of thought and planning has gone into developing strategies to support the project. Unfortunately, implementation of the pilots has been slow.

The HSRC believes that progress in primary health care reform must be made more quickly and on a province-wide basis. Now is the time for action.

**A New Approach**

The HSRC proposes a system where physicians and nurse practitioners work as true partners. This will happen through the creation of Primary Health Care Group Practices (PCGs). This approach recognizes each profession for the skills they offer. It also offers the best method for realizing efficiency with the health care dollar by matching services to be provided with the level of training required. The HSRC is also confident that leading professional groups and their members will embrace this plan.
The HSRC’s Model

Services will be delivered through PCGs, created by providers such as physicians, nurses and other professionals directly involved in the delivery of care. The HSRC's primary health care strategy emphasizes the consumer as the key focus of care. It builds on many of the elements and directions that have been suggested in other studies. It is made in Ontario for Ontarians.

Five Essential Features of the Strategy

The strategy contains five essential features that are fundamental to enhancing services for the consumer:

1. **Access to a comprehensive selection of primary health care services**
   Consumers will clearly know what primary care services they can expect to receive and providers will clearly know what services they are expected to provide. Access will improve with coordinated, one-stop shopping for a comprehensive range of primary care services.

2. **Services accessible 24-hours-a-day, 7-days-a-week**
   Consumers will be assured of available expertise to respond to their primary health care needs. Continuity of care will improve since care will be obtained from a consistent group of providers who will be fully aware of, and involved in meeting, the ongoing needs of their clients.

3. **Primary health care group practices**
   Access and continuity of care will improve since patients will be referred to someone else in the group when their personal care provider is unavailable. Quality of life and working conditions will improve for providers since they will support one another professionally and develop longer-term relationships with each other.

4. **Enrollment of consumers**
   Consumers will enroll with a primary care physician or a primary care nurse practitioner of their choice. Consumers who enroll with a nurse practitioner will co-enroll with a physician from the same group. Comprehensive primary health care will be supported since enrolled consumers and providers will remain relatively stable and their important relationship will be supported and formalized. Quality of care will increase since the health needs of the group will be assessed, services planned, and consumer satisfaction and health outcomes monitored and evaluated.

5. **Inter-professional primary care provider teams made up of physicians and nurse practitioners, and other professionals added to meet patient needs**
   Quality of care will increase since consumers will receive services from the professional who is best qualified to provide the care needed. Coordination and continuity of care will improve since consumers’ needs will be met through provider
collaboration and teamwork. Quality of working life and the utilization of Ontario’s family physicians, nurse practitioners and other professionals will increase since the skills and expertise of all health professionals will be maximized. This will improve access to primary health care especially in under-serviced areas of the province, and result in more cost-effective care.

**Improved Conditions for Primary Care Physicians**

Primary care physicians will be supported with an attractive compensation package that recognizes the importance of stable funding, benefits, pensions and vacations. In addition to a base salary and benefits, there will be opportunities for financial rewards for meeting quality incentive targets, and assistance with support and capital services to encourage members of group practices to locate in the same physical space.

**An Unprecedented Opportunity for Nursing**

The role identified for nurse practitioners in this model is unprecedented. It recognizes their potential to contribute clinical skills and care as part of a health team, unlike any other previous reports.

Primary care nurse practitioners will play a major role in providing primary care services in Ontario. They are well qualified to be members of the core team and work in partnership with physicians. Nurse practitioners will also improve access to primary care in rural and remote communities, and provide relief and on-call coverage for physicians in communities with limited access. An investment in stable and ongoing funding for training nurse practitioners should be made by government.

Registered nurses will also play an important role in PCGs. Examples of their activities include health promotion, and the assessment, care and treatment of health conditions.

Now is the time to reshape our primary care system to recognize the true potential of, and the contributions that can be made by, the nursing profession.

**A New Era of Accountability**

The HSRC believes that accountability must be an intrinsic part of the primary health care system. There must be accountability between all relationships: the care providers and the patients as well as between the care providers and the government payor. This approach will include regular report cards to patients and to the government addressing client care, human resources management and financial responsibility.

The HSRC also supports a quality incentive system where PCGs will receive additional resources when they meet agreed-upon targets in areas such as consumer satisfaction, disease management and overall access.
Three Group Models

The HSRC is committed to ensuring that this plan addresses Ontario’s diversity of population and geographic size. Accordingly, three models for PCGs have been developed – urban, rural and remote.

“Urban”: This model will apply in cities and towns that have a population of at least 15,000 within the immediate surrounding areas.

“Rural”: This model will apply in smaller towns where a PCG is in one physical location and can be reached within an hour by enrollees, and where the number of possible enrollees is at least 5,000.

“Remote”: This model applies to all other situations not covered by the other two models.

The capacity of each group would also be influenced by the age and sex of enrollees, reflecting different rates of utilization associated with these differences.

Critical Success Factors for Implementing this Strategy

The HSRC has identified three critical success factors necessary to implementation:

• Identifying one or more champions to provide leadership and to be responsible for ensuring that primary health care receives a high priority in government, and with consumer and provider groups.

• Investing in the structure to implement, monitor and support change, and provide the needed human and financial resources to make the change happen. An Implementation and Monitoring Committee should be established, reporting to the Minister of Health and supported by a secretariat.

• PCGs should be developed over the next six years in Ontario. The first year should be used for planning the subsequent five years of implementation. Priority should be given to underserviced areas and established group practices. Nurse practitioner training also needs immediate funding to ensure adequate supply.

Consumers, Health Care Providers and Government Will Benefit

This primary health care strategy will bring benefits to all participants in the system.

Consumers will benefit from greater access to a broader range of comprehensive primary health care 24-hours a day, 7 days-a-week and improved coordination of primary care services with other levels of care.

Health care providers will benefit from appropriate compensation for the work they do, stable funding, benefits, pensions, vacations, an improved physical and professional
environment, continuing education, working in a team setting and capitalizing on skills so that each professional does what he or she is trained to do.

**Government** will benefit when primary health care is maximized by equitable access for all Ontarians with more effective health promotion, greater coordination of all levels and types of health care, more effective use of health care resources, greater predictability of expenditures for primary health care, better quality improvement and accountability measures and increased integration of all aspects of health care.

**Summary**

The strategy outlined on the following pages contains detailed recommendations for improving Ontario’s primary health care services. The HSRC has said many times in the past three years that Ontario lacks a *true* health system. Together with other HSRC recommendations, including the Information Management Action Plan submitted in June 1999, this strategy will move us closer to building an integrated health system for Ontario. Building such a system should be a top priority. It is long overdue, but can be delivered just in time for the needs of the 21st century.
INTRODUCTION

WHAT IS PRIMARY HEALTH CARE

The Health Services Restructuring Commission believes that primary health care is the foundation of a genuinely integrated system of health and health care services, and is the core component to provide people with continuity of care. An effective system of primary health care helps us to stay healthy, treats the majority of our illness, advocates for the health care of consumers, and connects them to the rest of the system when they need other health-related services.

Primary health care has been defined differently by various organizations, depending on the values that these organizations hold and the priorities that they place on health-related activities. The HSRC’s definition of primary health care is:

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.

Services are coordinated, accessible to all consumers, and are provided by health care professionals who have the right skills to meet the needs of individuals and the communities being served. These professionals work in partnership with consumers, and facilitate their use of other health-related services, when required.

PRIMARY HEALTH CARE IN ONTARIO

A number of general observations can be made about primary health care in Ontario.

One, primary health care activities in Ontario are both extensive and resource intensive. Primary care is provided almost exclusively by general or family physicians. In 1997/98, there were 8,835 general or family physicians in Ontario. Their distribution per capita varies. To some degree, specialists also provide primary care services (e.g., paediatricians, internists, psychiatrists). Midwives provide primary obstetrical services, and in certain areas (e.g., remote areas, community health centres, some health service organizations), nurses with advanced training provide a broad range of primary care. Primary health care

---

1 See Appendix A for a more detailed discussion of primary health care in Ontario.
2 A general practitioner (GP) is someone who has successfully completed medical school and is licensed to practice medicine in Ontario. A family physician (FP) is a GP who has completed a residency in family medicine and is registered with the Ontario College of Family Physicians.
3 Ben Chan, Supply of Physicians’ Services in Ontario. Institute for Clinical Evaluative Sciences (November 1999). This report presented three methods for counting the number of physicians: a simple head count of those who bill OHIP; a count of active physicians who bill above $35,000 per year; and weighting physicians by their annual billings. There are limitations with each method.
services are also provided by pharmacists, social workers, physiotherapists, optometrists and other health care professionals, although there is little formal recognition of these contributions.

The practice settings for primary care vary widely. They include private offices and clinics, community health centres, health service organizations, free-standing walk-in clinics, long-term care facilities, and hospital in- and out-patient units and emergency departments, especially where there are too few general practitioners and family physicians.

Primary health care accounts for a large proportion of Ontario Health Insurance Plan (OHIP) billings. In 1996/97, primary care family physicians billed $1.7 billion or 40% of the total OHIP billing pool of $4.3 billion. Primary care services paid through program-based and capitation funding accounted for an additional $146 million.

Second, for a number of reasons primary health care is becoming even more important. The aging population, the increased prevalence of chronic diseases, increased empowerment of consumers in decision-making about their health care, and hospital restructuring are among the factors that are placing greater demands on primary care. They also underscore how important it is to establish responsive and well-coordinated primary health care services to meet the needs of Ontarians.

Third, the current system of primary health care services in Ontario does not meet those needs satisfactorily. Many people do not have ready access to primary care services. Those that are available are fragmented, unstructured, and cannot legitimately be described as a “system”. Similarly the linkages between primary and other levels of care, specialists’ services or home care for example, are not well coordinated. Continuity of care is often compromised.

The increasing demands on primary health care and recognition of its importance as the foundation for coordinating all levels of care, highlight these limitations. In terms of quality, accessibility and affordability, these limitations include:

<table>
<thead>
<tr>
<th>Quality</th>
<th>Accessibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Primary health care services are fragmented. Many consumers cannot depend on a single provider to oversee their primary health care and coordinate it with other levels of care.</td>
<td>• Some consumers do not have an identified primary care provider.</td>
</tr>
<tr>
<td>• Standards and guidelines for assessing quality are lacking.</td>
<td>• Primary care providers are maldistributed in Ontario.</td>
</tr>
<tr>
<td>• There is little integration within primary health care, and with other parts of the health care system (e.g., when the family physician makes a referral to a specialist or to community-based home care, information is often not communicated back to the family physician).</td>
<td>• Access to 24-hours-a-day, 7-days-a-week primary care coverage by primary care physicians is limited.</td>
</tr>
<tr>
<td>• There is limited appreciation that comprehensive primary health care includes prevention and promotion services.</td>
<td>• Accountability mechanisms do not exist for primary health care services.</td>
</tr>
</tbody>
</table>
Many consumers who need primary health care or information in the off-hours, are referred, or go, to hospital emergency departments or walk-in clinics. Their care is fragmented given that their family physician is often not informed of the treatment received by his or her patient.

### Affordability
- Primary care providers are not used to the full potential of their education and training. This keeps costs higher than they should be.
- The high proportion of solo-practice physicians in Ontario – 40% – does not facilitate cost sharing and economies of scale of group practices.
- Limited use of alternative payment arrangements and modes of non-traditional service delivery (e.g., telemedicine), impedes access to care and prevents cost-efficiencies.
- The lack of adequate primary health care coverage results in over use of hospital emergency departments, which is costly and often leads to wasteful duplication of services and diagnostic testing.
- The use of walk-in clinics in off-hours duplicates services when the consumer subsequently visits his or her family physician for the same problem.

Fourth, primary health care has been the subject of much study and debate in Ontario for a number of decades. Prior to 1995, numerous reports had been written addressing principles, issues, funding options and potential models. In 1996, the Provincial Co-ordinating Committee on Community and Academic Health Science Centre Relations (PCCCAR) considered all these reports and advised on future directions for primary health care in Ontario. Since then, an Ontario Medical Association Advisory Group on Primary Care Reform (1996) and a Ministry of Health-appointed Primary Care Implementation Steering Committee (1997) have addressed primary care. Recently, the Ontario College of Family Physicians released its model for primary care reform (1999). (See Appendix B for a comparison of some of these models.)

Many of these studies have made similar recommendations and have come to similar conclusions. The common conclusion is that a coordinated system of primary health care must be developed, and integrated with other levels of health care including community-based and specialty services. Common themes include enrolling the population with a group of providers, making the best use of various professionals to provide primary care, broadening the range of primary care services that consumers can expect to receive, providing 24-hours-a-day, 7-days-a-week coverage, offering incentives to caregivers to provide a broad range of services, adopting funding mechanisms other than fee-for-service, creating processes to coordinate the care of consumers, identifying methods for quality improvement, and supporting the system with information technology.

A final observation is that despite all the study, debate and agreement on the need for change and the components necessary to support it, there has been little substantive progress on improving primary health care services in Ontario. In 1998, the Ministry of Health and the Ontario Medical Association embarked jointly on primary care reform pilots. Through the pilots, a tremendous amount of thought, planning and detailed background work has gone into developing strategies to enroll the population, link

---

4 For a list of primary health care studies and reports prior to 1995, see Subcommittee on Primary Health Care of the Provincial Co-ordinating Committee on Community and Academic Health Science Centre Relations (PCCCAR). *New Directions in Primary Health Care* (July 1996).
5 Enrolling has also been referred to as listing, rostering, registering, panelling and patient choice.
physicians into networks, establish alternative funding mechanisms, provide 24-hours-a-day, 7-days-a-week coverage through the use of direct care providers and telephone triage, and ensure a high quality of working life for providers and high patient satisfaction. Implementation of the pilot projects, however, has been very slow and limited.

It is well known that a vigorous system of primary health care would benefit consumers, health care providers and the system as a whole. However, the potential of primary health care reform has yet to be realized. The reasons include:

- There remains little appreciation of the pivotal role of primary health care.
- There incentives and disincentives inherent in fee-for-service funding impede change.
- The effectiveness of primary care funded through alternate arrangements remains unevaluated.
- There is a maldistribution of primary care physicians in Ontario, and limited use of well qualified other health professionals such as nurse practitioners.
- There are inadequate information systems to support primary health care.
- Professional boundaries often frustrate collaboration.

**THE HSRC’S APPROACH TO DEVELOPING A PRIMARY HEALTH CARE STRATEGY**

The HSRC is an objective, arms-length body from government mandated to act in the public interest. It does not advocate on behalf of any particular provider or group of providers. The HSRC’s approach to primary health care is to:

- Put the people of Ontario at the centre, on the presumption that they will play an active role in their health care.
- Build on the strengths and positive attributes of current primary care models, and incorporate many of the elements and directions that have been suggested or that exist.\(^6\)
- Identify the key conditions needed to support change, such as education of health professionals.
- Develop a strategy to implement primary care reform provincially, in a planned and comprehensive manner over the next six years.

The HSRC’s primary health care strategy is not novel. The vast majority of its characteristics are common to other primary care models previously proposed. It does, however, have a number of different features:

- An enhanced role for nursing. Primary health care is provided by primary care physicians and nurse practitioners working in partnership, recognizing the particular skills and approaches each brings to health care. This core team is enhanced by other health care professionals. This combination makes better use of the skills of health professionals (especially of nurses), improves access to primary health care services, and reduces the reliance on emergency departments.

---

\(^6\) These include community health centres, health service organizations, the OMA primary care pilots, the Ontario College of Family Physicians, the Registered Nurses Association of Ontario, and various Northern and rural initiatives such as the Northern Group Funding Plans and the community-sponsored contracts for family physicians.
- True group practices with supporting administrative structures. This feature enhances professional peer support, and leads to improved quality of care and system efficiencies.
- Improved conditions for primary care physicians. This includes an attractive compensation package, a quality incentives system for meeting established targets, and assistance with support and capital services. These are incentives to encourage members of group practices to locate in the same physical setting.
- Funding flows to the group based on the enrolled population served. This highlights the group’s responsibility for the health and health care of its enrolled population. It encourages and permits the selection of payment mechanisms most suitable to the members of each primary health care group.
- Comprehensive provincial implementation of the strategy. The HSRC believes that progress must and can be made more quickly if primary health care is to meet the changing needs of Ontario’s population and contribute to the development of a genuinely integrated health care system.

This report is the culmination of an extensive review of background information, consultations, and discussions and debate. The HSRC believes that the characteristics that it has identified are critical to the establishment of a successful primary health care system, made in Ontario by and for Ontarians. Development of a comprehensive primary care system based on group practices and enrolled populations, will play a vital role in integrating all health and health care services to ensure that every citizen has ready access to top quality health care close to home and at a price we can all afford.

**Overview of the Report**

This report presents the HSRC’s vision and goals for primary health care in Ontario with a strategy to realize them. Critical success factors and an implementation plan are also included.
THE HSRC’S STRATEGY FOR PRIMARY HEALTH CARE IN ONTARIO

People have a broad range of health care needs. They include staying healthy through health promotion and disease prevention, episodic and ongoing care, acute, rehabilitative and long-term care, and palliative care in the final stages of life.

PROPOSED IMPLEMENTATION PLAN

Year One

These needs are met by a broad range of health care professionals and organizations including public health, general and specialist physicians, nurses, dentists, pharmacists, physiotherapists, and other health care professionals, hospitals, and long-term care and home care organizations (coordinated by community care access centres), etc.

1. Communicate support for the concept of PCGs.
   a. Announce that PCGs will be established. (R3)
   b. Make commitment to develop groups over the next six years in Ontario. (R29)

2. Put a structure in place to support implementation activities.
   a. Appoint a champion to affect the change in primary health care. (R27)
   b. Establish an Implementation and Monitoring Committee of external representatives supported with a secretariat, and reporting directly to the Minister of Health. (R28)
   c. Commit funds for PCG development.
      Funding for PCGs incorporate: population-based funding or capitation, and funding for special programs. Other services outside of group funding supported with additional funds, and paid as sessionals. (R8)
   d. Invest stable and ongoing funding immediately to support the education of nurse practitioners in Ontario. (R10)

3. Do the groundwork for PCG development.
   a. Establish an education task force to address education issues. (R9, R11, R12)
   b. Develop criteria for selecting PCGs.

4. Start PCG development.
   a. Solicit expressions of interest to establish PCGs, and establish mechanisms that will assist sites to establish their operations.
### Year One

<table>
<thead>
<tr>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>b. Prepare contracts between PCGs and consumers.</td>
</tr>
<tr>
<td>Registration contracts clearly outlining the relationships, rights and</td>
</tr>
<tr>
<td>responsibilities of the participants of a PCG. (R20)</td>
</tr>
<tr>
<td>5. <strong>Prepare contracts between PCGs and the Ministry of Health.</strong></td>
</tr>
<tr>
<td>The contract between the PCG and the MOH will set out the expectations and</td>
</tr>
<tr>
<td>operational standards of PCGs. (R22)</td>
</tr>
<tr>
<td>The contracts will include PCGs monitoring the extent to which their enrolled</td>
</tr>
<tr>
<td>consumers seek primary health care outside the group, and evaluating and</td>
</tr>
<tr>
<td>addressing the reasons why this is occurring. In the second year of operation,</td>
</tr>
<tr>
<td>PCGs should be negated for 100% of the cost of care if any of their</td>
</tr>
<tr>
<td>consumers seek their primary health care outside the group. (R5)</td>
</tr>
<tr>
<td>6. Develop and implement a system to monitor performance and activities of</td>
</tr>
<tr>
<td>PCGs.</td>
</tr>
</tbody>
</table>

### Year Two

<table>
<thead>
<tr>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Develop directories of community resources to support PCGs.</strong> (R15)</td>
</tr>
<tr>
<td>Local Community Care Access Centres and District Health Councils</td>
</tr>
<tr>
<td>2. **Initiate the development of systems so that each PCG has electronic</td>
</tr>
<tr>
<td>access to drug and laboratory information.** (R14)</td>
</tr>
<tr>
<td>Ministry</td>
</tr>
<tr>
<td>3. **Choose the sites to become PCGs from expressions of interest: 50%</td>
</tr>
<tr>
<td>underserviced and 50% established group practices (HSOs and others)**</td>
</tr>
<tr>
<td>Implementation and Monitoring Committee, and Secretariat</td>
</tr>
</tbody>
</table>

### Year Three

<table>
<thead>
<tr>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. **Develop guidelines for inter-professional quality management in primary</td>
</tr>
<tr>
<td>health care settings.** (R22)</td>
</tr>
<tr>
<td>Implementation and Monitoring Committee, and Secretariat</td>
</tr>
<tr>
<td>2. **Choose the sites to become PCGs in Year 3: remaining 50% underserviced</td>
</tr>
<tr>
<td>and remaining 50% established group practices (HSOs and others)**</td>
</tr>
<tr>
<td>Implementation and Monitoring Committee, and Secretariat</td>
</tr>
</tbody>
</table>
### Year Four

<table>
<thead>
<tr>
<th>Responsibility</th>
<th>1. Choose the sites to become PCGs from expressions of interest: 33% of the remaining population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation and Monitoring Committee, and Secretariat</td>
<td></td>
</tr>
</tbody>
</table>

### Year Five

<table>
<thead>
<tr>
<th>Responsibility</th>
<th>1. Choose the sites to become PCGs from expressions of interest: remaining 50% the population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation and Monitoring Committee, and Secretariat</td>
<td></td>
</tr>
</tbody>
</table>

### Year Six

<table>
<thead>
<tr>
<th>Responsibility</th>
<th>1. Establish final sites for PCGs: 100% of the remaining population.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation and Monitoring Committee, and Secretariat</td>
<td></td>
</tr>
</tbody>
</table>
### Summary of Implementation, and Annual and Cumulative Rollout of PCGs

<table>
<thead>
<tr>
<th>Year</th>
<th>Activities</th>
<th>Cost (mil)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Planning for implementation. Committing funds for nurse practitioner education, and six year implementation activities.</td>
<td>$ 5</td>
</tr>
<tr>
<td></td>
<td><strong>Annual Rollout</strong></td>
<td><strong>Cumulative Rollout</strong></td>
</tr>
<tr>
<td>2</td>
<td>50% of underserviced and 50% of established group practices (HSOs and other group practices)</td>
<td>50% of underserviced and 50% established group practices (HSOs and other group practices)</td>
</tr>
<tr>
<td>3</td>
<td>Remaining underserviced and established group practices (HSOs and other group practices)</td>
<td>100% of underserviced and 100% established group practices (HSOs and other group practices)</td>
</tr>
<tr>
<td>4</td>
<td>33% of the remaining population</td>
<td>100% of underserviced and established group practices (HSOs and other group practices) + 33% of the remaining population</td>
</tr>
<tr>
<td>5</td>
<td>50% of the remaining population</td>
<td>100% of underserviced and established group practices (HSOs other group practices) + 66% of the remaining population</td>
</tr>
<tr>
<td>6</td>
<td>100% of the remaining population</td>
<td>100% of underserviced and established group practices (HSOs other group practices) + 100% of the remaining population</td>
</tr>
</tbody>
</table>

* Cost estimates use current dollars. No allowances are made for inflation and cost increases. Capitation amounts include an amount to repay start up capital costs.
### When Established, Each PCG Will Incorporate The Following:

<table>
<thead>
<tr>
<th>Key elements</th>
<th>• Provide a defined range of primary health care services. (R1)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Arrange for 24 hours-a-day, 7 days-a-week response and extended office hours. (R2)</td>
</tr>
<tr>
<td></td>
<td>• Enroll consumers with a primary care physician or primary care nurse practitioner. (R4)</td>
</tr>
<tr>
<td></td>
<td>• Incorporate inter-professional primary care providers, with primary care physicians and primary care nurse practitioners forming the core team and other professionals added to meet the needs of the enrolled population. (R6)</td>
</tr>
<tr>
<td>Funding</td>
<td>• Determine how providers will be remunerated within the group. (R7)</td>
</tr>
<tr>
<td>Information Management</td>
<td>• Incorporate clinical management systems in PCGs. (R13)</td>
</tr>
<tr>
<td>Coordination of Care</td>
<td>• Compile, as well as be the custodian of a health record for each enrolled consumer. (R16)</td>
</tr>
<tr>
<td></td>
<td>• Develop agreements with organizations and health care providers offering different levels of care (e.g., between PCGs and local hospitals, which includes hospital privileges for primary care physicians). (R17)</td>
</tr>
<tr>
<td></td>
<td>• Establish standard communication and transfer protocols with other referral organizations, health care providers and sectors (R18).</td>
</tr>
<tr>
<td></td>
<td>• Develop care paths with local health care providers for common medical conditions, paying special attention to hand-off points. (R19).</td>
</tr>
<tr>
<td>Accountability Mechanisms</td>
<td>• Identify indicators and develop mechanisms to report to the public on an ongoing basis, the performance of the group. (R21)</td>
</tr>
<tr>
<td></td>
<td>• In the short-term, establish arrangements for supporting the development of policies and strategic directions to guide their operations, including obtaining input from the enrolled population. In the longer-term, PCGs consider establishing more formal mechanisms such as governing boards made up of the enrolled population. (R23)</td>
</tr>
<tr>
<td></td>
<td>• Establish a management structure that includes two key functions: a group administrator and a clinical director. (R24)</td>
</tr>
<tr>
<td></td>
<td>• Establish mechanisms to monitor and evaluate their effectiveness and efficiency on an ongoing basis. (R25)</td>
</tr>
</tbody>
</table>
SUMMARY OF RECOMMENDATIONS

Access to a defined range of comprehensive primary health care services

1 All Ontarians be assured access to a defined range of comprehensive primary health care services that include:
   1. Health assessment;
   2. Illness prevention and health promotion;
   3. Education and support for self-care;
   4. Diagnosis and treatment of episodic and chronic illness and injuries;
   5. Primary reproductive care;
   6. Palliative care;
   7. Primary mental health care;
   8. Co-ordination and provision of rehabilitation services;
   9. Co-ordination of and referral to other health care services (such as specialists’ services, home and long-term care, etc.); and
   10. Supportive care in hospital, at home and in long-term care facilities.

In some areas, additional services may be offered to meet the needs of the community served.

Services accessible 24-Hours-a-Day, 7-Days-a-Week

2 Ontarians have access to primary health care services 24-hours-a-day, 7-days-a-week. Coverage should be provided directly by caregivers during regular office hours and in the evenings (i.e., extended office hours). Arrangements should be also be made to ensure coverage through the availability of primary health care services after-hours. A 24-7 telephone triage service should be an intrinsic part of continuous service to consumers. This service should be supported provincially, based regionally, and connected to local providers so that continuity of care is maintained.

Primary Health Care Group Practices

3 Primary Health Care Groups (PCGs)* be established with the mandate to provide comprehensive primary health care to a defined population. PCGs should be established as not-for-profit entities. They should include physicians and nurse practitioners, together with other health care professionals directly involved in the delivery of care in the group practice.

(* Primary Health Care Group Practices or PCGs is a working name only and should not be taken as the name suggested by the Health Services Restructuring Commission.)

Enrollment of consumers

4 Consumers enroll with a primary care physician or primary care nurse practitioner of their choice, who is a member of a Primary Health Care Group. Patients enrolled with a primary care nurse practitioner will also co-enroll with a primary care physician in the group.
In the first year of operation, PCGs should monitor the extent to which their enrolled consumers seek primary health care outside the group. The PCG should evaluate and address the reasons why this is occurring. In the second year of operation, PCGs should be negated for 100% of the cost of care if any of their consumers seek their primary health care outside the group. Use of services outside a reasonable geographic boundary and for emergencies should be exempt from negation.

Inter-professional provider team

All Primary Health Care Groups be organized as groups of inter-professional primary care providers. Primary care physicians and primary care nurse practitioners should form the core team, with other clinical and administrative support functions added to meet the care needs of the enrolled population for comprehensive primary care.

Population-Based Group Funding

Funding for PCGs flow to the group based primarily on the enrolled population being served. The PCG will then determine the method(s) of remuneration for all providers within the group.

Funding for PCGs incorporate the following:

- population-based funding or capitation to pay for the core basket of primary health care services (the rate should be adjusted for age and sex); and
- funding for programs that go beyond the core basket of services to address the specific needs of a defined community or consumers that are difficult to enroll. Other services such as emergency work, surgical assists, telemedicine consultations, and visits to homes, hospitals and long-term care facilities, should not be part of PCG funding but should be supported with additional funds, and paid as sessional payments to the group.

A quality incentive system must be established whereby PCGs are paid incentives when they meet agreed-upon targets in defined areas.
Education

9 An education task force be established to identify education initiatives that will support the primary health care strategy. The key priority of the task force will be to develop:
- strategies to increase training opportunities for primary care nurse practitioners; and
- a plan to support cross training of midwifery and nursing to encourage professionals to develop both sets of skills.

10 The Ministry of Health invest stable and ongoing funding immediately to support the education of nurse practitioners in Ontario.

11 The Education Task Force develop strategies to support collaborative education opportunities among the health professions.

12 The Education Task Force develop and recommend:
- educational and training programs on how to work effectively in groups of inter-professional providers;
- educational and training programs to enhance the skills of health care providers so they practise to the full extent of their scope of practice; and
- strategies on how PCGs can educate enrolled consumers to maintain health.

Information Management

13 PCGs incorporate clinical management systems in their practices to support the real-time capture of consumer-oriented health information, and the secure exchange of relevant and accurate information as appropriate in the delivery of care.

14 Each PCG have electronic access to drug and laboratory information.

15 The local Community Care Access Centre and District Health Council develop directories of community resources to enable PCGs to arrange the best services for their enrolled populations.

Mechanisms to Coordinate Care

16 PCGs compile, as well as be the custodian of a health record for each enrolled consumer.

17 Primary Health Care Groups develop agreements with organizations and health care providers who offer different levels of care, so as to ensure access to a full continuum of coordinated care for the enrolled population. PCGs must be sensitive to the element of consumer choice when developing these agreements. One formal agreement should be between PCGs and local hospitals, setting out the mechanisms by which PCG providers will be fully informed of the condition and treatment of
enrolled consumers, when they are hospitalized. Primary care physicians should hold hospital appointments.

18 Standard communication and transfer protocols be established between
• the PCG and other organizations to which the consumer is being referred (e.g., acute, rehabilitation and complex continuing care hospitals, home care through community care access centres, long-term care facilities);
• the PCG and other health care providers who are caring for the same consumer (e.g., specialists, emergency departments); and
• the PCG and other sectors such as education and social services.

19 PCGs, in collaboration with local health care providers, develop care paths for common medical conditions, paying special attention to hand-off points.

Mechanisms to ensure accountability

20 The relationships as well as the rights and responsibilities of the participants of a PCG be clearly outlined in an enrollment contract. This contract should include, but not be limited to:
• The consumer’s commitment to seek primary care services at the PCG with which they are enrolled except in emergencies, out-of-town situations, or when services are not part of the contract;
• The defined range of services that are available;
• Hours of operation;
• Mechanisms for ensuring 24-hour response (phone number and type of service to expect);
• Minimum period of roster commitment;
• Procedures for enrolling and de-enrolling; and
• Mechanisms for compliments and complaints.

21 PCGs identify indicators and develop mechanisms to report regularly to the public on the PCG’s performance.

22 A contractual agreement be established between the PCG and the Ministry of Health, that sets out the expectations and operational standards of PCGs. These should include:
• service provision including clinical services;
• telephone support, hours of operation and on-call provisions;
• registration of population served and size of the population;
• reporting requirements to the enrolled population and the MOH (e.g., monthly reports to the MOH on client encounters);
• records and information including encounter information, operations and staffing;
• participation in internal quality improvement activities, program evaluation and monitoring;
• reporting requirements associated with population registration; and
- operations, staffing and other requirements.

**Governing and Managing Operations**

23 In the short-term, PCGs establish arrangements to support the development of policies and strategic directions to guide the operations of the PCG. These arrangements should include mechanisms to obtain input from the enrolled population. In the longer-term, PCGs should consider establishing more formal mechanisms such as governing boards made up of members of the enrolled population.

24 Each PCG have a management structure that includes two key functions: a group administrator and a clinical director.

25 PCGs be required to monitor and evaluate their effectiveness and efficiency on an ongoing basis. This must be supported with the establishment of mechanisms for continuous quality improvement, and participation in external quality assurance programs and audits.

26 The MOH develop guidelines for inter-professional quality management in primary health care settings.

**Critical Success Factors**

27 The Ministry of Health identify/appoint a champion with sufficient authority to affect change, who will be responsible for leading the transition in primary health care and ensuring that primary health care receives a high priority in government and the full support of groups representing both providers and consumers.

28 The Ministry of Health establish an Implementation and Monitoring Committee made up of external representatives of consumers, health care professionals and managers to implement the HSRC’s primary health care strategy. The committee should be supported with a secretariat and report directly to the Minister of Health.

29 Primary Health Care Groups be developed over the next six years in Ontario.
APPENDIX A: PRIMARY HEALTH CARE IN ONTARIO

The following describes why primary health care is increasing in importance, how primary care is provided in Ontario and why it has not achieved its potential in Ontario.

WHY IS PRIMARY HEALTH CARE INCREASING IN IMPORTANCE?

Primary health care has always been important but a number of factors are making its importance increase. Changing demographics and the changing nature of disease, the changing health care consumer and hospital restructuring are not only placing greater demands on primary care, they are also underscoring the importance of establishing responsive primary health care services to meet the needs of Ontarians.

Changing Demographics

Ontario’s population is aging. The number of citizens 65 years of age and older is expected to double in the next 25 years. Aging is associated with an increase in chronic diseases and disabilities that usually require some type of health assistance or support. Although the older population is quite healthy and functions well until advanced ages, many older persons live with one or more chronic conditions. Primary health care has an important role to play in helping older persons achieve their highest level of functioning.

Changing Nature of Disease

In this century, the major causes of illness and death have shifted from infectious diseases to chronic diseases such as cardiovascular conditions and cancer. This increased prevalence of chronic disease has intensified the amount of health care activity directed at consumers and has increased the demands on primary health care providers. For example, education directed at consumers about health promotion, disease prevention and health maintenance is increasing in importance. As well, individuals with chronic ailments require more ongoing primary care. Given the aging population, this trend is expected to intensify.

Changing Health Care Consumer

Consumers are taking a more active role caring for their own health. Information technology such as the Internet has allowed consumers access to a broad range of health-related information. Increasingly, they are becoming more aware of the various determinants of health, and how to maintain health and prevent illness. Consumers want to participate in decisions about their care and take advantage of the latest technological advances. The primary care physician-client relationship has become more of a partnership rather than one of unquestioning acceptance of expert advice from the professional. This is placing greater demands on primary care and its providers. For example, consumers are more likely to want information and discuss treatment options, than they did in the past.
Restructuring of Hospitals

Hospital restructuring is part of the HSRC’s goal to rebalance the health care system, and encourage the shift from institution- to community-based care. The underlying premise has been that hospital resources can be used more effectively as long as corresponding investments are made in other health care sectors. Pressures are being felt by hospitals where these investments have not been made. For example, many hospital emergency departments are used inappropriately as providers of primary care in the community. Hospital restructuring has intensified complaints about the inappropriate use of emergency departments for non-emergent care, overcrowded emergency rooms and long waits to see a physician.

Hospital restructuring has highlighted several issues:

- The inappropriate use of emergency departments and hospitals for primary care services will continue to occur until there is a comprehensive community-based system of primary care to meet the needs of consumers.
- Since patients are being discharged from hospitals sooner, they need access to a good system of primary health care and other community-based services to meet their needs.
- There are increasing pressures to contain costs and design a health care system that uses resources effectively and efficiently. The emphasis is on care being provided by the most appropriate person, in the right place, at the right time, for the best outcome.

How is Primary Care Provided in Ontario?

Primary care in Ontario is almost exclusively provided by general or family physicians. To a certain degree, specialists also provide primary care to their patients. Midwives can provide primary obstetrical services. In certain areas (e.g., remote areas, community health centres, some health service organizations), nurses with advanced training (e.g., nurse practitioners) provide primary care. There is little formal recognition of primary health care that is provided by other health care professionals such as pharmacists, social workers, physiotherapists, optometrists and others.

In Ontario, there were 8,835 active GPs/FPs in 1997/98. This translates into 7.9 active GPs/FPs per 10,000 population. The distribution of primary care physicians per capita varies by region in Ontario from a high of 10.0 per 10,000 population in Toronto, to a low of 5.8 in Essex/Kent/Lambton.

---

32 A general practitioner (GP) is someone who has successfully completed medical school and is licensed to practice medicine in Ontario. A family physician (FP) is a GP who has completed a residency in family medicine and is registered with the Ontario College of Family Physicians.

33 Ben Chan, Supply of Physicians’ Services in Ontario. Institute for Clinical Evaluative Sciences (November 1999). This report presented three methods for counting the number of physicians: a simple head count of those who bill OHIP; a count of active physicians who bill above $35,000 per year; and weighting physicians by their annual billings. There are limitations with each method.
Practice settings for primary care include private offices and clinics, hospital in- and outpatient units, long-term care facilities, community health centres and clinics, free-standing walk-in clinics, academic centres and health service organizations. Hospital emergency departments are also important settings for primary care services, especially in areas where there are too few general practitioners and family physicians.

The settings in which primary care providers practise, tend to be characterized by one of three funding arrangements that reimburse physicians for medical services: fee-for-service, program-based and capitation funding.

**Fee-for-service**

Fee-for-service (FFS) is paid to physicians according to a pre-determined schedule of benefits that allocates a certain fee for each approved medical service. FFS accounts for 86% of total income received by primary care physicians in Ontario. As well, 93% of physicians receive all or part of their income from FFS. In 1996/97, annual expenditures for primary care physicians through FFS were approximately $1.7 billion.

The vast majority of primary care physicians – 81% – provide their services solo or in group practices from private offices or clinics. Almost 40% of family physicians are in solo practice. Other settings include walk-in clinics, urgent care centres and hospital emergency departments.

**Program-Based Funding**

Program-based funding is allocated by government to support a package of primary care programs, that are provided to a selected community or population. In Ontario, program-based funding is used to support community health centres (CHCs). Approximately six percent or 552 Ontario family physicians practise in CHCs as salaried employees, although they may not work exclusively in CHCs. CHCs also employ other health professionals such as nurse practitioners, enrolled nurses, social workers, and health promotion workers.

CHCs are not-for-profit corporations with boards of directors that are usually drawn from the local community. First formed in Ontario in the 1960s CHCs, as well as providing traditional primary care-type services, have a strong focus on health promotion and health maintenance, and try to target the social determinants of health. While there are common characteristics among all CHCs, programs are targeted to meet the specific needs of a community that may have difficulties accessing appropriate primary health care services. Examples of targeted communities include youth, seniors, aboriginals, francophones, homeless, transient and immigrant groups. CHCs also provide health care to persons without health insurance.

---

34 The HSRC attempted to analyse the effectiveness of community health centres and health service organisations, but the information was inadequate to draw firm conclusions.


There are 57 CHCs in Ontario located mainly in urban areas. In 1996/97, annual expenditures for CHCs were $75 million from the Ministry of Health. CHCs may also get additional funding from other provincial ministries, other levels of government and charitable organizations.

**Capitation**

Capitation funding is allocated by a payor – in Ontario, the Ministry of Health – based on a set amount of money for each consumer enrolled with a practice. Capitation funding is used to support Health Service Organizations (HSOs), which are the only form of capitation-funded physician care in Canada. Approximately four percent or 341 Ontario family physicians work in HSOs, although they may not work there exclusively. The average HSO has three physicians.

First developed in Ontario in the 1970s, HSOs were viewed as an alternative payment plan for physicians to support general medical care and a focus on health promotion and health maintenance activities, and to provide programs to meet local needs.

Since funding is tied to the patient roster and not to physician services, there is an incentive to include non-physician providers, who cost less than physicians, in HSO practices. The standard HSO contract includes a definition of services to be provided such as after hours coverage, capitation rates, roster size and penalties if enrolled patients obtain treatment outside the HSO. There is no incentive to increase the volume of service unnecessarily. There is an incentive, however, to ensure that enrolled patients get their care from the HSO since negotiation occurs when a patient goes elsewhere. There are 77 HSOs in Ontario, which accounted for an annual expenditure of $71 million from the Ministry of Health in 1996/97.

**WHY HASN’T PRIMARY HEALTH CARE ACHIEVED ITS POTENTIAL IN ONTARIO?**

Primary health care has a pivotal role to play as a consumer advocate, ensuring that every person in Ontario has access to top quality primary and other health care services. Primary health care, however, has not achieved its potential in this province.

Primary health care has been the subject of much study and debate in Ontario for a number of decades. Prior to 1995, numerous reports have been written addressing principles, issues, funding options and potential models. In 1995, the Provincial Coordinating Committee on Community and Academic Health Science Centre Relations (PCCCAR) considered all these reports and advised on future directions for primary health care in Ontario. Since then, an Ontario Medical Association Advisory Group on Primary Care

---

37 For a list of primary health care studies and reports prior to 1995, see Subcommittee on Primary Health Care of the Provincial Co-ordinating Committee on Community and Academic Health Science Centre Relations (PCCCAR), *New Directions in Primary Health Care* (July 1995).
Reform (1996) and a Ministry of Health-appointed Primary Care Implementation Steering Committee (1997) have addressed primary care. Recently, the Ontario College of Family Physicians released its model for primary care reform (1999). (See Appendix B for a comparison of some of these models.)

Although the need to develop and support a coordinated system of primary health care has been recognized in the multitude of studies that have been released, there has been limited progress to date. In May 1998, the Ministry of Health announced the first of five Ontario Medical Association primary care reform pilots. In addition to announcing pilot sites, a tremendous amount of thought, planning and detailed background work has gone into developing strategies to support the pilots. Unfortunately implementation of the pilots has been slow and progress has been limited. One year later, negotiations with the physicians are still ongoing. Meanwhile, problems of quality, accessibility and affordability continue to characterize primary health care in Ontario and affect all aspects of health care. These problems include:

<table>
<thead>
<tr>
<th>Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Primary health care services are fragmented. Many consumers cannot depend on a single provider to oversee their primary health care and coordinate it with other levels of care.</td>
</tr>
<tr>
<td>- Standards and guidelines for assessing quality are lacking.</td>
</tr>
<tr>
<td>- There is little integration within primary health care, and with other parts of the health care system (e.g., when the family physician makes a referral to a specialist or to community-based home care, information is often not communicated back to the family physician).</td>
</tr>
<tr>
<td>- There is limited appreciation that comprehensive primary health care includes prevention and promotion services.</td>
</tr>
<tr>
<td>- The education and skills of family physicians are underutilized when they perform tasks that are within the scope of practice of nurses and other health professionals.</td>
</tr>
<tr>
<td>- Accountability mechanisms do not exist for primary health care services.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Accessibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Some consumers do not have an identified primary care provider.</td>
</tr>
<tr>
<td>- Primary care providers are maldistributed in Ontario.</td>
</tr>
<tr>
<td>- Access to 24-hours-a-day, 7-days-a-week primary care coverage by primary care physicians is limited.</td>
</tr>
<tr>
<td>- Many consumers who need primary health care or information in the off-hours, are referred, or go, to hospital emergency departments or walk-in clinics. Their care is fragmented given that their family physician is often not informed of the treatment received by his or her patient.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Affordability</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Primary care providers are not used to the full potential of their education and training. This keeps costs higher than they should be.</td>
</tr>
<tr>
<td>- The high proportion of solo-practice physicians in Ontario – 40% – does not facilitate cost sharing and economies of scale of group practices.</td>
</tr>
<tr>
<td>- Limited use of alternative payment arrangements and modes of non-traditional service delivery (e.g., telemedicine), impedes access to care and prevents cost-efficiencies.</td>
</tr>
<tr>
<td>- The lack of adequate primary health care coverage results in over use of hospital emergency departments, which is costly and often leads to wasteful duplication of services and diagnostic testing.</td>
</tr>
<tr>
<td>- The use of walk-in clinics in off-hours duplicates services when the consumer subsequently visits his or her family physician for the same problem.</td>
</tr>
</tbody>
</table>
It is widely recognized that a vigorous system of primary health care has benefits for consumers, health care providers and the system as a whole. However, the potential of primary health care has not been realized for a number of reasons. These reasons include:

- There is little appreciation for the pivotal role of primary health care.
- There are limitations inherent in fee-for-service funding.
- The effectiveness of primary care funded through alternate arrangements is unclear.
- There is a maldistribution of primary care physicians in Ontario, and limited use of non-physicians such as nurse practitioners to help provide care.
- There are inadequate information systems to support primary health care.
- Enabling legislation to support a system of primary health care is limited.
- Professional autonomy can impact on efforts to collaborate.

These challenges are presented in greater detail on the next page.
Challenges to Achieving Primary Health Care’s Potential

There is Little Appreciation for the Pivotal Role of Primary Health Care

- Health and health maintenance tend to be equated with high technological medical care and hospitals.
- There is little appreciation of the pivotal role primary health care can play in keeping people well, advocating on their behalf, guiding them through the system, and coordinating their care.
- This lack of appreciation usually translates into less commitment to support the changes that are required to develop a strong system of primary health care.

The Effectiveness of Primary Care Funded Through Alternate Arrangements is Unclear

- Currently, community health centres (CHCs) and health service organizations (HSO) are not widely accepted as effective alternatives to fee-for-service (FFS) for primary health care.
- The potential of alternate funding arrangements for primary health care is difficult to assess because of the limitations of performance measures and accountabilities of CHCs and HSOs.
- e.g., CHCs are not required to provide a full range of primary care services, their hours of operation and arrangements for after-hours coverage vary, and there is a lack of accountability for CHC services.
- e.g., In HSOs, the use of non-physician primary care providers varies, there are difficulties maintaining an accurate record of enrolled patients, and mechanisms to ensure that HSOs are meeting the terms of their contracts are spotty, at best. It was expected that HSOs would improve access to care and thereby decrease reliance on institutions for emergency and inpatient care. This has not happened.*

There are Inadequate Information Systems to Support Primary Health Care

- Information systems used by primary health care providers tend to be limited to systems that are used mostly for submitting claims to the Ministry of Health. These systems are not used to monitor a patient’s health care, assist in accessing information on the range of services available in the community, or transmit health record information among providers.

There is a Maldistribution of Primary Care Physicians in Ontario and Limited Use of Non-Physicians to Help Provide Care

- Factors such as aging physicians, the lack of desire to practise in smaller and more remote communities, and physicians changing their work patterns to fit lifestyle choices, directly impact on the feasibility of every Ontarian having a primary care physician.
- Low population density, geography and distances between towns exacerbate the problem of insufficient numbers of primary care physicians in some areas of the province.
- Physicians in remote areas find it difficult to provide care over large areas. It is also difficult for physicians to be supported professionally when there are few if any peers to consult with, and to obtain consults with specialists who are far away.
- Recent legislation recognizes midwives and an extended class of nurses who practise as community nurse practitioners. One study estimated that nurse practitioners can perform 80% of tasks performed by physicians.* There has been little concerted effort to date to use these practitioners optimally in an integrated primary health care system. Limitations in funding and lack of acceptance of these professionals are barriers.


There are Limitations Inherent in Fee-For-Service Funding

- FFS breaks down the provision of primary health care into its component parts. Since each part is associated with a billing code and a fee, the FFS structure is not able to consider integrated primary health care as a total, comprehensive picture.
- Physicians who conduct more detailed assessments, and in-depth disease prevention, health promotion and client education activities are either funded inadequately for these activities or not at all.
- FFS physicians wanting to establish inter-professional group practices must find alternate sources of funding, since most non-physicians cannot bill for their services nor can physicians bill for services provided to their patients by non-physicians.
- FFS is an incentive for physicians to practise in more densely populated areas, since FFS pays physicians for the volume of work they do.
- The OMA-MOH agreement does not allow FFS funds to be transferred to alternate payment program funding, which could be used to support comprehensive primary health care.

Enabling Legislation to Support a System of Primary Health Care is Limited

- Current legislation limits the ability to establish innovative primary care arrangements since it: limits the ability of health care providers generally to amalgamate with other health care providers not operating under the same statute; and neither permits nor facilitates the formation of alliances or partnership arrangements between similar types of health care providers.

Professional Autonomy Can Impact on Efforts to Collaborate

- Most primary care physicians are solo practitioners. This impacts on their willingness to enter into more collaborative arrangements, especially if they anticipate a loss of personal autonomy or feel they must manage other health care providers.
- Fee-for-service reinforces autonomy and solo practice. Physicians wanting to establish inter-professional group practices must find alternate sources of funding, or pool their billings to finance other care providers.
### APPENDIX B: COMPARISON OF PRIMARY CARE REFORM MODELS AND ESSENTIAL ELEMENTS

<table>
<thead>
<tr>
<th>Organization/Report</th>
<th>Enrollment</th>
<th>Inter-professional Group Practices</th>
<th>Defined Range of Service and 24-7</th>
<th>Co-ordination and Communication Mechanisms</th>
<th>Information Management</th>
<th>Quality Improvement and Accountability</th>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal/Provincial/Territorial Advisory Committee on Health Services</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes Core services with contractual requirements. 24-hour coverage.</td>
<td>Yes Primary care organizations to establish relationships with community organizations and government.</td>
<td>Promoted. Each primary care organization to maintain ongoing patient medical records.</td>
<td>Yes Through contractual agreement.</td>
<td>Capitation based funding. Explore GP fund holding system.</td>
</tr>
<tr>
<td>Ontario Chairs of Family Medicine</td>
<td>Yes</td>
<td>Yes Solo practices possible within a network.</td>
<td>Yes Comprehensive services including coordination, 24-hour coverage, referrals.</td>
<td>Yes Core service. Primary care physicians to provide in-hospital care.</td>
<td>Yes, to provide information on patient and population health status/needs assessment.</td>
<td>System for continuous quality improvement.</td>
<td>Support blended funding Option for fee-for-service (amount not to exceed what would be earned under blended approach).</td>
</tr>
<tr>
<td>Canadian Medical Association</td>
<td>Yes</td>
<td>Multidisciplinary care encouraged but not required.</td>
<td>Primary care physician should provide: General care Maternal &amp; child Psychosocial care Rehabilitative and palliative care Advocacy</td>
<td>Yes including clinical patient management software.</td>
<td>Yes Enhance information systems for practice management.</td>
<td>Payment for health promotion. Incentives to recruit physicians to underserviced areas.</td>
<td></td>
</tr>
</tbody>
</table>

---

<table>
<thead>
<tr>
<th>Organization/Report</th>
<th>Enrollment</th>
<th>Inter-professional Group Practices</th>
<th>Defined Range of Service and 24-7</th>
<th>Co-ordination and Communication Mechanisms</th>
<th>Information Management</th>
<th>Quality Improvement and Accountability</th>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>College of Family Physicians of Canada(^{41})</td>
<td>Client rostering for purpose of records, not a basis for payment.</td>
<td>Yes</td>
<td>Yes, including 24-hour availability.</td>
<td>Yes National family physician computerized network. Clinical practice management tools designed around practice guidelines.</td>
<td>Yes</td>
<td>Yes</td>
<td>Support blended funding mechanism.</td>
</tr>
<tr>
<td>Ontario Medical Association(^{42})</td>
<td>Rostering on a voluntary basis for providers and public.</td>
<td>MD as principal coordinator of care and collaborative relationships with other providers.</td>
<td>24-hour response. No core services defined. Health maintenance activities.</td>
<td>Provider-based patient database to promote screenings and ongoing care.</td>
<td>Yes</td>
<td>Yes</td>
<td>Range of payment plans needed to achieve goals. Support a reformed FFS funding plan.</td>
</tr>
</tbody>
</table>


\(^{43}\) Subcommittee on Primary Health Care of the Provincial Co-ordinating Committee for Community and Academic Health Sciences Centre Relations (PCCCAR), *New Directions for Primary Health Care* (1996).
<table>
<thead>
<tr>
<th>Organization/Report</th>
<th>Enrollment</th>
<th>Inter-professional Group Practices</th>
<th>Defined Range of Service and 24-7</th>
<th>Co-ordination and Communication Mechanisms</th>
<th>Information Management</th>
<th>Quality Improvement and Accountability</th>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Task Force on the Funding and Delivery of Medical Care in Ontario</td>
<td>Yes</td>
<td>Promising but not essential.</td>
<td>Yes Including minimum weekly operating hours, 24-hour coverage, defined range of services.</td>
<td>Yes Access to medical specialists only with referral from primary care provider. Includes minimum communication requirements.</td>
<td>Yes Additional information required for all levels of decision making. Initial focus on clinical practice management.</td>
<td>Yes Practice audits with rewards for “good” performance.</td>
<td>Capitation, fee-for-service and CHC funding models with funding pools for each model determined on a capitation basis.</td>
</tr>
<tr>
<td>OMA, Primary Care Reform Physician Advisory Group</td>
<td>Yes</td>
<td>Group practices or practice networks with enhanced role for nurses.</td>
<td>Yes 24-hour coverage.</td>
<td>Yes Access to all levels of health care through family physicians. Every family</td>
<td>Yes Family physician responsible for managing comprehensive electronic</td>
<td>Yes Community report cards. Peer assessment through physician groups.</td>
<td>Two models: Reformed fee-for-service, and Blended funding model.</td>
</tr>
<tr>
<td>Ontario College of Family Physicians</td>
<td>Yes</td>
<td>Encouraged by offering program funding arrangements to rostered practices.</td>
<td>Yes Defined services. 24-hour coverage.</td>
<td>Yes Primary care MD as coordinator of care.</td>
<td>Yes Incremental development of information systems based on electronic patient record.</td>
<td>Implementation of evidence-based clinical practice. Guidelines and decision tools.</td>
<td>Capitation funding allocated to each model with a range of provider payment mechanisms.</td>
</tr>
</tbody>
</table>

---

<table>
<thead>
<tr>
<th>Organization/Report</th>
<th>Enrollment</th>
<th>Interprofessional Group Practices</th>
<th>Defined Range of Service and 24-7</th>
<th>Co-ordination and Communication Mechanisms</th>
<th>Information Management</th>
<th>Quality Improvement and Accountability</th>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>physician to be an active member of medical staff of a hospital. Formal networks.</td>
<td>health record.</td>
<td></td>
<td>funding includes a base salary, overhead costs, no-volume modifiers and volume modifiers.</td>
</tr>
</tbody>
</table>
APPENDIX C: DEFINITION OF PRIMARY HEALTH CARE SERVICES

The Provincial Co-ordinating Committee for Community and Academic Health Sciences Centre Relations (PCCCAR) developed detailed descriptions of eleven services that were identified as mandatory functions within a defined basket of primary health care services.

One of PCCCAR’s services was advocacy, whereby primary health care groups would advocate on behalf of enrolled clients by providing support, referral, and liaison for consumers who are aware of their need, but unable to organize help themselves. Advocacy includes supportive listening, accompanying consumers if needed, writing letters, making telephone calls or speaking on their behalf, and organizing case conferences.

The HSRC believes that advocacy is an intrinsic part of one of the services – co-ordination and referral – and should be used to empower consumers and help them optimize their health.

1. Health assessment;
2. Illness prevention and health promotion;
3. Patient education and support for self-care;
4. Diagnosis, initial and ongoing treatment of chronic illnesses;
5. Primary reproductive care;
6. Palliative care;
7. Primary mental health services;
8. Co-ordination and access to rehabilitation;
9. Service co-ordination and referral; and
10. Support for care in hospital, in home and in long term care facilities.

1. Health Assessment

A health assessment is the process of determining a consumer’s current health status and potential health problems by collecting information on the consumer's physical and psycho-social condition and life-style. This information is gathered through a physical examination and appropriate laboratory/diagnostic evaluations, conversation with the consumer and data on the community's health needs.

2. Illness Prevention and Health Promotion

Health promotion is an approach (rather than a specific set of services) that focuses on the broad determinants of health, the underlying causes of illness, and factors that affect the ability to cope. Rather than dealing primarily with people at high risk, health promotion looks at the health of an entire population.

Health promotion includes education and support, based on clinical evidence, to help populations:

48 Adapted from Subcommittee on Primary Health Care of the Provincial Co-ordinating Committee for Community and Academic Health Sciences Centre Relations (PCCCAR) New Directions in Primary Health Care (1996).
• reduce any health risks associated with life-style; and
• take responsibility for and become actively involved in decisions that affect their health.

Clinical prevention activities are based on health professionals, as experts, working with individual consumers who are at high risk of becoming ill or who have already developed a disease. Clinical prevention activities include screening people who are at risk, early detection, early intervention and counseling people to help them reduce their risks. They also include specific interventions, such as immunization and periodic health examinations.

Clinical prevention services for individual consumers and their families, based on evidence-based guidelines such as the periodic health exams, should be the prevention and promotion priority for primary health care groups.

To provide effective prevention/promotion services, primary health care groups must be aware of the health promotion needs of the people on their roster. They should also become more involved in broader population health activities within their communities.

Primary health care providers can make a valuable contribution beyond their clinical role by sharing information about the needs of their consumers, educating consumers, participating in service planning, and working with individuals and groups at risk.

Health promotion should be an integral part of primary health care. The role of the primary care setting in health promotion can be carried out in many ways, and could involve the following:
• promoting healthy life-styles as a standard part of both illness intervention and episodic screening;
• providing health promotion literature and advice and helping consumers get access to health promotion services through other organizations or institutions;
• co-operating with others in the community involved in health promotion, such as the school system, housing and social services, public health, and industrial health and safety organizations;
• helping the community identify any impediments to health;
• attempting to incorporate or affiliate allied health professionals involved in health promotion as part of the service provided to enrolled consumers (e.g., public health nurses and social service workers); and
• helping consumers connect with support groups that encourage healthy lifestyle changes or offer support with coping.

The primary health care group may also be an appropriate setting for community-oriented health promotion activities such as community development, advocacy and education.

3. Education and Support for Self-care

Primary health care groups must encourage in their enrolled population greater self-reliance, self-care and mutual aid. To do this, primary health care groups will:
• provide health education, counseling and follow-up;
• link consumers to appropriate formal and informal resources in the community; and
• promote access to phone health information, advice and triage services where they exist.
Primary health care groups may also collaborate with other groups or networks to establish support groups and information resources.

4. Diagnosis and Treatment of Episodic and Chronic Illnesses and Injuries

Detecting and treating consumers with chronic illnesses requires a range of primary care services including:

- providing anticipatory care and monitoring to prevent and/or treat flare-ups before they become more serious;
- maintaining appropriate information on interventions and their results over a period of time;
- using results from various investigative procedures, including the consumer's objective and subjective responses, to reflect the course of the disease process;
- providing appropriate referral to other primary care providers, allied professionals and consultants to slow or reverse the disease process or to ease its impact on the consumer's life;
- providing ongoing education for the consumer and family or support group, designed to encourage compliance, improve their ability to make informed decisions about the care, and maximize caregiver support and understanding; and
- conducting follow-up at appropriate intervals (either in the office, institution or the consumer's home) and evaluating the consumer's care and health.

To provide quality care for people with chronic illnesses, providers must be knowledgeable about community-based services (e.g., community care access centres, local volunteer and support groups, illness-specific societies, local interest groups, home care and homemaking groups), and help the consumer gain access to them.

In the case of an illness or injury, consumers need timely access to primary care services either through simple telephone advice, direct consumer contact, and/or referral to secondary and tertiary care. Depending on the consumer's needs, appropriate interventions could include:
- taking a history;
- conducting a physical exam;
- utilizing and co-ordinating a range of investigative procedures such as lab tests and x-rays;
- making a diagnosis or diagnoses; and
- managing the problem.

Management implies a range of options including:

- advice for self-care;
- advice to prevent reoccurrence or aggravation of the condition;
- the explanation of the risk and benefit aspects of treatment options or failure to comply with treatment; and
- co-ordination of more intensive or specialized care.

Management must also involve appropriate follow-up to encourage the consumer to comply with treatment or to ensure that the problem has been resolved.
5. **Primary Reproductive Care**

Primary health care groups must offer primary reproductive care including counseling for birth control and family planning, education, screening and treatment for sexually transmitted diseases, and antenatal and post natal care. Maternal care services (i.e., antenatal care to term, labour and delivery, and immediate maternal and newborn care) could be provided to a group’s enrolled population by providers in the group or by a midwifery practice group or obstetrician linked to the agency. Groups that do not provide full maternal care in-house must have a relationship with another agency that provides this service and must ensure that consumers are linked as required, provide appropriate remuneration for these services and provide antenatal care until the transfer is complete.

6. **Palliative Care**

A growing number of terminally ill people want to receive palliative care at home. Primary health care providers must be available to work with people who are terminally ill, and their families, partners, friends and community-based service providers, to deliver/co-ordinate high quality palliative care at home. Palliative care services should be tailored to meet the dying person's diverse needs, which may be influenced by his or her beliefs, values, culture and the strength of his or her support network. To provide quality care, it is essential for the primary care provider to maintain good communications with the terminally ill person and other caregivers.

As part of their responsibility to support people with a terminal illness, all primary health care providers must do home visits and have the capability to ensure timely response when needed for care and advice. As part of their responsibility to co-ordinate services, all primary health care groups will co-ordinate medical care with home care (through community care access centres ) and other community agencies.

The most responsible provider will ensure that people who have a terminal illness have access to advice about services to support the family, such as respite and hospice services. Primary health care groups will also ensure that people who are dying have timely access to hospital care, and are also discharged appropriately.

The most responsible primary health care provider should talk to the person with a terminal illness about advanced directives, and help the person and family/partners understand the implication of these decisions. A family physician from the primary health care group must be available on a timely basis to pronounce death, issue the certificate of death and make arrangements to remove the body from the home. He or she should also provide or arrange support for the family at this time.

7. **Primary Mental Health Care**

Primary health care groups will be the cornerstone of community mental health care. They must be equipped to:
- recognize emotional and psychiatric problems;
• work out and implement a comprehensive management plan;
• be aware of available resources in the community;
• know when to refer;
• work collaboratively with other mental health providers; and
• keep up-to-date on available treatments.

About four out of every ten people who visit a primary care physician have an identifiable emotional or psychiatric problem. These problems may be due to:
• stress or change in relationships or life circumstances;
• the process of adapting to a physical illness and its consequences; and/or
• acute or ongoing psychiatric disorders.

Many people in Ontario already receive mental health care from their family physician, often without the involvement of any mental health service. This suggests that primary health care groups recognize mental health care as a central component of their services. It also indicates that primary care providers should be linked with/supported by specialized mental health providers.

Primary health care groups should link their enrolled consumers to appropriate community resources, such as self-help groups and other services. Consumers will be able to access these community resources directly, but should be encouraged to work with their primary health care agency to ensure service co-ordination and continuity of care.

8. Co-ordination and Provision of Rehabilitation Services

Primary health care groups will be responsible for ensuring enrolled consumers receive appropriate rehabilitative care. This care is designed to help people recovering from an accident or injury to optimize their physical abilities, return to work or school in a timely way, and to become as self-reliant as possible in activities of daily living.

Primary health care groups will:
• refer consumers to rehabilitation therapists;
• participate in their treatment planning and follow up; and
• provide education and advocacy.
• develop a care map leading to return to function/school/work.

9. Co-ordination of and Referral to Other Health Care Services

Primary health care groups will be responsible for providing primary health care to their enrolled consumers and co-ordinating community, secondary or tertiary care as necessary. In cases where the primary care provider needs advice from a specialist, the family physician or most responsible provider will continue to provide ongoing care in collaboration with the specialist. To ensure primary health care providers remain involved with secondary and tertiary medical care for their enrolled consumers, they will receive copies of all referral correspondence and consultation reports and be consulted when one specialist wishes to refer a consumer to another specialist. This communication gives the family doctor or most
responsible provider opportunities to co-ordinate specialist care with other health care needs as required.

Primary health care providers will refer their enrolled consumers for secondary and tertiary care only when specialized skills and facilities are needed to diagnose, treat and manage an illness. Referral to specialists will be for a consultation or a single episode of illness. For most people referred to specialists, the most responsible provider in the primary health care agency will continue to be responsible for providing their continuing care and monitoring their condition. The specialists' involvement will be determined by the consumer’s needs. It is the responsibility of the most responsible provider to be involved with the specialist care, monitor progress and be available to share in the management of health problems.

10. Support Care in Hospital, at Home and in Long-term Care Facilities

In many communities, primary health care providers will continue to deliver or co-ordinate and monitor hospital care for their consumers. However, the role of primary health care groups in supporting hospital care will vary based on the hospitals' admitting and courtesy privileges. As a minimum, primary health care groups must be involved in pre- and post-hospital care planning (or ensure that it is done) so consumers will know what to expect and can arrange necessary home and family supports. The primary health care group should ensure that consumers being discharged from hospital are linked with community care access centres for home care, and with other community services.

Primary health care groups must play a role in partnership with community care access centres to support the care and treatment of people. Home visits are essential to support hospital restructuring and the shift to community services. Primary health care groups will also visit enrolled clients who live in long-term care facilities.

When distance makes it difficult or impossible for providers to visit consumers at home or in long-term care facilities, they should discuss alternative arrangements with the consumers, such as changing rosters and making greater use of phone assistance and monitoring.

Primary health care groups have a responsibility to:
- develop links with, and make referrals to, community care access centres for home care and to other community services;
- be accessible to liaise and consult with home care providers; and
- share information that will help in overall care planning.
APPENDIX D: IMPLEMENTATION AND MONITORING COMMITTEE

Goal

The Implementation and Monitoring Committee is a time-limited, task oriented group. Its goal is to oversee and coordinate the implementation of the HSRC’s primary health care strategy.

Objectives

- Develop a detailed implementation schedule.
- Establish working groups targeted at specific initiatives including, but not limited to, education.
- Develop criteria for the selection of Primary Health Care Groups (PCGs).\(^{49}\)
- Solicit expressions of interest to establish PCGs according to the timing in the implementation schedule, select the sites and establish mechanisms that will assist sites to establish their practices.
- Develop a registration contract and information systems to support roster management.
- Develop a contractual agreement between PCGs and the payor, which set out expectations and operational standards.
- Identify targets for PCGs in the areas of clinical practice, disease management, population health, access and consumer satisfaction. Incorporate these targets in a system of quality incentives.
- Develop funding mechanisms to guide the funding of PCGs.
- Develop and implement a system to monitor the performance and activities of PCGs. This includes defining useful and accurate consumer-encounter information. The ongoing monitoring function will become the responsibility of the Ministry of Health.
- Develop systems to establish electronic access to drug and lab information.

Membership

The committee will be made up of representatives of the following groups:

- Consumers
- Health care professionals (primary care physicians, specialists, nurse practitioners, nurses, midwives and others, as appropriate)
- Health care management
- Academic health science centres
- District health councils
- Community care access centres
- Public health
- Long-term care
- Ministry of Health (ex officio)

\(^{49}\) Potential criteria could include: 1) underserved areas, as defined by the Ministry of Health, express an interest in setting up a PCG; 2) well established group practices where the group is interested in reconfiguring its structure to meet the requirements of the strategy; 3) an appropriate mix of providers is proposed including nurse practitioners as an intrinsic part of the core team; and 4) an appropriate roster size can be achieved.
Support

The committee will be supported by a secretariat.

Reporting

The committee will report to the Minister of Health

Note:

It is recognized that a great deal of preparatory work has been done in the development of the OMA pilots including a registration contract, contractual agreement and systems to enroll the population. This work should be used by the Implementation and Monitoring Committee to assist them to meet their objectives.
## APPENDIX E: COMPARISON OF PRIMARY HEALTH CARE DELIVERY SYSTEMS AND STRATEGIES

<table>
<thead>
<tr>
<th>Essential elements</th>
<th>Fee-for-service practices (FFS)</th>
<th>Health Service Organizations (HSO)</th>
<th>Community Health Centres (CHC)</th>
<th>OMA Primary Care Pilots (PCN)</th>
<th>Ontario College of Family Physicians (OCFP)</th>
<th>HSRC Primary Health Care Groups (PCG)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollment</td>
<td>Not required</td>
<td>Required for most individuals.</td>
<td>Not required</td>
<td>Voluntary enrolment with physician.</td>
<td>Enrolment with family physician required.</td>
<td>All consumers to be enrolled with primary care physician or nurse practitioner. Those enrolled with a nurse practitioner will co-enroll with a physician in the group.</td>
</tr>
<tr>
<td>Handling of non-enrolled patients, exclusion of patients</td>
<td>Not applicable</td>
<td>For non-enrolled consumers, Ministry of Health allows FFS billing of up to $50K per FTE physician &amp; maximum average of all physicians in an HSO of $30K of FFS billings to non-members.</td>
<td>No consumers refused care, even those without health insurance.</td>
<td>No person refused the opportunity to enroll with a PCN Physician and no person terminated from Enrolled Membership on account of his or her health status or need for health services</td>
<td>No clear policy outlined</td>
<td>No person to be refused enrolment or terminated on basis of health status. Person can be removed from roster for any bona fide reason consistent with proper &amp; ethical medical practice</td>
</tr>
<tr>
<td>Enrolment with whom?</td>
<td>Not applicable</td>
<td>Roster to HSO but individuals are associated with physician sponsors. Payment and responsibilities with the HSO</td>
<td>Not applicable</td>
<td>With physician</td>
<td>With family physician</td>
<td>With primary care physician or nurse practitioner. Enrolment with nurse practitioner requires co-enrolment with family physician.</td>
</tr>
<tr>
<td>Defined range</td>
<td>Not defined</td>
<td>Services are not specifically</td>
<td>No mandatory services</td>
<td>Required services: PCCCAR basket of</td>
<td>Adapted from PCCCAR</td>
<td></td>
</tr>
</tbody>
</table>

Adapted from PCCCAR
<table>
<thead>
<tr>
<th>Essential elements</th>
<th>Fee-for-service practices (FFS)</th>
<th>Health Service Organizations (HSO)</th>
<th>Community Health Centres (CHC)</th>
<th>OMA Primary Care Pilots (PCN)</th>
<th>Ontario College of Family Physicians (OCFP)</th>
<th>HSRC Primary Health Care Groups (PCG)</th>
</tr>
</thead>
<tbody>
<tr>
<td>of services</td>
<td>defined, however the objectives are to:</td>
<td>defined, however, a strong emphasis on the determinants of health. CHCs have a wide range of services depending on the population being served including diagnosis and treatment.</td>
<td>- Health assessment - Diagnosis &amp; treatment - Primary reproductive care - Primary palliative care - Primary mental health care - Access to obstetrical &amp; newborn care - Service coordination, where possible - episodic care - Access to hospital care &amp; coordination, where possible - Patient education &amp; preventive health care - Appropriate periodic health assessments - On-call coverage/after-hours coverage services: 1. Health assessment 2. Illness prevention and health promotion 3. Diagnosis and treatment of episodic illness 4. Primary reproductive care 5. Palliative care 6. Primary mental health care 7. Coordination and access to rehabilitation (i.e. referral or direct provision of rehabilitation services) 8. Service coordination and referral (e.g. long term care, home care, specialists etc.) 9. Access to hospital care and coordination 10. Patient education and support for self-care 11. Advocacy</td>
<td>basket of services: 1. Health assessment 2. Illness prevention and health promotion 3. Education and support for self-care 4. Diagnosis and treatment of episodic and chronic illness and injuries 5. Primary reproductive care 6. Palliative care 7. Primary mental health care 8. Coordination and provision of rehabilitation services 9. Co-ordination of and referral to other health care services 10. Supportive care in hospital, at home and in long-term care facilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24-hours-a-day, 7-days-a-week coverage and extended</td>
<td>Not required</td>
<td>Required but may take many forms including contracting FFS physicians.</td>
<td>Arrangements for 24/7 required but these are inconsistent. I.e. may mean access to PC</td>
<td>Weeknight coverage must be available in at least one PCN location from 5 p.m. to 9 p.m. Weekend hours</td>
<td>Required for urgent care</td>
<td>Access to PC services 24-7.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Tele-triage system available 24-7 for advice and to direct</td>
</tr>
<tr>
<td>Essential elements</td>
<td>Fee-for-service practices (FFS)</td>
<td>Health Service Organizations (HSO)</td>
<td>Community Health Centres (CHC)</td>
<td>OMA Primary Care Pilots (PCN)</td>
<td>Ontario College of Family Physicians (OCFP)</td>
<td>HSRC Primary Health Care Groups (PCG)</td>
</tr>
<tr>
<td>-------------------</td>
<td>---------------------------------</td>
<td>-----------------------------------</td>
<td>-------------------------------</td>
<td>-------------------------------</td>
<td>------------------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>hours</td>
<td></td>
<td>through emergency departments after hours.</td>
<td>determined by practice type &amp; population need. After hours telephone triage to achieve 24-hour access to health care</td>
<td>calls to most appropriate service.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Inter-professional provider groups**

FFS funding does not lend itself to the inclusion of other professions. Employing other health professionals may only be feasible in large group practices with pooling of incomes.

Institutional Substitution Program (ISP) grants available to fund PC services not already funded in MD cap. These may include non-MD provider programs such as nutrition counselling and chiropody services.

Inter-professional care providers are a key feature of CHCs. (e.g. MDs, NPs, social workers etc.)

No stated role for other providers except MDs. Opportunities for NPs in globally funded groups if allowed enrolment size is increased from 2,200 per MD to 3,000.

OCFP endorses a collaborative practice model between physicians and nurse practitioners.

The OCFP recognizes that other professionals have a role in the delivery of primary care as well.

Enhanced role for nurses and nurse practitioners since consumers can enroll with an NP. Minimum of one NP required within the Core Team.

Additional professionals will be determined by the defined range of primary care services. These will include RNs, probably social workers and midwives, and possibly professionals such as physiotherapists, dieticians or psychologists.

**Group practices (networks)**

Not required. Approximately 40% of PC MDs are in solo practice. Many MDs in group practice are organized as office sharing arrangements.

Not required.

True group practices

Primary care reform pilots are either organized as group practices in a single site or as electronically linked networks.

Size of group varies.

PCNs comprised of 7 to 30 family physicians.

Allow for formal group practices or practice networks (virtual groups).

Integration of PC groups or networks with the use of Family

Enhanced role for nurses and nurse practitioners since consumers can enroll with an NP. Minimum of one NP required within the Core Team.

Additional professionals will be determined by the defined range of primary care services. These will include RNs, probably social workers and midwives, and possibly professionals such as physiotherapists, dieticians or psychologists.

Encourages true group practices through location on a single site.

Only for remote PCGs where co-location may not be feasible due to low population density and distance, will groups be located at different sites.
<table>
<thead>
<tr>
<th>Essential elements</th>
<th>Fee-for-service practices (FFS)</th>
<th>Health Service Organizations (HSO)</th>
<th>Community Health Centres (CHC)</th>
<th>OMA Primary Care Pilots (PCN)</th>
<th>Ontario College of Family Physicians (OCFP)</th>
<th>HSRC Primary Health Care Groups (PCG)</th>
</tr>
</thead>
</table>
| rather than true group practices⁵⁰. | Practice facilitator (1 per 50-60 MDs). The facilitator would integrate groups with the broader health care system, encourage QI & collaborative relationships. Facilitators may be chief of staff in local hospital. Facilitator may be part of a regional network. | Not formally required. Negation is an incentive to provide full range of high quality care. | CHCs in the process of installing an information system which will facilitate quality improvement efforts | Financial rewards to individual MDs for achieving health targets. | OCFP recommends a “report card” to the community on its health status as method of assessing effectiveness of care being delivered by group. | • Implementation & use of clinical pathways, protocols and guidelines  
• Identify indicators and develop mechanisms to report to the public on an ongoing basis  
• Continuing education  
• PCGs required to monitor and evaluate their effectiveness and efficiency on an ongoing basis  
• Establishment of mechanisms for continuous quality improvement and participation in external quality assurance programs and audits |

Accountability Reporting on Required to submit monthly Standard reporting to Contractual arrangement Accountability to Accountability of PCGs to:

<table>
<thead>
<tr>
<th>Essential elements</th>
<th>Fee-for-service practices (FFS)</th>
<th>Health Service Organizations (HSO)</th>
<th>Community Health Centres (CHC)</th>
<th>OMA Primary Care Pilots (PCN)</th>
<th>Ontario College of Family Physicians (OCFP)</th>
<th>HSRC Primary Health Care Groups (PCG)</th>
</tr>
</thead>
<tbody>
<tr>
<td>mechanisms</td>
<td>patients and procedures necessary for reimbursement.</td>
<td>service encounter reports to MoH (failure to do so may result in financial penalty). Monthly roster change information is also required.</td>
<td>MOH.</td>
<td>between PCN &amp; MoH. Reports on client-based encounters submitted to MoH monthly. Failure to report may result in financial penalty. Registration contract between PCN and consumer.</td>
<td>community through report cards. “Patient choice” (registration) outlines responsibilities of MD &amp; consumer.</td>
<td>• Payor through defined reporting requirements re: costs, utilization, quality of services, population health outcomes. • Registered population for provision of contractual services, health outcomes &amp; satisfaction. Reports on client-based encounters submitted to MoH monthly.</td>
</tr>
<tr>
<td>Governance and organization</td>
<td>No specific governance arrangements required. A number of organizational models possible.</td>
<td>71 HSOs are physician-sponsored (i.e. Owned &amp; operated by MDs) 2 HSOs have community boards, i.e. are sponsored by non-profit corporations 4 HSOs are sponsored by health science centres and are therefore accountable to the hospital board</td>
<td>CHCs are non-profit organizations governed by community boards.</td>
<td>All PCNs to establish and maintain a written governance structure. Possible organization models include corporations, partnerships and unincorporated associations.</td>
<td>Primary care groups to be part of larger regional health care delivery networks. No specific recommendations for governance.</td>
<td>In short term, PCGs establish arrangements to support the development of policies &amp; strategic directions to guide the operations of the PCGs, including mechanisms to obtain input from the enrolled population. In long-term, PCGs should consider establishing more formal mechanisms such as governing boards that are made up of members of the enrolled population. PCGs to be organized as non-profit organizations.</td>
</tr>
<tr>
<td>Essential elements</td>
<td>Fee-for-service practices (FFS)</td>
<td>Health Service Organizations (HSO)</td>
<td>Community Health Centres (CHC)</td>
<td>OMA Primary Care Pilots (PCN)</td>
<td>Ontario College of Family Physicians (OCFP)</td>
<td>HSRC Primary Health Care Groups (PCG)</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>---------------------------------</td>
<td>-----------------------------------</td>
<td>--------------------------------</td>
<td>--------------------------------</td>
<td>-----------------------------------------------</td>
<td>--------------------------------------</td>
</tr>
</tbody>
</table>
| Information management      | Not required but some solo MDs & group practices have set up their own systems. | Not required but large HSOs have information systems (e.g. SSM Group Health) | Currently limited but being improved through standard electronic information system. | Each pilot site to have a Clinical Management System which includes:  
  • Electronic patient record  
  • Medication mgmt  
  • Lab test results delivery  
  • Preventive screening  
  • Enrolment  
  • Payment  
  • Practice mgmt functions  
  • Linkages to telephone health advisory system  
  • LAN/communications security | All members of group to share an electronic health records system which would include a record of any health care received (e.g. LTC, ER, specialists, community-based) | Basic information required for determining health status & the health care requirements of the registered population. Eventually, participants in PCGs should have access to:  
  • On-line consumer-specific drug & lab info (for providers)  
  • Tele-triage  
  • Tele-health (consumer information) |
| Communication & co-ordination | No formal requirements          | No formal requirements            | No formal requirements        | PC reform to provide incentives for coordination. For example:  
  • Team consultation & home care supervision fees  
  • Institutional Substitution Program funding (similar to HSOs) to be explored | MD to provide co-ordination for LTC, ER, specialists etc. |  
  • PCG maintains comprehensive medical record  
  • Agreements be developed for full continuum of services  
  • Standard communication & transfer protocols  
  • Clinical pathways & care maps. |
<table>
<thead>
<tr>
<th>Essential elements</th>
<th>Fee-for-service practices (FFS)</th>
<th>Health Service Organizations (HSO)</th>
<th>Community Health Centres (CHC)</th>
<th>OMA Primary Care Pilots (PCN)</th>
<th>Ontario College of Family Physicians (OCFP)</th>
<th>HSRC Primary Health Care Groups (PCG)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital appointments for MDs</td>
<td>Not required</td>
<td>Not required</td>
<td>Not required</td>
<td>Not required</td>
<td>MDs need to be an active or associate member of the medical staff of local hospital</td>
<td>Recommended</td>
</tr>
</tbody>
</table>
| Funding | FFS Sessional payments | Capitation funding (average $137 per person) Institutional Substitution Program Grants available as well Each MD can bill max. of $30K FFS | Globally funded Providers are salaried employees of CHC. | 2 Funding methods: 1. Global capitation Similar to HSOs 2. Reformed FFS including 5 additional fee codes. | Allow for a variety of MD payment methods but recommend Blended Funding. Blended funding includes 4 components (base, overhead costs, non-volume modifiers, volume modifiers) | Funding is provided to the PCG and can include three components:  
  - population-based funding to pay for mandatory primary health care functions;  
  - funds for services that are not included in population-based funding, specifically obstetrical deliveries, emergency department work, anaesthetic services, surgery assists, and visits to homes, hospitals and long-term care facilities; and  
  - funding for enhanced services and program beyond the mandatory functions, that address services for priority groups or those difficult to register (e.g., the socially and |
<table>
<thead>
<tr>
<th>Essential elements</th>
<th>Fee-for-service practices (FFS)</th>
<th>Health Service Organizations (HSO)</th>
<th>Community Health Centres (CHC)</th>
<th>OMA Primary Care Pilots (PCN)</th>
<th>Ontario College of Family Physicians (OCFP)</th>
<th>HSRC Primary Health Care Groups (PCG)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size of practice</td>
<td>Not limited</td>
<td>Maximum 2,500 per FTE M.D.</td>
<td>Variable</td>
<td>Maximum 2,200 per FTE M.D.. With the addition of a nurse practitioner, roster can be increased to 3,000. Exceptions include rosters rolled over from HSOs &amp; FFS MDs who have had more patients in their current practice. MoH planned for PC networks of 15 to 20 MDs but have approved smaller groups.</td>
<td>PC practice networks with 7 to 30 physicians. No discussion of enrolled population size.</td>
<td>Number of enrolled individuals per provider depends on practice setting: Urban 1,874 Rural 1,331 Remote 1,178 Core teams of 4 to 8 providers.</td>
</tr>
<tr>
<td></td>
<td>Average patients per GP/FP: 1,036</td>
<td>Average: 1,900 rostered per MD</td>
<td>No solo practice CHCs, however, one CHC in province with no MDs.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incentives</td>
<td>Service volumes</td>
<td>Incentive for keeping rostered patients out of hospital were provided Ambulatory Substitution Care Plans (ACIPs) by MoH. These were discontinued</td>
<td>None</td>
<td>Allowance for computer systems. Incentives for achieving health targets.</td>
<td>None specifically recommended. Maximum incentives of 20% to the group for achieving performance targets. The group will be responsible for allocating the incentive to the team.</td>
<td></td>
</tr>
<tr>
<td>Negation</td>
<td>Not applicable</td>
<td>Yes for use of FFS services outside HSO. Negation is equal to 50% of actual cost of care.</td>
<td>Not applicable</td>
<td>Negation included in Global Capitation funded groups for outside PCN use of medical services. Negation is equivalent to 100% of the actual cost of the service. Use of primary care services through hospital emergency departments and outside the geographic region is not negated.</td>
<td>Nothing recommended. OCFPs allows for a variety of funding models.</td>
<td>Negation to be equivalent to 100% of the actual cost of the service. Use of primary care services through hospital emergency departments and outside the geographic region is not negated. PCGs will be provided with feedback regarding outside use of primary care services by the enrolled population. PCGs will not be negated.</td>
</tr>
<tr>
<td>Essential elements</td>
<td>Fee-for-service practices (FFS)</td>
<td>Health Service Organizations (HSO)</td>
<td>Community Health Centres (CHC)</td>
<td>OMA Primary Care Pilots (PCN)</td>
<td>Ontario College of Family Physicians (OCFP)</td>
<td>HSRC Primary Health Care Groups (PCG)</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>---------------------------------</td>
<td>-----------------------------------</td>
<td>--------------------------------</td>
<td>--------------------------------</td>
<td>---------------------------------------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>Scope of implementation</td>
<td>FFS is the most common system</td>
<td>77 HSOs in existence.</td>
<td>57 CHCs in the province.</td>
<td>Very limited 8 sites approved. To date, 2 up and running. OMA’s strategy is to wait for full evaluation before recommending broader implantation.</td>
<td>Province-wide implementation.</td>
<td>Provincial. Staged with 5-year implementation plan.</td>
</tr>
<tr>
<td></td>
<td>Accounts for 86% of income for MDs</td>
<td>No new HSOs approved since 1990</td>
<td>Since April 1999 new CHCs have been announced for Waterloo, Grand Bend, Crysler and Ottawa.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Approximately 4% of PC physicians practice in HSOs</td>
<td>6% of PC physicians practice in CHCs.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---
### APPENDIX F: COMPARISON OF THE HSRC’S GOALS OF PRIMARY HEALTH CARE AND THE ESSENTIAL ELEMENTS OF THE STRATEGY

<table>
<thead>
<tr>
<th>Goals of Primary Health Care</th>
<th>Essential Elements of the Primary Health Care Strategy That Support the Goals</th>
</tr>
</thead>
</table>
| To empower consumers to take an active role in their health and health care | • Enrollment  
• Defined basket of primary health care services  
• Services accessible 24-hours-a-day, 7-days-a-week  
• Inter-professional providers  
• Information management  
• Mechanisms to co-ordinate care  
• Education  
• Primary health care group practices |
| To promote high quality care | • Mechanisms to ensure accountability  
• Inter-professional providers  
• Population-based funding  
• Information management  
• Enrollment  
• Defined basket of primary health care services  
• Mechanisms to co-ordinate care  
• Primary health care group practices |
| To provide ready access to primary health care services | • Inter-professional providers  
• Defined basket of primary health care services  
• Mechanisms for coordination of care  
• Population-based funding  
• Primary health care group practices  
• Services accessible 24-hours-a-day, 7-days-a-week |
| To enhance the continuity and coordination of primary with other levels of health care services | • Enrollment  
• Inter-professional providers  
• Defined basket of primary health care services  
• Mechanisms for coordination of care  
• Information management  
• Primary health care group practices  
• Services accessible 24-hours-a-day, 7-days-a-week |
| To facilitate the efficient and appropriate use of human and financial resources | • Enrollment  
• Multidisciplinary provider group practices  
• Defined basket of primary health care services  
• Mechanisms for coordination of care  
• Information management  
• Appropriate funding system  
• Mechanisms to ensure accountability |
| To provide accountability for the accessibility, quality and cost effectiveness of primary health care services | • Enrollment  
• Defined basket of primary health care services  
• Services accessible 24-hours-a-day, 7-days-a-week  
• Information management  
• Appropriate funding system  
• Mechanisms to ensure accountability |