PRIMARY CARE GOVERNANCE IN KW4 OHT REGION

July 18th, 2023

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Contents

Introduction 2
State of Primary Care Networks 3
The Assignment 4
Defining Primary Care and Primary Care Networks 4
Process 5
What We Heard 5
Why a PCN? 5
Who – in terms of providers - should be included in KW4 OHT PCN? 6
How best to organize the PCN? 7
Conclusions 7
KW4 Characteristics 7
Collaboration/Membership 8
Preferred Corporate Model 8
A Path Forward for KW4 OHT and Working Toward a PCN 9
Recommendations 11

Introduction

Ontario is building a connected health care system centered around patients, families, and caregivers. Ontario Health Teams (OHTs) are being introduced to provide a new way of organizing care that is more connected to patients and their local communities. The goal is to ensure that everyone in Ontario can benefit from better coordinated, more integrated care.

The Kitchener, Waterloo, Wilmot, Woolwich, and Wellesley Ontario Health Team (KW4 OHT) is a collective of over 40 member organizations including primary care, home care, hospitals, community agencies, long-term care, mental health, Indigenous health, municipalities, and post-secondary education. OHTs typically strive to integrate care provided by organizations such as community care organizations, hospitals, home care providers, long-term care providers, mental health and addictions and primary care providers.

The KW4 OHT encompasses the communities of Kitchener, Waterloo, Wilmot, Woolwich and Wellesley (a.k.a. "KW4") in the west region of Ontario. In its final submission to the Ministry of Health, the KW4 OHT seeks to provide integrated health services for approximately 400,000 residents in KW4 as well as approximately 56,000 others who live outside the KW4 geographic area but receive their care within the boundaries of KW4.[1] The attributed population is roughly split into 80% urban and 20% rural.[1]

Together with patients and families, the KW4 OHT is working towards co-designing a health and wellness system that offers seamless, interconnected care, and continuity across providers. The KW4 OHT has set short term objectives and identified its' priority populations including newcomers; residents living in priority neighbourhoods who are disproportionately impacted from a health and social determinants of health perspective and the frail elderly.

Experience worldwide has shown that effective primary care is a requirement in a successful integrated health system. One way health systems have organized primary care providers is by networks. The Primary Care Network (PCN) model is in its' infancy in Ontario and several regions in the province are experimenting with them. Ontario Health Teams across the province vary greatly, including in population size, urban/rural mixes, population densities, etc., so it is not surprising they have different means to organize primary care. In the north, they have a higher percentage of organized primary care under the Family Health Teams (FHT) model and Nurse Practitioner Led Clinics (NPLC) and less dependence on solo/group family practices. In large urban areas, there is more reliance on solo/group family practices and less on FHTs and NPLCs.

[1] Statistics sourced from the KW4 OHT Application. Access via: chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.kw4oht.com/_files/ugd/892206_41e4a0279ce543b18c6f1597c79fc404.pdf

Community Health Centres (CHC) are designed to serve a defined population are largely located in urban centres based on who they are serving. Based on INSPIRE data[2], 87% (337,454) of KW4 OHT's attributed population is attached to primary care. The breakdown of attached patients in the various enrollment models is as follows:

- 10,971 (3.3%) EFFS - Enhanced-Fee-For Service
- 252,695 (74.9%) CAP - Capitation
- 59,335 (17.6%) FHT - Family Health Team
- 8,544 (2.5%) NOG - Not in a primary care enrolment model
- 5,868 (1.7%) NOP - No primary care
- 42 (0.01%) OGP - Other primary care model

State of Primary Care Networks

In Ontario, primary care providers are largely organized in loosely associated networks with a small number of formal networks. Scarborough and East Toronto OHTs have incorporated as not-for-profit organizations for primary care in their respective OHTs (Scarborough Family Physicians Network and East Toronto Family Practice Network). Mississauga Health OHT has an informal association representing approximately 700 primary care physicians who care for approximately 940,000 patients (Mississauga Health Primary Care Network). The West Toronto OHT is in the development phase of organizing primary care physicians into a network. Halton region has organized physicians into an association (Halton Physicians Association) and is working with Connected Care Halton Ontario Heath Team. Network membership consists almost exclusively of General Practice/Family Practice physicians (GP/FP) who practice in primary care; however, they consider nurse practitioners (NP) and physician assistants (PA) as potential members of the network.

In Ontario the government, in its *Your Health - A Plan for Connected and Convenient Care* document, stresses the value of and support for family physicians and primary care providers as follows:

> "Primary care and family physicians are the foundation of our health care system in Ontario. To create a connected health care system for you through Ontario Health Teams, we are supporting collaboration and engagement with our primary care providers across the province through the creation of primary care networks. Every Ontario Health Team will include a group of primary care providers organized in a network to be part of decision-making and to improve access to care for patients."

The government further reinforced the direction in its *Ontario Health Teams – A Path Forward* document as follows:

[2] KW4 statistics sourced from https://www.ontariohealthprofiles.ca/ontarioHealthTeam.php

> "The Ministry recognizes the valuable role that primary care can play in OHTs. Many OHTs have made strides in creating structures and processes to ensure primary care has a strong voice within OHT decision-making and leadership structures. However, we know more can be achieved to ensure this foundation is strengthened. The Ministry and Ontario Health will work to support greater primary care involvement in OHTs including more consistency in how they are involved in OHT decision-making."

The Assignment

The over 40 organizations who make up the KW4 OHT signed a formal collaboration agreement to collectively work on the challenges in the KW4 region. They established a Steering Committee to guide the work, made up of a mix of provider organizations, including the Centre for Family Medicine, and community members. The KW4 OHT Steering Committee set a goal to increase physician engagement in it's OHT decision-making process and established a strategy to achieve that goal. The strategy includes the development of a collective physician voice at the OHT's regional table (which will eventually replace the current Steering Committee) and the goal for developing a Primary Care Network. One of the projects they approved was to investigate the potential for a primary care network, what it would look like, and what steps are necessary to achieve the establishment of a network for the KW4 OHT. The KW4 OHT contracted LBCG Consulting for Impact to engage the primary care community to complete this assignment.

Defining Primary Care and Primary Care Networks

Primary care has been defined in a variety of ways in the literature. For this report, we have chosen the World Health Organization's definition of primary care as **a model of care that supports first-contact, accessible, continuous, comprehensive and coordinated person-focused care.** The element of "first-contact" with the health care system separates this care from other models of care such as acute care. The definition supports the Ontario College of Family Physicians' (OCFP) desired end-state Patient's Medical Home Model for primary care as well as the PCN Implementation Blueprint authored by Association of Family Health Teams Ontario, Section of General and Family Practice and OCFP.

PCNs are not as clearly defined as primary care. A general description of a primary care network is an organizational structure that brings primary care colleagues together on an area basis to work on their collective challenges with the overall goal to improve care for the patients they serve. In Canada, provincial governments have defined PCNs in different ways. For example, British Columbia and Alberta associate PCNs with team-based care and provide funding based on a contract with the government. In Ontario, the government has allowed local OHTs to determine how to engage primary care

providers to create a PCN, with primary care being a part of the decision-making process going forward.

Process

With the help of the KW4 OHT staff and the Primary Care Leadership Council, a small working group (Team) of interested primary care providers was organized and volunteered their time for this project. The providers included general practitioners/family practitioners, medical specialists, nurse practitioners, midwives, and primary care administrators. Everyone who participated had an opportunity to express their opinions and advice throughout the project process.

The Team participated in a series of four themed meetings to obtain their feedback on specific topics. Themes included:

1. What is a PCN and what would it look like in KW4?
2. What are the potential principles and goals for a PCN and what are the challenges in primary care?
3. Who might be included in the KW4 OHT's PCN and what is the call to action for a PCN in KW4?
4. How might a PCN be formally organized in KW4?

The Team supported a survey of primary care providers to gain a broader perspective of what challenges might arise in organizing a PCN. The Team helped develop the questions as well as aided in distribution to existing professional networks. Follow-up activities were targeted to specific professions to ensure there were opportunities for these stakeholder groups to provide their feedback.

Finally, the KW4 OHT supported an open-invitation in-person townhall meeting where participants were given the opportunity to provide their feedback on the overall concept of a PCN. The open call outreach for attendees resulted in 58 RSVPs and 38 attendees from a broad spectrum of stakeholders including primary care physicians, nurse practitioners and those who work in primary care settings including medical specialists, social workers, mental health and addiction counsellors, as well as university primary care program educators.

What We Heard

Why a PCN?

Overall, we heard some very strong support for a PCN for the KW4 OHT. There were three prevailing elements to that support:

1. A desire to have a strong unified or a single voice that speaks on behalf of and advocates for primary care.

2. That primary care should be an effective voice at the table for KW4 decision-making in health care.
3. To deal with the inequities that already exist in the distribution of resources (the "haves" vs. the "have-nots") in terms of access to team-based resources in primary care.

We heard that many of the challenges in primary care would benefit from an organized approach. For example:

- Access to specialists needs to be streamlined for some specialties and better coordination for patients who are needing services outside primary care.
- A single medical record for patients would help in improving coordination and efficiency in an integrated KW4 health system.
- The challenge of hiring and retaining both clinical staff and operational support staff would be improved with a KW4 approach to prioritizing where people are needed most.

Communication is an issue in primary care. There is more than one channel for providers to communicate and they appear to be ineffective at cross sectoral communications. For example, a recent communication from Public Health about vaccine distribution was received by some clinics and physicians and not others. A common and complete distribution system would be helpful and resolve some of these inconsistencies.

Who – in terms of providers - should be included in KW4 OHT PCN?

The Team discussed this on many occasions. The Team took several ideas into consideration, for example:

- who would **benefit from** such an organization, such as the OHT and patients in the region, in addition to all providers.
- who would be of **benefit to** the organization (i.e., be critical contributors), and
- how the people in the organization would affect other organizations the PCN wants to influence?

The Team discussed and weighed the advantages and disadvantages of having a broader network of health professionals versus focusing on a primary care only (or physician only) network. In the end, they decided that a balance between allowing for inclusivity in the network and some level of control to ensure that the membership remains focused on the practical purpose of the organization to be the one voice for primary care. It was clear that the providers who have first contact with patients are to be included in a new PCN. GP/FPs, NPs, midwives, PAs and other allied health professionals who practice in primary care would be eligible for membership in a PCN. This criterion would give strength to the argument for a single voice and collective thinking around primary care. The Team wanted to be inclusive and decided they would

encourage other professionals to join on an individual approval basis. There are some medical specialists who practice entirely in the community, for example, respirologists and gerontologists, and they would be eligible to apply for membership in the network.

The Team also discussed the concept of a "provider care network" where membership would be open to all providers who wish to join. In the short term, it was suggested that it might be too complicated to start such a network with so many different priorities based on who might join. The Team wanted the discussions to be focussed on primary care and not diluted with other provider priorities in the short term. There was thought given to the idea that, in the longer term, it might be desirable to have the collective influence of all providers in one organization on a KW4 basis, which the Team will continue to consider.

How best to organize the PCN?

The Team considered five different models to organize a PCN for the KW4:

i. Informal association
ii. Association with a Collaborative Decision-Making Agreement
iii. General partnership
iv. Not-for-profit corporation
v. For profit corporation

The discussion began with an understanding of what each of these organizational models mean and how they differ. Some members of the Team were more familiar with the not-for-profit model as they work in FHTs, NPLCs or CHCs and it is the most common model in the Ontario health care system including hospitals, community mental health agencies and some home support agencies. The relative ease to start each model, their familiarity, their potential relationship to other OHT members and the ability to hold and be accountable for government and/or Ontario Health (OH) funds were all aspects they considered when they decided to support the Not-for-Profit Corporation.

Conclusions

KW4 Characteristics

The KW4 region is different from those that have achieved formal networks to date. KW4 clinicians are highly collaborative and have a history of working well together. There have been many steps taken to increase integration in the OHT, such as implementation of a successful Health Links program. The 80% urban / 20% rural presents a different challenge as providers are more dispersed in rural areas. The thriving NPLCs and CHCs in the region provide care for both the uninsured as well as specific populations which also set them apart from the urban centers that already have PCNs. The urban PCNs that have a formal structure do not have NPLCs in their

catchment area. A challenge the KW4 shares with many urban centers is the growing immigrant population as they require access to translation services for optimal health care delivery and may have cultural norms that are different and impact traditional health care delivery in our communities.

Collaboration/Membership

We heard very strong opinions on how the providers want to work and they all support a collaborative model. The providers who participated expressed that they appreciate opportunities to develop meaningful, lasting relationships with their colleagues and want a PCN model that supports this. A model that facilitates regular interactions with the same people for long periods enables relationship building with stronger communication practices for the regular and effective flow of information between parties. They want a model that is inclusive, includes all professionals who have first contact with patients. Whereas some PCNs that have a formal organization are focused on GP/FPs and may include NPs; the KW4 Team and stakeholders expressed interest in pursing a much broader approach that includes GP/FPs, NPs, midwives, PAs along with some medical specialties, such as gerontology and respirology, as well as social workers and other mental health professionals. Participating providers felt it would be more positive to include everyone who has an interest instead of excluding potential members from the outset. The challenge is that providers also want the model to be focussed on primary care so there will need to be a process where the boundaries of its mission and mandate are made clear.

Preferred Corporate Model

The most influential factors for choosing a not-for-profit model for the PCN were the relative strength to convey the “one voice for primary care” and to be on even ground with other players in the OHT. The ability to hold and be accountable for funding was secondary at this time as it is unknown whether the government/OH will provide funds for services to PCNs.

The not-for-profit model supports the aims of the organization that were expressed including working towards:

- being knowledgeable and relevant together,
- achieving a single medical record for all patients,
- integrated and streamlined care,
- decreasing administrative burden,
- increasing provider awareness of the services that are in the OHT,
- having “clean” (i.e., organized and easily actioned) and reliable data for primary care,

- an agile organization that seeks to collaborate with specialists to achieve smoother transitions and more effective integration.

While the KW4 OHT is being instrumental in pursing the development of a regional PCN, the intent is for the prospective PCN to be a separate entity from the OHT. It would not report to the KW4 OHT or KW4's Board.

The PCN will need to have a standing member on the KW4 OHT Board to ensure that the primary care voice is heard at the OHT.

As a separate entity, the PCN should have independent funding from Ontario Health to resource their capacity.

A Path Forward for KW4 OHT and Working Toward a PCN

There is a strong interest in establishing a PCN in KW4. However, there is more work to do to achieve the goal of creating a PCN. Momentum has been built with the work of the Team and KW4 OHT members that should be continued. There is a cadre of people who understand the value of a "single voice" for primary care and how that will influence health care decision-making in the future. Not everyone is convinced that this is different from other efforts to improve integration in the past; however, more and more people are seeing the potential value.

The survey suggested that 70% of respondents were not aware of what a PCN was so it is clear much more communication is necessary. KW4 OHT needs to increase the awareness of the value of a PCN to all primary care providers. The Team suggested they should use the various channels available to communicate with known primary care providers. Also, suggested advertisements through brochures and other printed material should be considered. KW4 OHT must seek continuous opportunities to engage the primary care sector with webinars, in-person events, and updates through their regular newsletters.

As previously mentioned, this initiative has developed a cadre of people who understand what a PCN could achieve. KW4 OHT should consider this group as ambassadors for developing a PCN. They should be involved with the development process and can answer other people's questions. Their personal networks are going to be key to spreading positive messages to other primary care providers. The ambassadors may also help with the content of the communications from the KW4 OHT; they know what resonates with providers and what doesn't.

The KW4 OHT should set goals in terms of timelines for achieving a PCN. There are many steps to achieving the goal including:

a) Establish a formal PCN Development Committee, tasked with the development of a not-for-profit corporation entity for the PCN. The committee should comprise of primary care providers who practice in the region, have established a level of

knowledge of the process and credence with their colleagues. The Committee must include GP/FPs, NPs and may include midwives, PAs and other professionals including specialists. The Committee should include “community members” who have specific expertise in government/agency relations, accounting, not-for-profit governance and legal services.

b) Set up a website to promote awareness, access of information and document the PCN development process. Important items to make available online include information on what a PCN is, what its role might be, who will be included, how to get involved, communications and up-to-date status reports on the development process.

c) Conduct a preliminary membership interest drive, with the goal of achieving over 50% of the potential membership. The first step is to establish who is the target population for the PCN. This is a more complex exercise than one might anticipate given the experience from other jurisdictions. The Team has established good knowledge of the target group of professionals, but it needs to be formalized into an official list with contact information. The second step is to send out a letter requesting their level of interest from the target group and ask that letter be signed and send back to the organizing committee. Some provider groups may be more readily mobilized than others, exceeding the 50%, whereas other groups may not reach the target. This early identification will help prioritize where outreach efforts will need to be focused for success during the full membership drive.

d) Draft mission, vision and values for the organization. This can be led by the PCN Development Committee and validating through engagement with the preliminary membership body.

e) Engage legal council to assist in drafting by-laws for the not-for-profit corporation.

f) Conduct a full membership drive including signed membership forms and vote to appoint officers of the corporation based on the by-laws noted above.

As this is a volunteer commitment for the primary care providers who step up to work on these tasks, it is very important for KW4 OHT to support this work on multiple fronts such as with financial, communication, information technology and project management resources. Consideration should be given to compensating the people who take leadership roles in this endeavour.

Recommendations

- KW4 OHT should establish a formal committee tasked with the development of a not-for-profit corporation for a PCN.
- Membership for PCN for the KW4 region should be inclusive of all professionals who have first contact with patients. This includes, but is not limited to GP/FPs, NPs, midwives, PAs along with some medical specialties, such as gerontology and respirology, as well as social workers and other mental health professionals. Given that an inclusive membership approach is being recommended, this put increased importance in defining clear boundaries of the PCN's mission and mandate to maintain the focus on primary care.
- KW4 OHT should set up a website for the PCN development with information on what a PCN is, what its role might be, who will be included, how to get involved, communications and up-to-date status reports on the development process.
- KW4 OHT should support an early membership interest drive with all necessary communication materials to get an early gauge on how much work will be necessary to move forward with the development of a PCN.
- KW4 OHT should seek every opportunity to engage primary care providers in discussions, events, and communications on the value of a PCN for KW4 OHT.
- As separate entity, the PCN should have independent funding from Ontario Health to resource their capacity.