

# Patient Medical Neighbourhoods in Primary Care: Expanding Access to Patient Medical Homes across Ontario

October 25, 2017

AFHTO Conference



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**Dr. Walter Wodchis**, Principal Investigator, Health System Performance Research Network, and Faculty, Institute of Health Policy, Management and Evaluation, University of Toronto



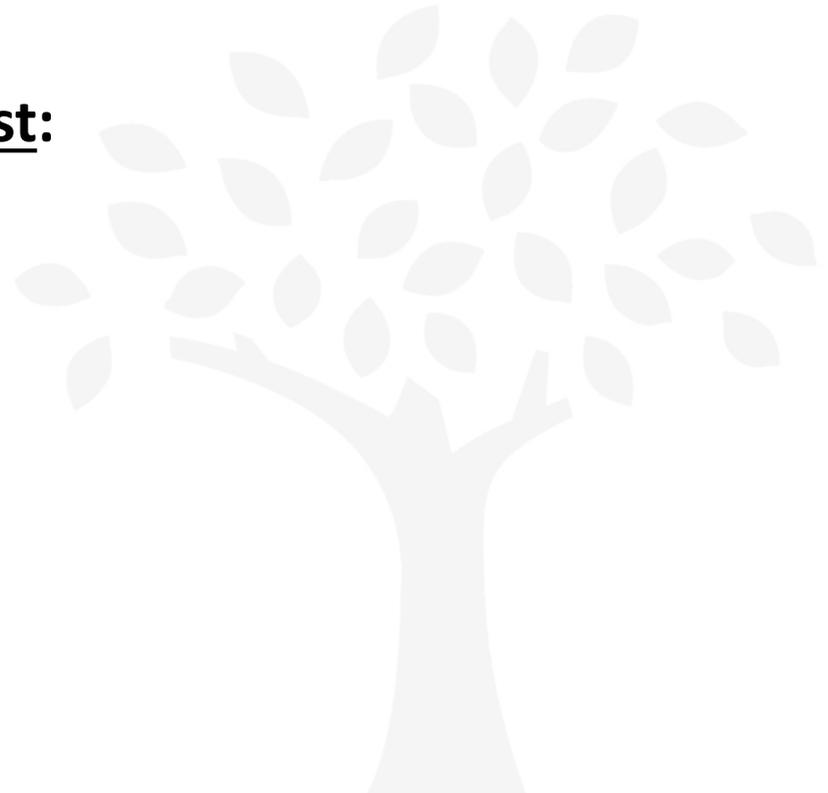
# Presenter Disclosure

- **Presenters: Dr. Elizabeth Muggah**
- **Relationships with commercial interests:**
  - **Grants/Research Support: None**
  - **Speakers Bureau/Honoraria: None**
  - **Consulting Fees: None**
  - **Other: None**



# Disclosure of Commercial Support

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# Mitigating Potential Bias

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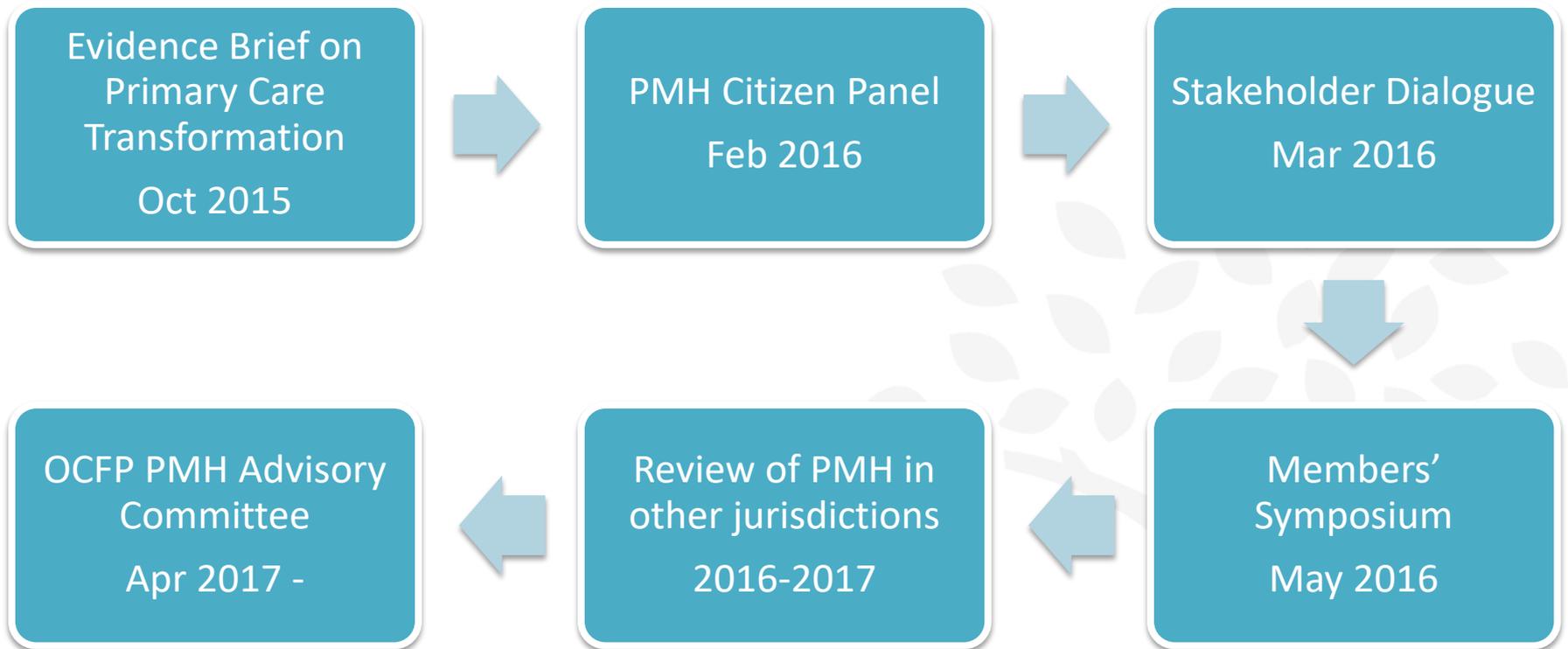


# Learning Objectives

1. Determine how the PMH concept can be implemented in your team
2. Identify tools and resources to support population-based planning with other practices in your PMH neighbourhood
3. Determine the role a FHT can play in supporting the PMH neighbourhood concept

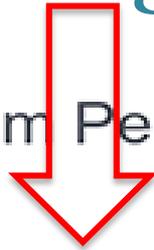


# OCFP's Path to Championing the PMH



# System Challenges

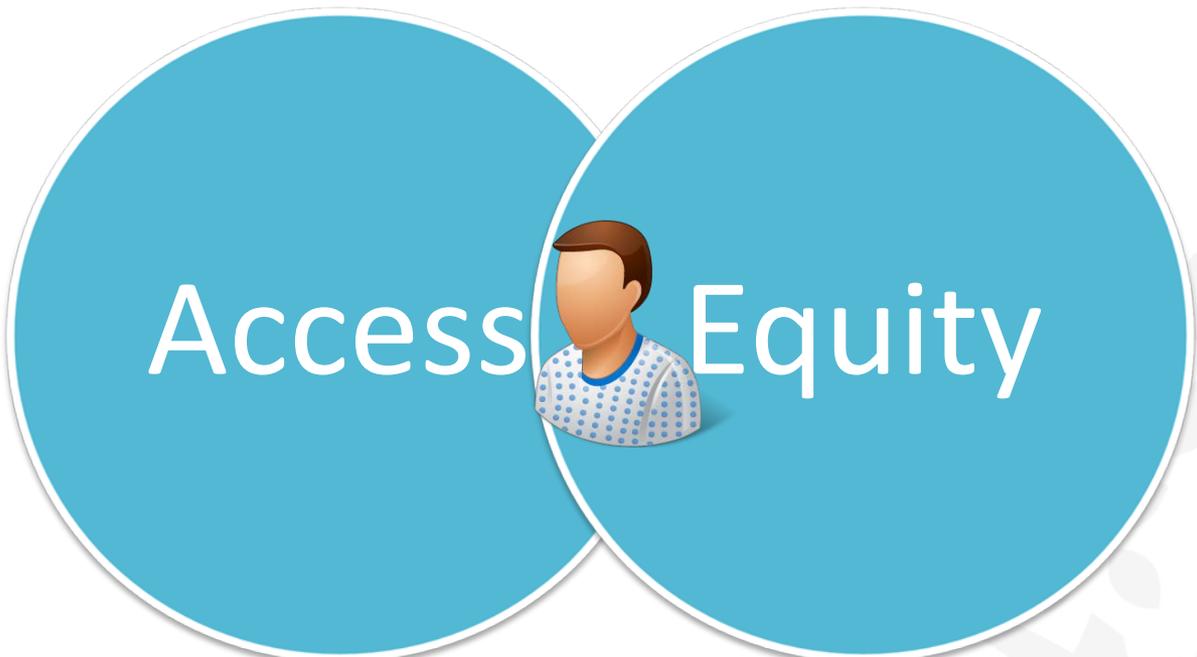
## Health Care System Performance Rankings



	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING	2	9	10	8	3	4	4	6	6	1	11
Care Process	2	6	9	8	4	3	10	11	7	1	5
Access	4	10	9	2	1	7	5	6	8	3	11
Administrative Efficiency	1	6	11	6	9	2	4	5	8	3	10
Equity	7	9	10	6	2	8	5	3	4	1	11
Health Care Outcomes	1	9	5	8	6	7	3	2	4	10	11

Source: Commonwealth Fund analysis.

# The Burning Platform in Ontario



Access Equity

**Risk-adjusted population-based planning and delivery**  
**Primary care transformation**



# Levers for system change

1. Change in culture and a culture of change
2. Transformational leadership
3. Family physician engagement
4. A foundation for integrated decision making and collaboration
5. Measurement

*OCFP Evidence Brief: Preparing for a Devolved, Population-Based Approach to Primary Care, 2016*  
D. McMurchy,<sup>1</sup> L. Clarke,<sup>2</sup> J. Hill<sup>2</sup>



# Engaged Leadership: Fostering a culture of change

“In our experience, clinicians who experience high burnout and dissatisfaction are receptive to transformation, but only if leaders can clearly articulate the vision, ensure adequate resources, and let teams take charge of the process of change. Technical solutions for improving primary care, such as payment incentives, can be instrumental in shaping change, but not without strong leadership.”

– *Dr. Robert Reid, 2010, Health Affairs, on the Group Health Experience*



# The Patient's Medical Home: Foundational Concepts

Based on the  
10 pillars of  
the PMH

Coordinated  
Care

Quality  
Improvement  
+  
Safety

FP-led\*  
Comprehensive  
Care with  
IHP Team

Patient-  
Centred

Enhanced  
Access  
+  
Equity

Continuing  
Relationship  
with  
Physician/  
Clinician\*

Health IT +  
Integrated  
EMRs

Training +  
Development

Aligned Payments

Governance +  
Management

Research +  
Evaluation

\* A Nurse Practitioner (NP) may be the  
Most Responsible Provider (MRP)



# Primary Care Practices in a PMH Neighbourhood



**Walk-in  
Clinic**



**Ontario's Community  
Health Centres**

**CHCs/AHACs/NPLCs**



**Fee For Service  
and  
Comprehensive  
Care Models**



**Family Health Team**  
IHPs and FHO/FHN  
practices



**Family Health  
Groups**



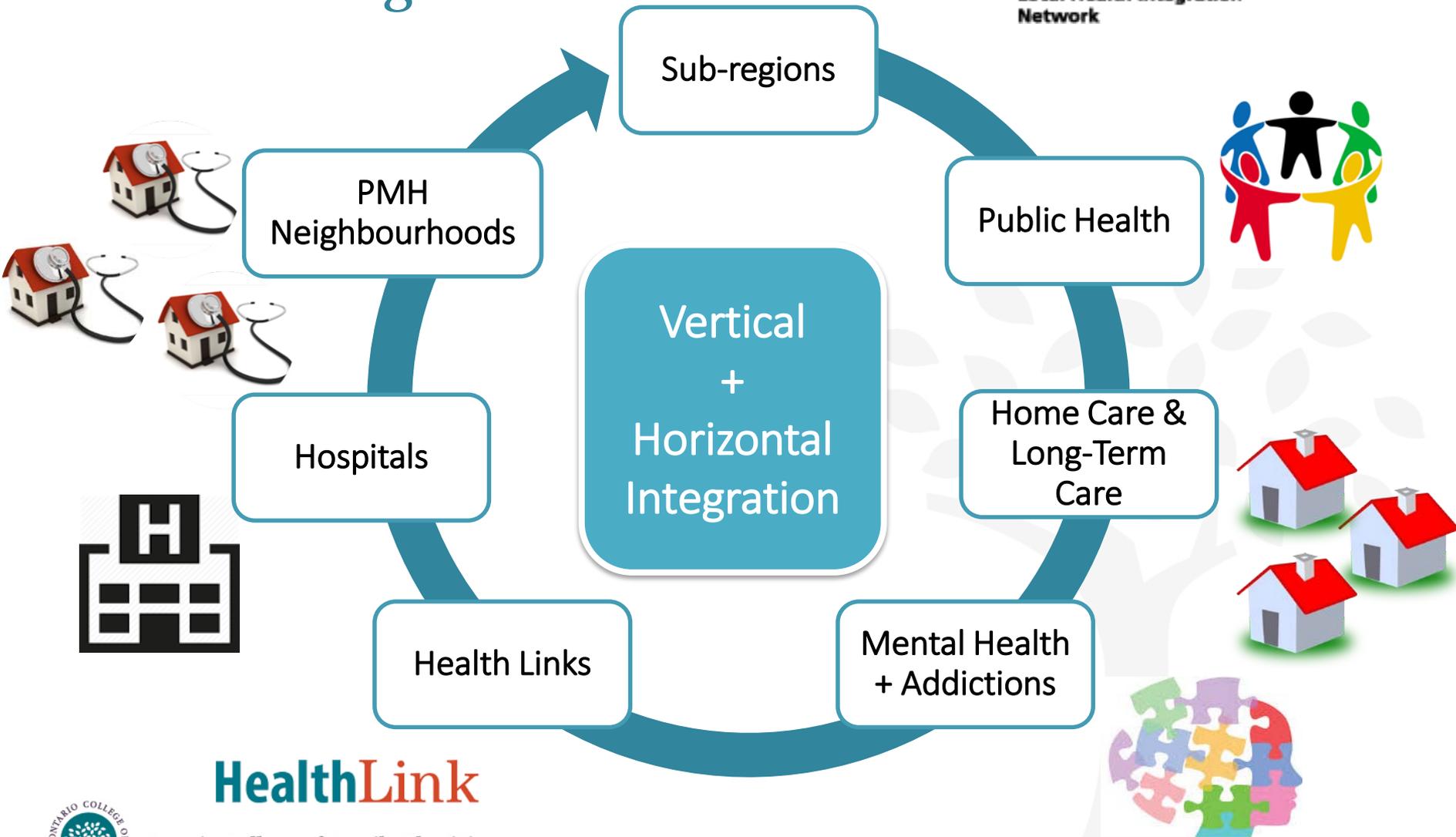
**RNPGA**



**Family Health  
Organizations  
& Networks**



# Supporting LHINs + the PMH “neighbourhood”



HealthLink

# PMH Advisory Committee

## Purpose:

To provide strategic advice to the OCFP in order to support its members in addressing their priority clinical and practice challenges using:

- a PMH lens,
- best evidence,
- knowledge of Ontario's system, and scalable innovations.

## Membership:

1. Dr. Mira Backo-Shannon
2. Dr. Sundeep Banwatt
3. Dr. Ken Barss
4. Dr. Mario Elia
5. Dr. Geordie Fallis
6. Dr. Rick Glazier
7. Dr. Michael Green
8. Dr. David Kaplan
9. Dr. Elizabeth Muggah (Chair)
10. Dr. Aaron Sacheli
11. Dr. David Schieck
12. Dr. Ross Upshur
13. Dr. Walter Wodchis



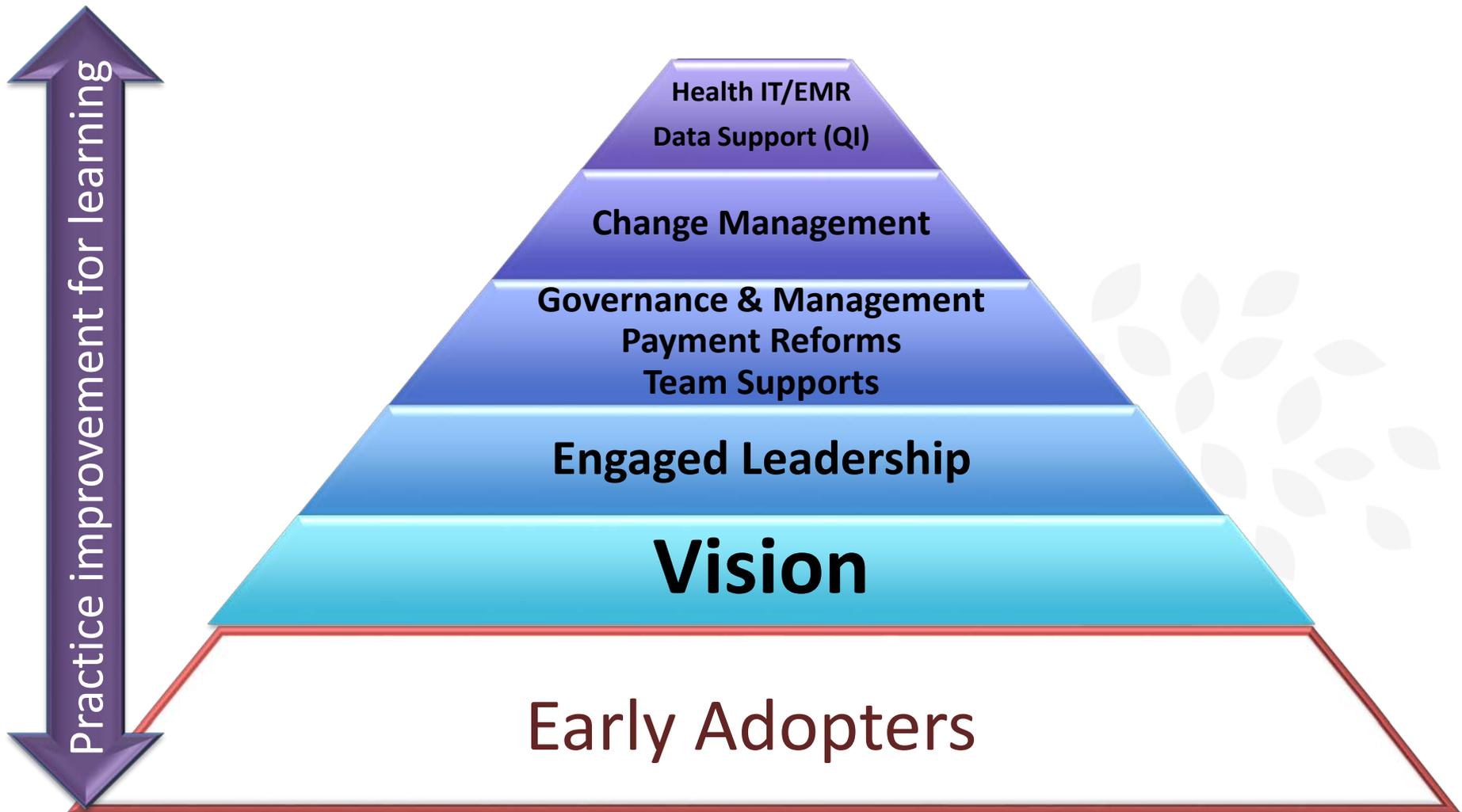
# PMH Advisory Committee

## Direction for future work:

1. Clearly define sub-components of PMH vision at the:
  - Practice Level
  - Neighbourhood Level
2. Adapting PMH Implementation Toolkits. i.e. NCQA, AHRQ, Ontario and Alberta toolkits
3. Support early adopters
4. Build and strengthen alliances and develop a shared voice for family medicine and PMH
5. Future...engage patients and public – build ownership for primary care



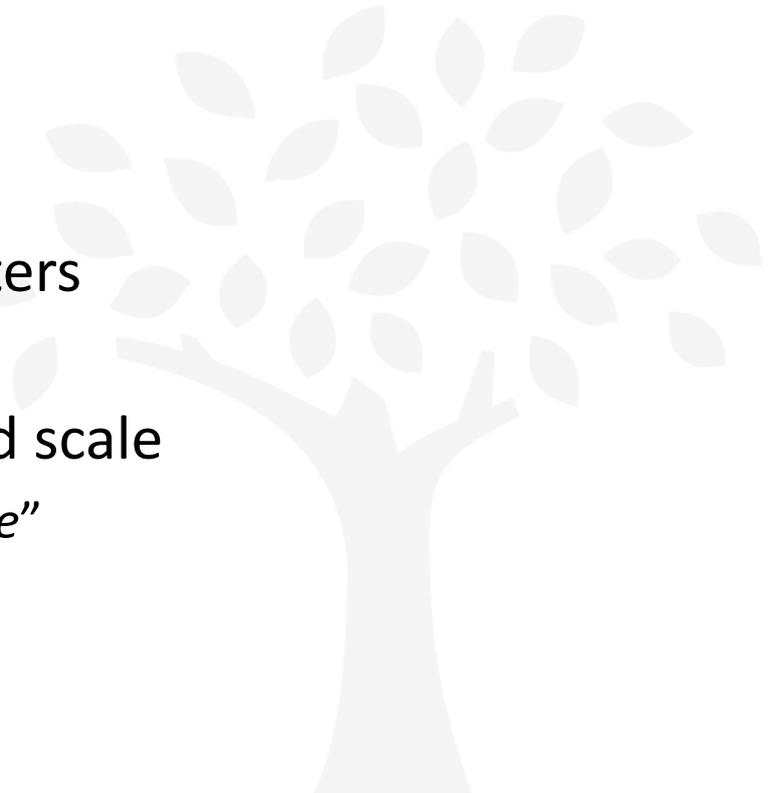
# What will it take?



# Next Steps?

## A PMH Proof of Concept for Ontario

1. Describe key PMH design elements at:
  - the *practice level* and
  - the *neighbourhood level*
2. Co-design toolkit with early adopters
3. Support sustainability, spread, and scale
  - Create a PMH “*Community of Practice*”
  - Share lessons learned



# Current Collaborations

Potential  
fellowship to  
evaluate PMH  
implementation

AFHTO

Creating  
meaningful  
measures

HQO

Leading primary  
care planning

LHINs

Sub-  
Regions

MHA  
Planning  
Table

Voicing support  
for PMH vision

MOHLTC



# Leveraging Existing Capacity and Resources

Care Coordination Table

Leadership Development

AFHTO D2D

CAMH

Ontario MD

**PMH Advisory Committee  
Members**

**Early Adopters**

**U of T Teaming Project**

**HQO**

Sub-regional Planning

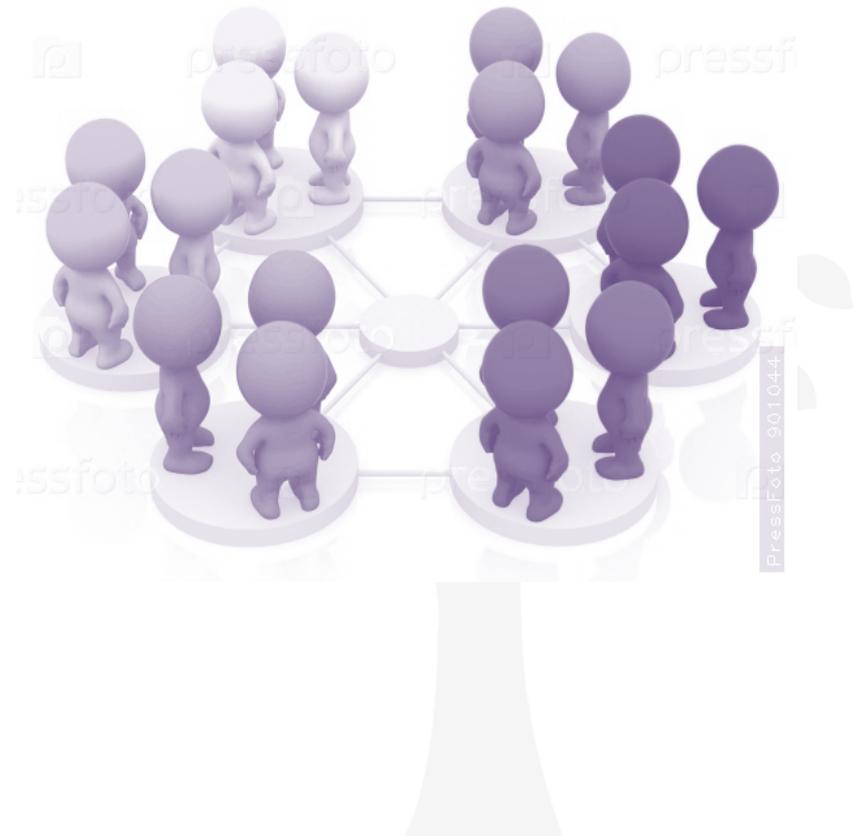
Academic Detailing



# Creating a PMH '*Community of Practice*'

Bring leaders together to:

- ✓ Share lessons learned
- ✓ Share toolkits for adoption
- ✓ **Support spread and scale**
- ✓ Celebrate successes
- ✓ Showcase early adopters



# Supporting Spread of the PMH

PMH “*Community of Practice*”

OCFP PMH Advisory Committee

Southwest  
Mississauga Halton  
LHIN Sub-region

Waterloo  
Wellington LHIN

Hamilton LHIN  
Sub-Region

South West LHIN  
Sub-Region

Supporting Early Adopters

## ENABLERS:

Toolkit Development • Leadership/Mentorship • Evaluation/Practice Improvement

## PARTNERS:

AFHTO • HQO • Leadership Development





# Questions?



# Patient Medical Home and Expanding and Enhancing Interprofessional Primary Care Teams

AFTHO Patient Medical Home Presentation

Wednesday, October 25, 2017

Dr. Mira Backo-Shannon, Vice President, Clinical

Dr. Sundeep Banwatt, South West Mississauga Sub-Region Clinical Lead



**Ontario**

Local Health Integration  
Network

Réseau local d'intégration  
des services de santé

# Presenter Disclosure

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- **Relationships with commercial interests:**
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  - **Speakers Bureau/Honoraria: None**
  - **Consulting Fees: None**
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# Mitigating Potential Bias

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# The Opportunity

- Major investment in interprofessional primary care in Ontario
  - Investing in \$15.5M in 2017/18 and an additional \$27.8M in 2018/19 to expand interprofessional primary care teams (IPCT) in Ontario.
- Supports on-going efforts in Ontario's health care system to strengthen primary health care to ensure Ontarians can receive the right care, at the right time and in the right place.

# Best Practice: Patient Medical Home and Meeting the Quadruple Aim

A vision for the future of family practice.

A vision for better patient-centred care.

A vision for better health outcomes.



# Patient Medical Home - Pillars



1. Patient Centred-Care



2. Personal Family Physician



3. Team-Based Care



4. Timely-Access



5. Comprehensive Care



6. Continuity of Care



7. Electronic Medical Records



8. Education, Training and Research



9. Evaluation and CQI



10. Internal & External Supports



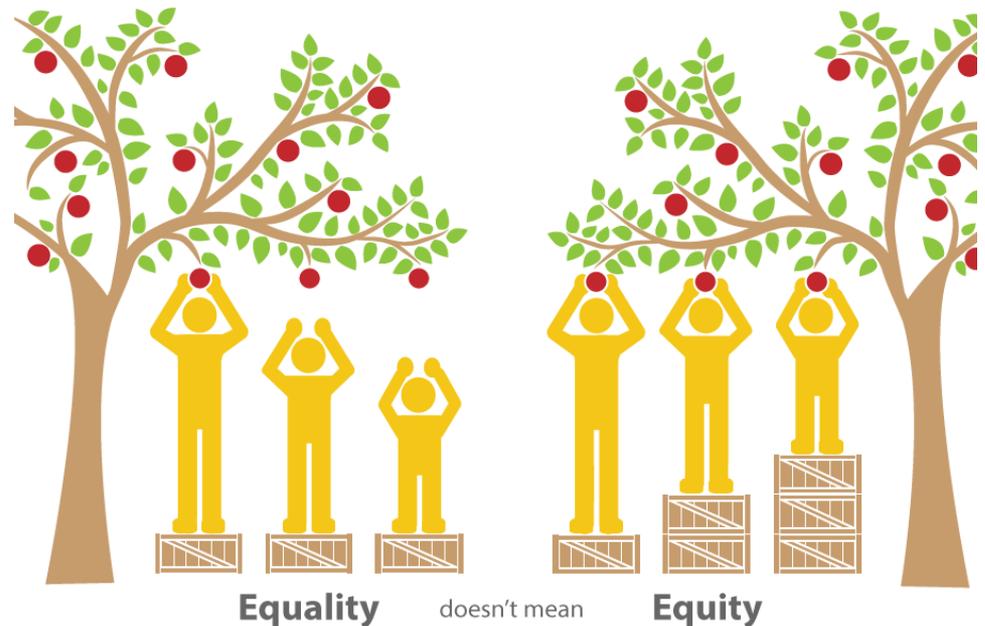
+Patient Accountability



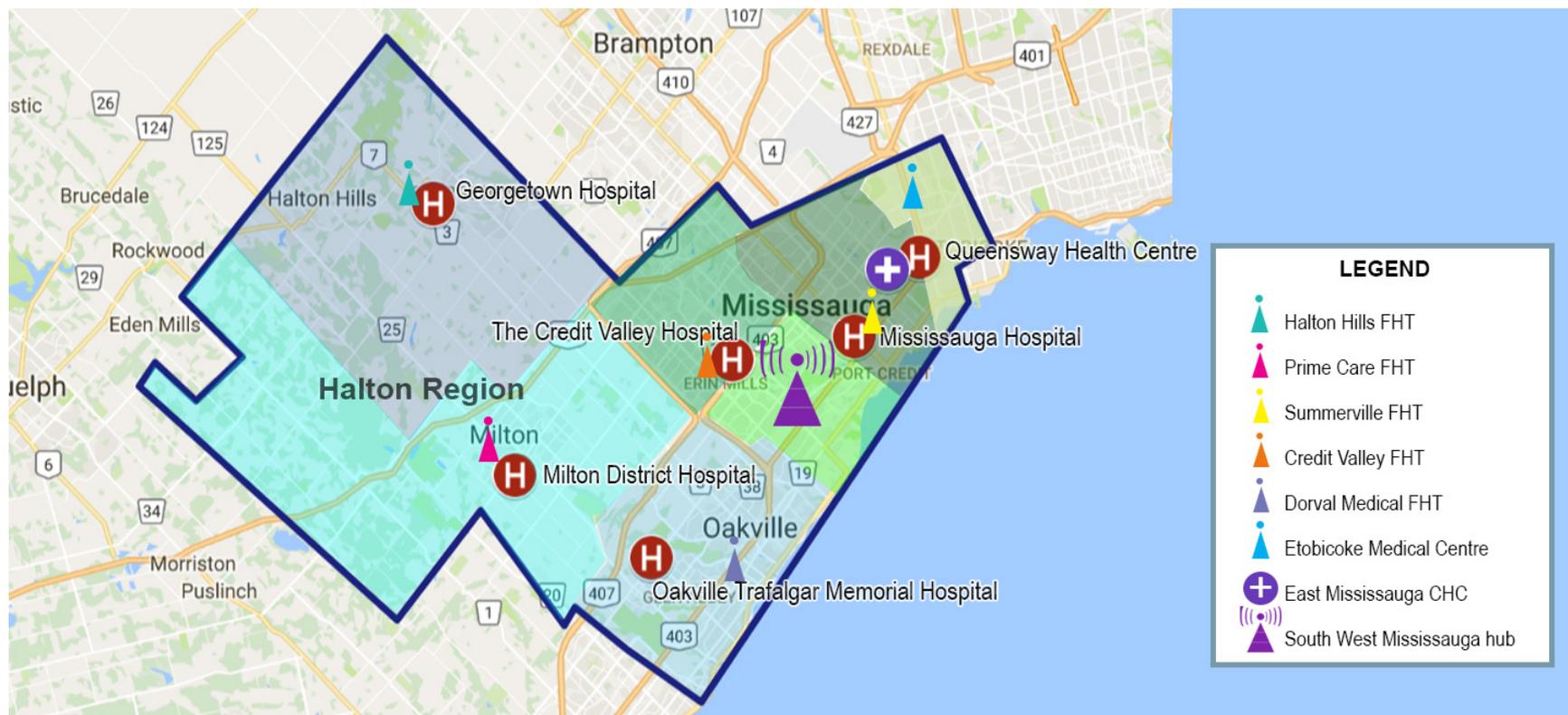
+Health Literacy

# Looking Forward: From Practice to Population-Based Planning

- Ensuring patients are receiving the right care at the right time
- Sub-Region planning and the implementation of sub-region clinical leads



# Looking toward the future



Community Agencies

Regional Programs

THP

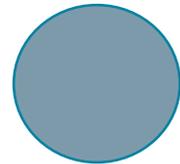
McM. & UoFT

IBH

OCFP/AFHTO

Seniors, MHA

Home and Community Care



- Process, policy, implementation
- Clinical intervention and system design change
- IHP+MD training
- Virtual Care

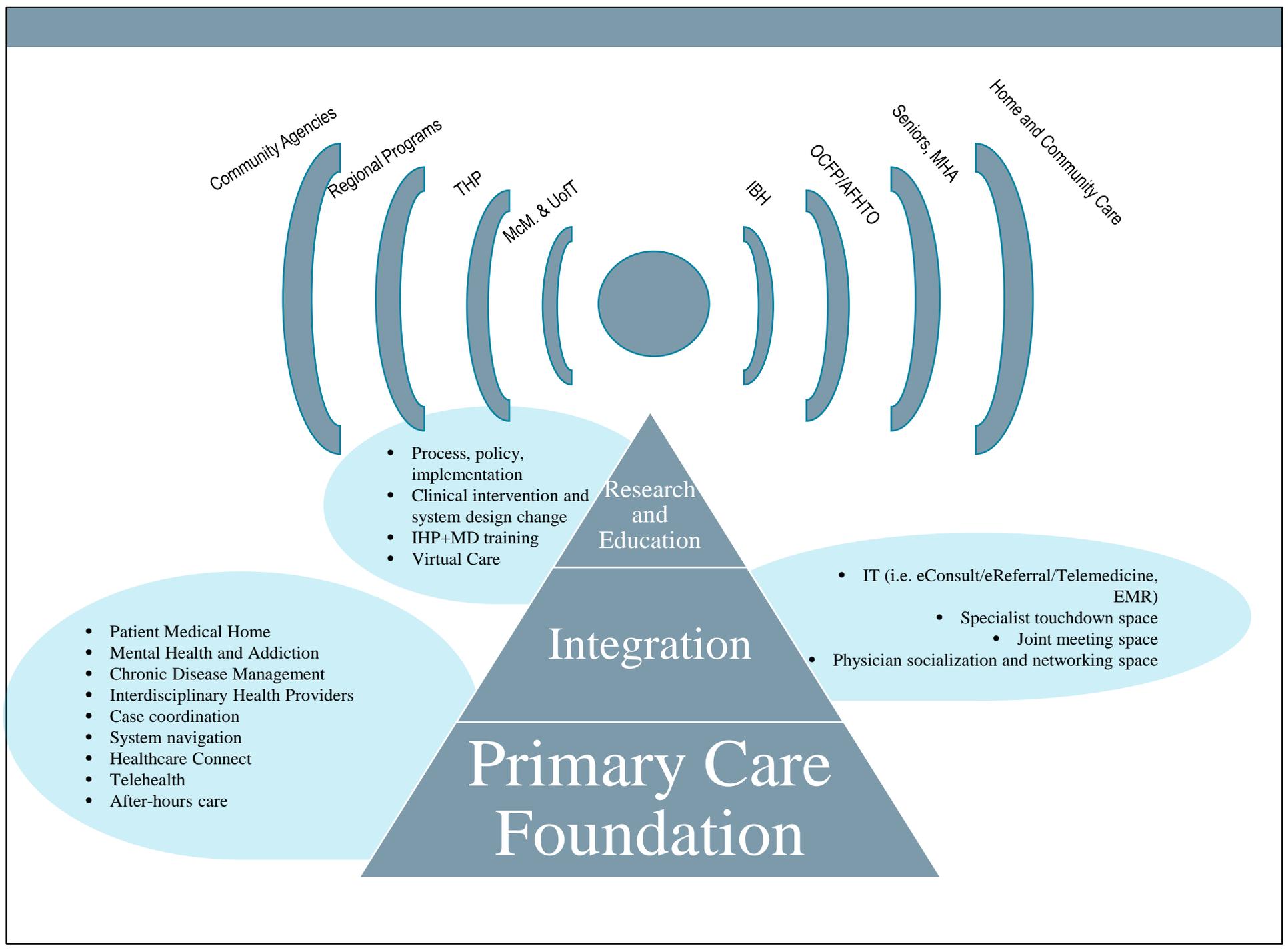
Research and Education

- IT (i.e. eConsult/eReferral/Telemedicine, EMR)
  - Specialist touchdown space
    - Joint meeting space
- Physician socialization and networking space

Integration

- Patient Medical Home
- Mental Health and Addiction
- Chronic Disease Management
- Interdisciplinary Health Providers
- Case coordination
- System navigation
- Healthcare Connect
- Telehealth
- After-hours care

Primary Care Foundation



# Dr. Sundeep Banwatt

## My Reality

- Community physician working FFS for 15 years
- Taken on an advisory role at the Mississauga Halton LHIN because I am committed to improving primary care in our region



# Current State – challenges for PMH implementation in ON

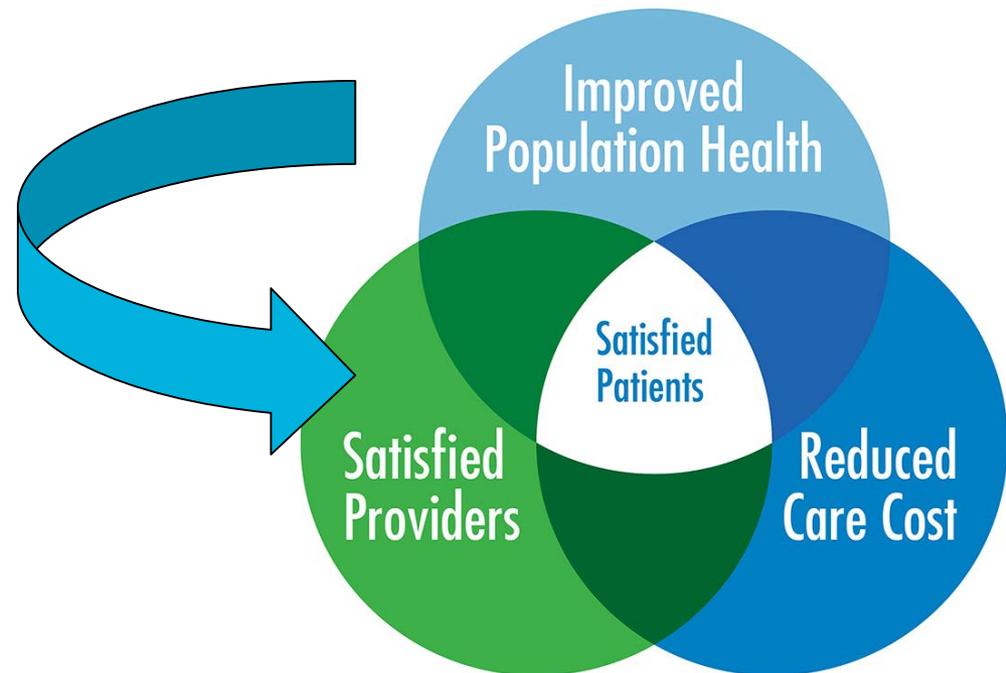
Key PMH Feature	Challenges
Comprehensive Family Physician-led* care with an interdisciplinary team	<ul style="list-style-type: none"> <li>• Distribution of IHP team resources not currently linked to high-risk populations and overall investments not yielding access and equity targets compared to other countries</li> <li>• 75% of practising FPs aren't in funded IHP practice models</li> <li>• Ability to share existing IHP resources within and across practices</li> <li>• Integration of IHP teams with physician teams</li> </ul>
Coordinated care across delivery system	<ul style="list-style-type: none"> <li>• Care coordination a key need in primary care; opportunity to support all practices</li> <li>• Primary and secondary care will need to work together on integration</li> </ul>
Continuity – relationship with MRP*	<ul style="list-style-type: none"> <li>• Rostering of patients supported by linked EMRs</li> <li>• Linking focused practices, walk-in clinics with comprehensive FPs and teams</li> </ul> <p style="text-align: right;">* A NP may be the MRP</p>
QI and safety	<ul style="list-style-type: none"> <li>• Consistent and reliable data/data extraction from EMRs</li> <li>• Support for QI implementation across all practice models</li> </ul>
Enhanced access and equity	<p>There are many payment models for physician services that don't align with promoting PMH implementation and that create a disparity between physicians and their patients who "have" and those who "have not"</p>

# Why am I optimistic?

- **Step 1: Recognizing the problem**
  - Awareness that the current system is unsustainable
- **Step 2: Motivated toward change**
  - Strong desire to provide the best care to our patient
  - Letting doctors get back to doctoring
- **Step 3: Seizing the opportunity**
  - Community PCPs are keen to have IPCTs available for the patients that need it (equity)

# Interprofessional Primary Care Team Expansion in South West Mississauga

- Expanding access to resources
- Collaboration
- Coordinated care
- Quadruple aim
- Equitable care



# Patient Medical Home for all Practices

- ✓ The PMH is a vision for all practice models to move toward with a set of common principles
- ✓ Developed by family physicians for family medicine and primary care
  
- X The PMH is not a physical location
- X The PMH is not a funding model
- X The PMH is not only for FHTs

# Working together toward a sustainable health care system – Engaging key stakeholders

- How do you see community physicians connecting with FHTs?
- What commitment, if any, does the FHT have to the rest of the community?
- What do you think is the first step in starting to organize a Community of Care (aside from funding)?



**Thank you for  
your attention!**

**Questions?**

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# Improving Access to Teams

Dr. Walter Wodchis, MA, MAE, PhD,  
Institute of Health Policy, Management  
and Evaluation  
University of Toronto



# Presenter Disclosure

- **Presenters: Dr. Walter Wodchis**
- **Relationships with commercial interests:**
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  - **Speakers Bureau/Honoraria:** None
  - **Consulting Fees:** NRC Health
  - **Other:** None



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  - There is no potential conflict of interest because there is no product or funding associated with this program or organization.



# Mitigating Potential Bias

- The topics discussed in this session and at this conference do not relate to advice provided by Dr. Wodchis through his advisory role with NRC Health.



# Improving Access to Team-based Care

- Several programs exist in Ontario that have opened access to team-based care for patients who are not enrolled or rostered to primary care physicians within those teams (CHCs or FHTs).
- E.g :
  - Solo Practitioners in Need (SPIN) in 7 CHCs in Toronto;
  - Primary Care Outreach (PCO) in 5 CHCs in Ottawa
  - People in Need of Teams (PINOT) in 2 CHCs in Ontario
  - Guelph Family Health Team



# Improving Access to Team-based Care

- We are aiming to spread these programs in four LHINs where implementation sites already exist. We are doing this with involvement at each spread site of:
  - Mentor site that has already implemented the program
  - Research and Evaluation team to assess and track : readiness for implementation (collaboration and teamwork); provider engagement; patient access; cost and utilization.
  - Implementation facilitator....to facilitate implementation.



# Improving Access to Team-based Care

## Team Leads

Dr. Walter Wodchis  
Dr. Jennifer Rayner

## Implementation and Evaluation Experts

Dr. G. Ross Baker  
Dr. Jenna M. Evans  
Dr. Elina Farmanova  
Dr. Agnes Grudniewicz  
Dr. Maritt Kirst  
Dr. Kerry Kuluski  
Dr. Jay Shaw  
Dr. Carolyn Steele Gray

## Implementation Site Leads

Leslie McDiarmid  
Deborah Andrews  
Cliff Ledwos  
Allan Madden

## Spread Site Leads

Lynne Raskin  
David Gibson  
Susan Hocking  
Eric Goldberg

## Physician Advisors

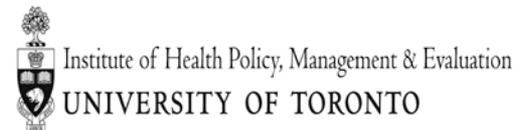
Dr. Pauline Pariser  
Dr. Geordie Fallis  
Dr. Gord Schacter  
Dr. Laura Muldoon

## LHIN Leads

Cal Martell  
Kristy McQueen  
Lisa Bitoni-Bengert  
Greg Stevens/Margery Konan



# Our Partners



South-East Ottawa  
Community  
Health Centre  
Centre de santé  
communautaire  
du sud-est d'Ottawa  
Every One Matters.  
Chaque personne compte.



Sandy Hill  
Community Health Centre  
Centre de santé  
communautaire Côte-de-Sable



London  
InterCommunity  
Health Centre



South East Grey  
Community Health Centre



Access Alliance  
Multicultural Health and Community Services



Ontario College of Family Physicians  
Education | Leadership | Research | Advocacy  
A Chapter of the College of Family Physicians of Canada



Association of Ontario Health Centres  
Community-governed primary health care  
Association des centres de santé de l'Ontario  
Soins de santé primaires gérés par la communauté



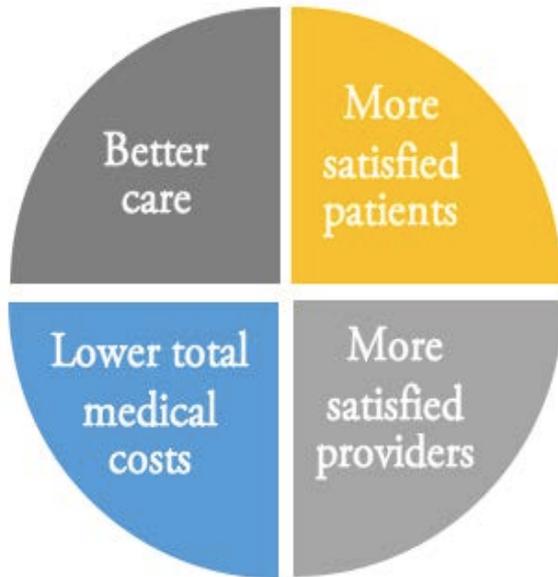
Ontario College of Family Physicians

# Team-Based Care



- Team-based care is an integrated, collaboration model that facilitates access to interprofessional teams for primary care providers and their patients who do not have access to team based care
  - Deliberate outreach
  - Interprofessional shared and integrated care

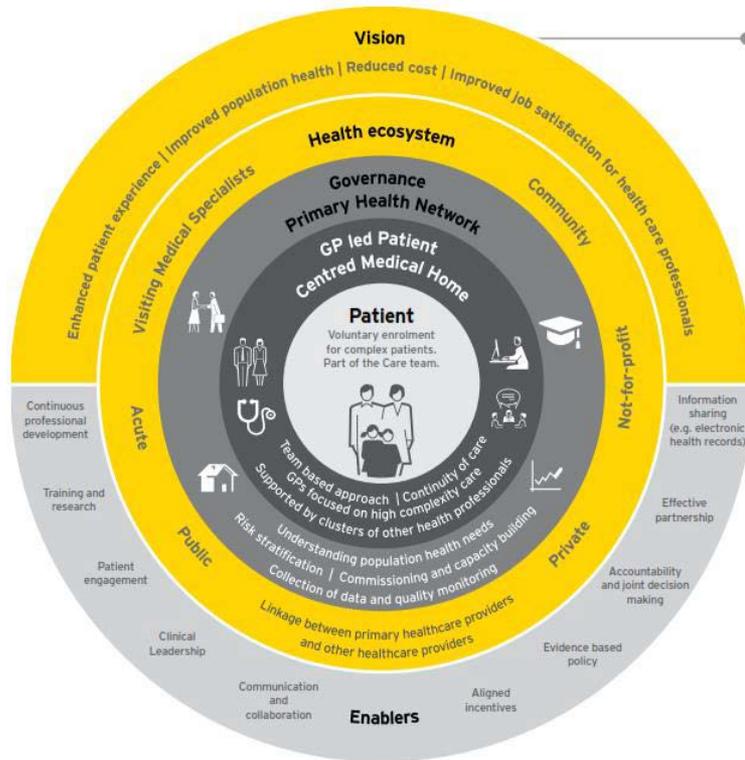
# Evidence For Team-Based Care



- Superior coordination and access to care
- Improves provider experience and greater job satisfaction
- Positively impacts patient experience of care
- Improvements in health outcomes
- Reductions in healthcare utilization
- Cost savings

# Context: Access to Interprofessional Team-based Care

## Patient-Centred Medical Home



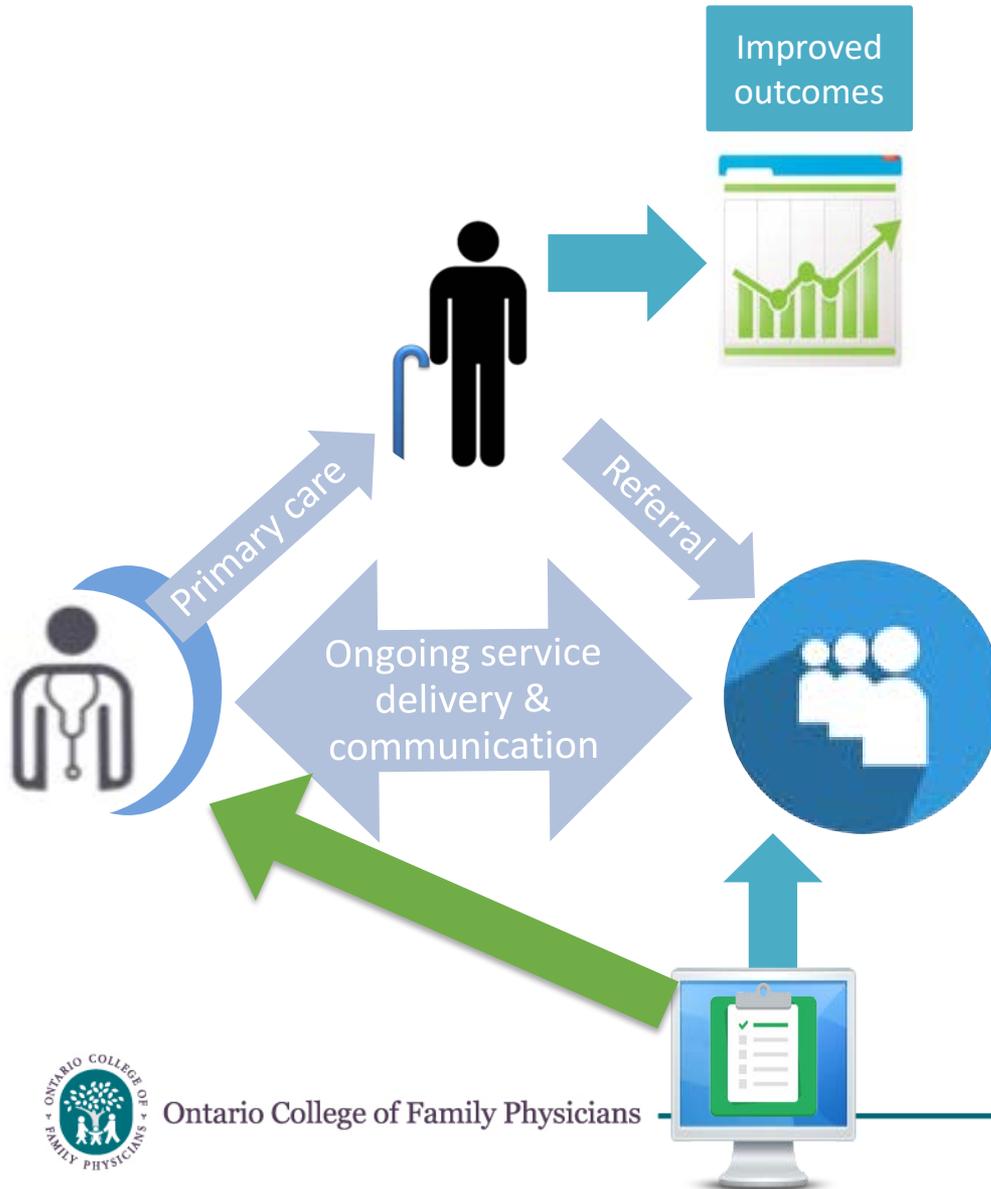
- **It's an equity issue**
  - ~ 30% of Ontarians have access to team-based primary health care but 70% do not
- **Patients First → Better integration of primary care at the sub-region level**
  - Improved access to interprofessional teams for those who need it most
  - Improved flow through the system
- **Alignment with LHIN sub-region, population health based primary care planning**

# Bridging Cultures: Role of Facilitator



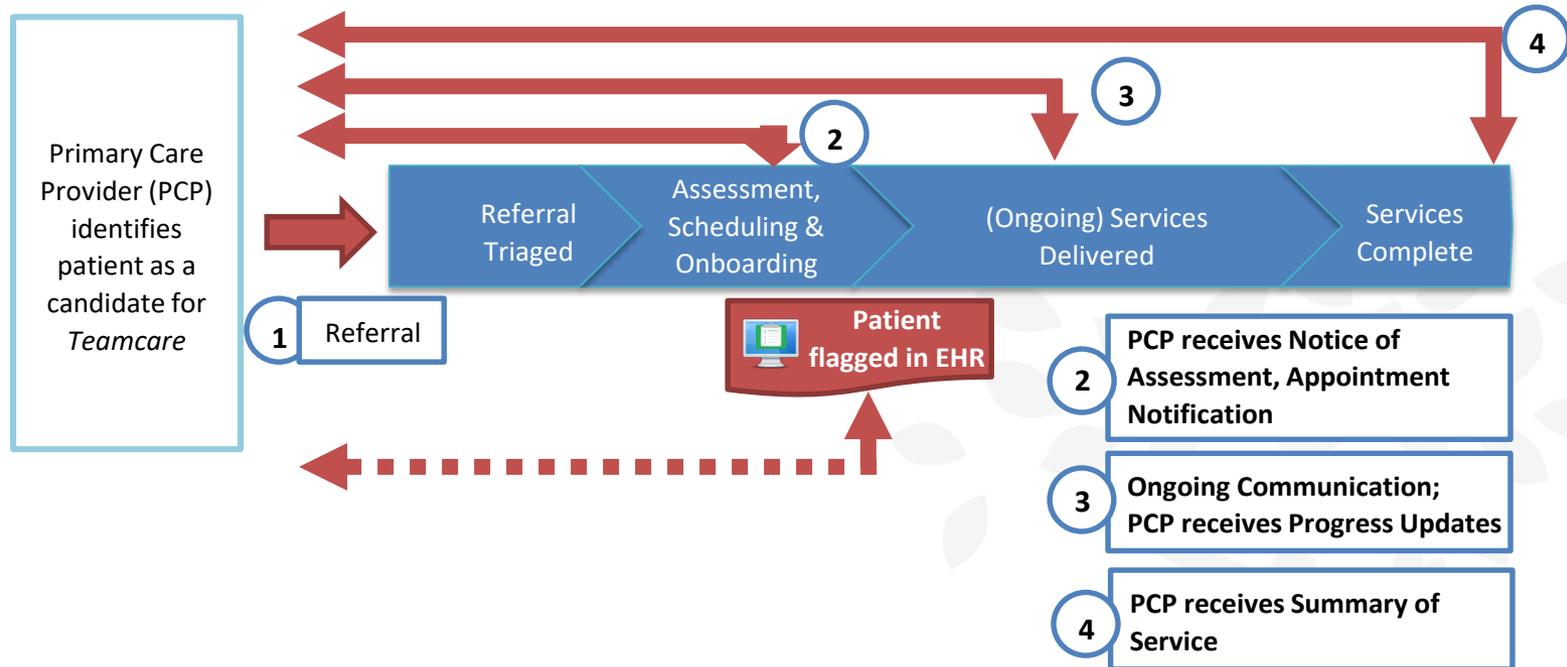
- Evidence supports use of facilitation to connect practice across sites and support change management
- Main objectives for facilitators will be to build relationships, enable communication & share data
- Goal is to create greater integration rather than change organizational cultures
- Relationship and trust is critical to success

# Operational Model



- Physicians without teams informed and trained in engagement
- Interprofessional team assess and carry out ongoing care with patient
- Information flows between physician and Interprofessional team
- Performance metrics tracked and flow to physicians and Interprofessional teams

# Communication Flow



# Successful Implementation

Successful implementation is “an orchestrated (active, planned) effort to make evidence-based changes by organizations, teams, and individuals that result in sustained improvements to care, patient outcomes and service delivery” It is achieved when evidence is robust and practitioners agree with it, when the context is receptive and where implementation processes are appropriately facilitated internally or externally.

(Rycroft-Malone et al., 2013 Implementation Science).



# Success & Challenges

Enablers	Challenges
Policy Context	Remuneration for non-team physicians
Leadership	Time & Resources
Trusting Relationships	No Co-location
Communication	
Information Sharing (Technology)	





