afhto association of family health teams of ontario
60 St. Clair Avenue East, Suite 800, Toronto ON M4T 1N5

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Dr. Atul Kapur,
Chair, OMA Negotiations Committee
Ontario Medical Association
150 Bloor Street West, Suite 900
Toronto, Ontario, M5S 3C1

Sent via e-mail to: **negotiations@oma.org**

Dear Dr. Kapur:

AFHTO is grateful for this opportunity to contribute ideas for the OMA's upcoming discussions with the Ministry regarding the Physician Services Agreement. Our response is grounded in AFHTO's vision that all Ontarians have access to high-quality comprehensive primary care, care that is:

- Informed by the social determinants of health – the conditions in which people are born, grow, live, work and age
- Delivered by the right mix of health professionals, working in collaborative teams in partnership with patients, caregivers and the community
- Anchored in an integrated and equitable health system, promoting good health and seamless care for all patients
- Sustainable – efficiently delivered and appropriately resourced to achieve expected outcomes

The following recommendations have been developed in consultation with both FHT physicians and executive directors and approved by the AFHTO board.

Please note that physicians working in FHTs are compensated under a number of different funding models – FHO, FHN, RNPGA, BSM and APP. AFHTO's recommendations apply to all team-based settings regardless of physician funding model; however some of the examples used to illustrate may apply to one or more of these funding models.

Meeting patient and community needs:
AFHTO would strongly support steps to design and implement more balanced and evidenced-based approaches to compensating physicians (and FHTs as well) for the complexity and size of their rosters. Existing models do not accurately reflect the factors such as diseases, system use or the needs of patients with a combination of other challenges.

Entry to practice in capitated arrangements must be kept sufficiently open so that physicians who want to work in team models can do so, where there is community need. Newly graduating physicians have been trained in team settings and should be able to practice in these settings; mid-career physicians should also be able to enter a team-based model at their option where there is community need.

The transformation to patient-centred, integrated care delivery requires leadership from primary care physicians. This necessitates appropriate support – not only in terms of how the time of physician leaders is valued, but also in developing their leadership capacity. We understand the current Agreement provided the OMA with a small fund for physician leadership training, and ask that consideration be given to continuing (and possibly expanding) this initiative.

There is also need to consider an overall primary care funding model that is firmly grounded in population needs and maximizing "better health and better value." While this point edges beyond the scope of the Physician Services Agreement, a more holistic approach is needed to look at both the physician compensation and FHT funding models. The goal is to ensure that the appropriate mix of professionals and related resources can be put into place; that they can continue to be supported as roster size, patient complexity, innovation and best practice evidence evolve over time; and that quality of care and patient outcomes are maintained and improved.

Incentives and penalties:
Incentives to physicians must be aligned with the goal of "better health and better value" and the priorities for achieving it, while avoiding unintended negative consequences.

One issue that must be addressed applies to all FHO physicians, whether or not they practice in a FHT: Negation for the Access Bonus. Examples include cases where FHO physicians may be penalized for completely appropriate visits to other family physicians at weight loss clinics, mental health or methadone treatment. This also has different and inequitable implications for physicians depending on whether they are practicing in rural or remote environments or in a setting where patients have multiple other primary care options available instead of there being one or a few large FHOs. Replacing the access bonus with a bonus based on patient-reported timely access is one suggestion for improved alignment of the incentive with the objective.

Other issues are unique to physician practice in an effective and efficient team-based model. Areas in need of review include:

- Incentives that can lead to duplicated work and/or are not fully conducive to full scope of practice (e.g. diabetes and preventive incentives)
- Services that should be in or out of basket (e.g. time-based fee for housecall travel, mental health case management, team consultations for complex patients)
- Support for physician work in non-clinical tasks such as Health Link development, Quality Improvement Plans, data collection, etc.
- Capitation fees in teams where both NPs and FPs are primary providers.

Payment to Specialists:
Specialists need to be fully integrated in to the primary care team where possible. Several disincentives exist at the moment. For example:

- Specialist compensation for practicing in a FHT setting should not be less than can be obtained for the same services delivered elsewhere. FHTs are funded to access specialist services, but the current sessional fee rates are not attractive, and FHTs are frequently unable to recruit effective and efficient specialty support.
- Referrals from Nurse Practitioners should be compensated at the same rate as referrals from family physicians. The lower rate means NPs must refer to a FP to refer to a specialist in order for the specialist to take the patient. This is an inefficient use of health care resources.

Funding for EMR adoption and maturity:
Electronic health records are the backbone of a high performing health system. The primary care EMR is the core source for the EHR, as well as providing the vital platform for collaboration across a family health team and beyond. There is unanimous agreement that a sustainable model for funding EMR infrastructure is essential.

Thank you again for this opportunity for AFHTO to provide this input. We would be pleased to provide additional detail and work with the OMA and other system partners if there is interest in pursuing any of these ideas.

Sincerely,

Angie Heydon
Executive Director
On behalf of the AFHTO Board of Directors