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Family Health Networks – The Future of Primary Care in Ontario?

Welcome to another edition of Thames Valley Views! The theme for this edition is Sustainability in Health Care – Opportunities for Integration. This is an issue that is affecting every province across Canada. Here in Thames Valley, your DHC is working on many levels to promote comprehensive local health care planning. Several of our initiatives are highlighted in this edition.

In setting the stage for local initiatives, it is important to understand the broader provincial context. We are therefore very pleased to provide you with an overview of the provincial Family Health Network Initiative from three different perspectives.

Perspective A:

Dr. Ruth Wilson, Chair of the Ontario Family Health Network (OFHN)

Q. *What do you think the Family Health Network is trying to achieve?*

A. Family Health Networks represent a primary care reform model. The core of the Family Health Networks is a group of five (5) family physicians. That is not to say that I don't recognize, nor does our agency not recognize, that there is more to primary care reform than family doctors. But currently, what we have to offer is the ability for family doctors to join together and form networks.

We expect and hope that there will be announcements soon about funding for other disciplines to be part of Family Health Networks. We hope it will be more than just family doctors. Having just said that, we now have the ability to move the mainstream of family doctors to a new model of delivery of primary care, which is very exciting.

Q. *What are the goals of the Network?*

A. The goal of a Network is to enable and support groups of family doctors and other professionals to work together to provide access to primary care 24 hours a day, 7 days a week. This is accomplished through a combination of regular office hours, extended office hours, and a telephone triage system backed up by a family doctor on call at night. Also to offer enrollment to patients for a number of good purposes, not the least of which is to target preventive health maneuvers towards enrolled patients.

In addition, the Network will support the introduction of electronic medical records and some activity between Family Health Networks, Labs, Hospitals and other health care providers. We think this will bring about some efficiencies and improvements in quality of care. As I mentioned, we are hopeful that we will have the ability to add other health care professionals to this constellation of family doctors working in Networks. It achieves access for patients to the high quality of care that we know that family doctors provide. It will, I hope, provide access to other health care professionals that Canadians want to access. From the family doctors point of view, it is a financial investment in primary medical care that family doctors provide, both in terms of their own remuneration and in terms of the funded supports like computerization, teletriage, and other health care professionals to join their Network.

We hope that this will stabilize the family physician workforce and perhaps attract some family physicians back into comprehensive care.

I should also mention that the model provides financial incentives for family doctors to keep providing comprehensive care such as house calls, palliative care, obstetrics, in-hospital work, as well as their regular office work and health promotion.

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Q. *What challenges have you encountered in developing the Network?*

A. I feel that we are doing very well. This is a very new offering. We are certainly receiving many, many calls, so I am scrambling to make sure that I have the resources at the Network's end to respond to the interest that is there. So that is a good kind of challenge to have.

I do not want to focus too much on barriers because we are overcoming them. Our challenge is to communicate this model to those that might be interested and make it easy for them to sign up if they want. That is what we are in the process of doing every day. That is what I am doing right now with you people—helping to communicate what the offering is.

Q. *In the past months, there have been stories in the London Free Press regarding doctors not believing that the revenue matches their current revenue. How are you able to get around those issues and types of press?*

A. Any doctor who wants to make a decision about whether this is a financially good model needs to simply ask us to run the numbers from the OHIP database for him/her and we will give them a comparison and they can make their own judgement. Also, on our web site we have a calculator and a little work sheet that they can use to just roughly estimate the revenue – it actually produces quite an accurate result. When these tools are used, most physicians will see that there are financial advantages.

The story in the paper is referring to this: about 55-60% of the revenue for physicians in the Family Health Network is made up of a base rate payment, which is age/sex adjusted and is similar to a capitation rate. That rate on average is $96.85, which does work out to 25 cents a day – I think, I haven't actually done that calculation. That is roughly what is being billed for primary care services in the province now, so this is not a decrease by any means, it is more a statement of the current reality. That is what they are making now—25 cents a day per patient. However, there are considerable incentives on top of that base rate, which I could go through if you like. They include a 10% fee for service premium for included codes to rostered patients, and a 20% access bonus if their patients don't seek use outside the Network for primary care services. There are bonuses for hospital care, obstetric care, and the preventative bonuses. I've mentioned bonus money for backing up the telephone triage system. There is an administration fee, and on and on and on.

The revenue package that they were describing is not 25 cents on the dollar, but 25 cents a day. That is only a portion of what makes up the revenue.

Q. *How can local doctors enter into a discussion with you?*

A. Through a number of ways. I am open to coming to meet with groups of doctors if they would like to invite me. They can certainly contact us through our web site, or through our 1-800 numbers.

Q. *Why would a physician want to be involved in the Network?*

A. I think the Network is good for doctors in a number of ways. First of all, there is the benefit of a group practice. This doesn't mean that they have to leave their own offices. The advantage of joining together in a group is that you can get some coverage for your patients for illness or vacation, or CME, so there is that flexibility. There are considerable financial advantages to joining Networks, and I do not apologize about that. I think it is a useful way of bringing about change in a voluntary way.

Almost every doctor will find it advantageous to join the Network. The funded teletriage is a tremendous advantage for providing call. The doctors in the 'pilots' tell us that the calls from patients for advice have dropped off dramatically, so that the only times that they are called now is when it is really necessary for them to be contacted.

The funded information technology is a major boom—this is government money—one hundred and fifty million dollars being invested in family doctors offices to computerize them. The only access to that money is through Family Health Networks. So I think that it will be a tremendous advantage to doctors who want to computerize. Again, it is not mandatory that they do so.

The potential for funding other health care practitioners is very attractive. I do not have news on that right now—but I feel that will be attractive to many doctors who wish to work with other health care professionals.

The bottom line is that they will be able to serve their patients in a very good way. I know family doctors that already serve their patients well, but this will strengthen and support them in providing the kind of care that they want to provide.

Perspective B:

Andrew Touw, Medical Student, UWO (2004)

Q. *From a student's perspective, how do the goals of the Network, as you understand them, relate to you? Do you see it as a model that would interest you?*

A. Family medicine is not my top priority. It never was for me. I am interested in surgery or emergency. What is interesting about the model is how it makes family medicine sound very interesting and current, looking into the future and developing a new way of doing things.

Q. *Would you consider doing a placement at a Network if the opportunity came up?*

A. I think it would be interesting. We have to do some work in family medicine no matter what area we are going into. I think if it was in the context of a primary care setting, or network setting that has been set up for that, a more professionally run kind of thing, and not just one doctor in their office where you follow them around, it would be a more valuable experience.

Q. *From your perspective, what do you see are the benefits and the challenges of the Network?*

A. One of the impressions that I have, is that we are moving away from a very decentralized, independent system, where each unit in the health care system is independent of each other. Someone would have a family doctor and other health care professionals looking after them, and the Network is moving towards a more integrated model where information about the patient is shared. I think this is a great benefit, but I also think this is going to be a huge challenge

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to get all that information together so that it works and actually helps health care practitioners at the moment when they are interacting with the patient.

Q. *What are your views on a collaborative practice? Because with this Network you are looking at nurse practitioners, you are looking at an integrated model.*

A. From a very pragmatic viewpoint, it is kind of scary for my generation of people heading into the health care system, because we look at it now and see such a shortage of doctors. Then you look at the demographics and increasing number of patients who are aging, and the increasing number of doctors who are retiring, so I think that our only choice is to try and get more help from other health care professionals.

Q. *If you had been exposed to this model earlier on, would it have affected your opinion about family practice?*

A. I think it would have, because I think that this is one of the things that impressed me the most in the presentation. I think that there are a very few number of family medicine physicians who give the rest of them a bad name in medical school because we always hear stories from specialists about patients with uncontrolled hypertension. We look at specialists and they work in hospitals and they all work together, so they see each other and they go on rounds and things like that. It all seems very professional whereas family doctors seem to be on their own. That is the perception that you get as students. I think that it impressed me that this would be a more professional way of doing things. As a young doctor you could ask the opinion of a more experienced doctor, in the Network that you were working in, about a patient, if you had a question. Whereas in the old system you might just refer that person.

Q. *Will the fact that technology is a key factor in the model make it more attractive to the new generation of medical students?*

A. I think so. We see a lot of the great difficulties right now integrating information technology into our medical school curriculum and how that is being developed. But I think if it was done well, in consultation with people who are actually using it, then it would be a real bonus in helping to attract people to work at a Network.

Q. *Do you think that the current curriculum lends itself to this type of practice or to primary care practice?*

A. I would have to say not as much as it could. Western, as a medical school, always graduates more specialists than family doctors. I am not sure why that happens, but I think that the way our curriculum is structured now it emphasizes the role of specialists a lot, because we have subject blocks. If we are doing skin week we are taught by dermatologists.

Q. *Do you have primary health week?*

A. No. We do not have a GP week because it is not an identifiable body system or a process like pregnancy and childbirth.

Q. *Having been exposed to this model, how has it impacted on your views on primary care?*

A. I think it can only increase the communication between all the different health care professionals and the family doctors and specialists. Even if the initial design of the Networks isn't meant to do that, I think that it is the inevitable direction that the health care system is moving toward.

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Local Health Planning In Action

Beyond the Band-Aid - Sustainability in Rural Health Human Resources

On February 15th, key health human resources players in Southwestern Ontario had an opportunity to engage in dialogue with international experts concerning successful models of health human resources and education programs for rural communities without ever leaving London. Using live video hook up, participants interacted with experts in Australia, Norway, Quebec and New Mexico with a view to understanding different models and identifying potential applications for health human resources best practices in Southwestern Ontario. Participants heard about lessons learned and discussed potential future directions that can augment efforts of current health sciences educational programs.

Feedback from the session will be used to develop recommendations and implementation strategies to promote best practices in rural health human resources planning in Southwestern Ontario. For more information on this initiative, contact Tricia Potter at (519) 858-5015 Ext. 222 or by email at tpotter@tvdhc.on.ca

Phase One of Nursing Review in Thames Valley Completed

The Nursing Supply Workgroup of the Health Human Resources Planning Committee is pleased to announce the release of "Setting the Context: Nursing in Thames Valley Understanding Demand". The Report is designed to create a quantitative snapshot of nursing resources in Thames Valley. Using available data from Hospitals, Long Term Care Facilities, Community Care Access Centres and Public Health Units, current and projected nursing levels were developed.

Phase Two of the initiative will focus on supply issues and will be launched in June with the networking session for local nursing stakeholders. For more information on the Report or on plans for Phase Two, contact Tricia Potter at (519) 858-5015 Ext. 222 or by email at tpotter@tvdhc.on.ca

A Patient Focused Model of Service for Northeast London

The TVDHC's London Health System Planning Committee, St. Joseph's Health Care London, The UWO Faculty of Medicine and Dentistry, Department of Family Medicine and Psychiatry, the Middlesex London Health Unit and the Community Care Access Centre of London-Middlesex are partnering to develop a patient focused multidisciplinary primary health care model of service in Northeast London. This model of service will be coordinated in such a way that health and social services are supported on site so that navigation for the patient is perceived seamless. This patient focus also aligns itself with the Ontario Family Health Network (OFHN). In addition, it will address the multidisciplinary collaboration of social workers, nurses, recreation and other supports that address the broader determinants of health and potentially provide a learning environment for students. For more information, contact Linda Hebel at (519) 858-5015 Ext. 224 or by email at lhebel@tvdhc.on.ca

A Cross-Canada Perspective

Who Is Doing What Across Canada

As part of Council's Annual Retreat, an Expert Panel was convened on April 24th, 2002 to discuss the future of Canada's health system. The purpose of the Expert Panel was fourfold:

1. To inform Council on the issues related to identifying a preferred future for Canada's health system.

2. To assist Council in preparing advice to its Minister of Health and Long Term Care on the implication of these issues for the Thames Valley District.

3. To assist Council in preparing to provide informed input to the Romanow Commission on the Future of Health Care.

4. To provide members of Council and its Committee members, a context for comprehensive and integrative health system planning.

In preparation for the Expert Panel, Council staff reviewed a number of reports on the health care system produced by the federal government, selected provincial governments, and independent organizations. A summary document containing the results of this review may be accessed on our website http://www.tvdhc.on.ca. The focus of the summary is to provide an overview of the salient issues that your Health Council will be exploring in the upcoming year.

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Perspective C:
Dr. Tom Freeman, Chair-Department of Family Medicine, UWO

Q. *What do you think the Ontario Family Health Network is trying to achieve?*

A. My sense of what the Network is trying to achieve is that it will offer an alternative way of practicing family medicine to what is now available. First and foremost it alters the way in which physicians are paid. To succeed, however, it needs to be about more than just changing the way that people are paid. It needs to support methods and goals of practice that are more consistent with family medicine goals than what has been possible in the fee for service system. It provides a voluntary means by which family physicians can change the way that they are remunerated, and it supports them in developing networks that are mutually supportive so that they will able to provide their patients 24hr/7day a week coverage. It rewards people who do more than just an office-based practice, which is not currently well recognized in the fee for service system. I also see the Network as encouraging networks of care.

Q. *Do you think that the current curriculum, particularly at Western, lends itself to this type of practice?*

A. It could do better. Our undergraduate curriculum does not do any (at least I'm not aware of any) teaching that takes place between say the School of Nursing and the Faculty of Medicine. Now we have talked about that but it has never actually happened. We talk about it a lot to students and they observe a lot of team-based care in the family medical centres. In fact it's always been a frustration of mine that we train, as I was trained, and we continue to put residents through a system that includes interdisciplinary and team-based approach. It has never been supported out in the community after they finish. I think we do that at the postgraduate or the residency level. I don't think we do a very good job at the undergraduate level.

Q. *Do you see this as being a driver to change that situation?*

A. I'm not aware that the talk about Ontario Family Health Network has stimulated any movement toward that.

Q. *Do you think the structure of the Ontario Family Health Network would promote integration, if not within the educational period, after? Do you see it actually as a structure that would promote integration?*

A. Potentially it could. There's some confusion about the details, about how a Network would develop the funding to bring in other people other than just physicians. And, if it's going to work, it needs to be able to do that. You know the early models of this had included the idea that if you could justify, for example, a mental health worker, based on a needs assessment, you could potentially be eligible to obtain funding for that position. I haven't seen that in the current template, and maybe I'm just missing the subtleties of it, but I think that it would be really desirable to have that in place. There is going to have to be some evolution and that seems to be missing from the first roll-out. It may develop in the future if things succeed.

Q. *Do you feel that students would be attracted to this type of practice?*

A. Well I pitch it to them that way. I point out that it specifically addresses some of the things I've heard from students and residents that they dislike, or are fearful about, in family medicine. The image they have sometimes is that the single practitioner out there doing 24hr/7 days a week gets burned out, or has no family life and no personal life. This allows people to maintain their obligation to their practice population without necessarily sacrificing their personal life. So I think it does address some of the things that have concerned students. That's certainly what I tell them when I talk to them.
At this point in time, however, while the details of this are still being worked out, I don't think it's highly useful for them to get involved in the details of what's exactly in the template. By the time they graduate it will have been changed and modified. But the overall direction of it is something that I think addresses some of the concerns they have expressed to me, specifically the lifestyle concern. I'm hoping that we can point to the advantages of it so that it actually attracts more students to family medicine.

Q. *Do you see the Networks as offering feasible learning opportunities for students? Can you see once some of these Networks are established that it would be an ideal location for students to do some of their clinical work?*

A. It certainly would be. They'd be perfect, I think. Although I don't think they were designed with that in mind. Certainly if we want people to practice in that kind of environment, we should be training them in that environment. To some extent we do that in the teaching units, but when they get out in the practice, so far they don't see that. If we have Family Health Networks that are part of our community teaching lists, I think that would be an ideal way for students to have that, to develop some experience and see that this can happen in the real world. So yes, I do see that.

Q. *And maybe in fact learning experience for medical students, nursing students, and others too.*

A. Absolutely.

Q. *As a practicing physician, in your opinion what are the challenges and opportunities of the Ontario Family Health Network?*

A. The challenges are, as I understand them, talking to people in the pilot studies and so on, are that the stage of rostering a practice as you enter into this is extremely time consuming and can be very difficult for a practitioner to undertake. The information technology piece, which is really a vital component of it, has not worked that well in the existing pilot studies and I know Ruth has told me that they've made some changes to try and improve that. Another challenge is that there's suspicion, a lot of suspicion, among community physicians. I don't think anyone has any illusions that the government is doing this out of the goodness of its heart. I think that kind of suspicion is probably understandable, and maybe not necessarily a bad thing because you need to have some healthy skepticism before you enter into anything of this kind.
I think an opportunity is that the project is headed by someone like Ruth Wilson, who's extremely respected. She has a very high degree of integrity and is someone who has experience in the rural small town, urban practice, teaching, and administrative. She speaks with

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credibility, and she has integrity. I think that was a major coup for them to be able to have her agree to become the director of the Network. I think it's our best opportunity to revive family medicine, which has gone into (I think if we're honest about it) a decline. In this sense we are seeing the fragmentation over the last, particularly in a more rapid way, five to ten years where people are more and more getting their primary care in walk-in clinics and emergency departments. Even in a city like this, significant numbers of people have no other choice. To me that is an extremely poor way of delivering primary health care, and that decline has happened because primary care family medicine has been largely ignored in all the talk about health care reform until quite recently. We have had a lot of interest in the federal and provincial level of primary care reform. I think that this interest and recognition will bring home the point that we are not going to have a healthy health care system unless you have a good primary care system. If that message gets through and we make some changes in the direction that this is going, then I think there's hope that we'll reverse this trend that we've been seeing.

"We have had a lot of interest in the federal and provincial level of primary care reform. I think that this interest and recognition will bring home the point that we are not going to have a healthy health care system unless you have a good primary care system."

Q. *Do you see the Network as having the potential for making the environment better for physicians as well as allowing more people to access primary care?*

A. Well, it's a hot political issue among physicians. When you talk about environment you have to take into account the financial issue. You know that there's the Coalition of Family Practitioners and they're a fairly skeptical group of family physicians. They're not part of the OMA, and they're not part of the Ontario College, and they send out periodic issue statements. They're very skeptical of anything of this nature and believe that the Network will create economic hardships. I think that some skepticism is absolutely necessary, but I don't think that it should get to the point where they don't even want to look at anything. All that the Network is asking right now is that, if you're interested, have a revenue analysis done, which doesn't commit you to anything, the Network will perform one. This means that if you give your permission, the Ontario Family Health Network will look at your OHIP billings and the profile of your practice based on your OHIP billings a year ago and plug this information into a template to show you what you would've received if you would have been in one of the Networks. Now, if you have just a 9-5 office practice, you don't cover your practice, never visit your patients in the hospital, don't do any emerg, don't do any obstetrics, don't go to a nursing home, you're going to probably lose in this. And to me, that is exactly what we want. Because that's the kind of practice that the fee for service system has been perversely supporting for too long. If, however, you do more than your office practice such as visit and better manage your patients in the hospital, see them in the emergency department when necessary, do some obstetrics, or palliative care, or you do some nursing home visits or work, those activities are rewarded over and above what you get for your roster. With this scenario you would actually benefit financially. Some of the people I've talked to who have had a revenue analysis done, who do a full service family practice like I've just described, have told me that their revenue goes up about 30%. We have to have people go through and do the revenue analysis, and some of them are going to be disappointed because they want to do the kind of practice we don't want to reward anymore. So I think you are going to hear people be negative about it. We'll just have to be okay about that. The real thing here, to me, is that this has the ability to actually support what we should be supporting and the fee for service system has not been doing that. We had some hope earlier this year that the RVBS (Relative Value Based Revisions) and the OHIP fee schedule would recognize some of these things. That whole project has been going on for a couple of years now at the OMA, to look at the imbalances that have occurred in the fee schedule over the years, as new procedures have come in and old ones have become easier to do. And often what they paid was based on a time when it was a lot more time consuming to do some of them then it is now. They looked at all that and they applied that, and it was presented to the OMA, and of course what it meant was that some of the very high paying procedurally oriented specialties would make less money. And the outcry, as predicted, has been loud and long. Any family physician who thought that balancing out was going to answer some of our problems, has to realize that it isn't. That politically, those changes are not going to happen at the OMA, that the entrenched forces there are too well entrenched and I don't think we're going to see that the fee for service schedule is going to change substantially in the favour for family physicians. So this reform, the Ontario Family Health Network option, is our best hope for changing things for the better.