



Increasing Access to Integrated Health Care

Pre-Budget Submission

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Executive Summary

The Ontario Medical Association (OMA) has been working with the government over the past 18 months on measures to improve Ontario's health-care system, including putting an end to hallway medicine, investing in front-line care and supporting those struggling with mental illness and addiction. The OMA welcomes this opportunity to provide input to the 2020 Budget. Our submission focuses on investments in four areas: Increasing access to palliative care; enhancing timely access to mental health and addiction services; enabling Ontario Health Teams (OHTs); and addressing physician burnout.

Increasing Access to Palliative Care

The number of Ontarians requiring palliative care is growing and the lack of palliative care resources puts pressure on emergency departments and hospitals. To increase access to palliative care, which will reduce overall costs of and pressures on the health-care system, the OMA recommends that the government:

- 1. Build capacity through palliative education and training to ensure physicians and health-care providers have basic competencies through medical education and continued education programs.**
- 2. Lift the freeze on the number of palliative medicine physicians able to provide services through the Community Palliative Care On-Call (CPOC) program, which will increase availability of urgently required care.**
- 3. Develop, in partnership with the OMA, a provincial strategy for palliative care in rural and remote communities, which would improve equitable and sustainable access to palliative care.**
- 4. Ensure enhanced palliative care is included as part of the integrated health services offered through OHTs.**

Enhancing Timely Access to Mental Health and Addictions Services

Improving mental health and addiction support and investing in early intervention programs will help reduce wait times by getting people the care they need before a crisis occurs. It would also ease the burden on hospital emergency doctors. To improve timely access to mental health and addiction services in Ontario, the OMA recommends that the government:

- 1. Partner with doctors to define consistent, reasonable service standards that would apply to all Ontarians accessing mental health and addiction care. The service standards should reflect the real world of the physician's practice, local hospital and community-based providers.**
- 2. Conduct a provincial capacity assessment for mental health and addictions care and investments in areas with unmet needs.**
- 3. Provide opportunities for physician leadership as it develops its mental health and addiction strategy, beginning in the planning and development stages.**

- 4. Develop a strategy that combats stigma and encourages all Ontarians to be comfortable openly discussing their mental health at home, in the community and with their doctor.**
- 5. Expand and enhance the availability of publicly funded and evidence-based psychotherapy services.**

Enabling Ontario Health Teams

Physicians have long championed a more integrated health-care system. If implemented effectively, one of the most significant results of the new OHTs would be to allow physicians to spend more time caring for patients. To help create and enable OHTs, the OMA recommends the government:

- 1. Invest in physician leadership at all levels and stages of OHTs.**
- 2. Prioritize the exchange and integration of health information across all sectors, especially to support patient transitions in care.**
- 3. Work to achieve integration between different provider EMRs within OHTs; this is expected to require standards-based integration.**
- 4. Provide cybersecurity support for physicians to protect physician practices and reduce system vulnerabilities so that providers can focus on care delivery instead of securing technology.**
- 5. Locate existing care co-ordinators within primary care settings whenever possible on a voluntary basis and with the support of primary care leadership involved. Additional funding/reimbursement to support overhead costs is an important consideration.**
- 6. Ensure that the role of care co-ordinator is expanded to include co-ordination and patient/system navigation, which would address patient needs and the broader social determinants of health.**
- 7. Ensure that the role of care co-ordinators/system navigators be co-designed with physicians, patients, families and other health-care providers, to avoid a one-size-fits-all approach.**
- 8. Establish the necessary IT infrastructure to support patient access and information exchange with care co-ordinators.**

Addressing Physician Burnout

Within our increasingly resource-constrained health-care system, Ontario physicians are facing pressures that affect their own physical and mental health, as well as their ability to do their jobs. The OMA has struck a Burnout Task Force, which will make recommendations this year, based on the contributors and solutions that are identified as most significant by our front-line Ontario doctors. To address the growing problem of physician burnout, the OMA recommends that the government:

- 1. Look to the OMA for leadership on this issue and partner with the OMA to implement the recommendations of the Burnout Task Force.**

The OMA believes we need to focus on finding system-level solutions so we can create an enabling and supportive environment that promotes physician wellness and prevents burnout.

Conclusion

The OMA understands the serious fiscal issues facing the province and the need to spend taxpayers' dollars wisely. Enhanced access to palliative care and mental health and addiction services will lower costs by reducing pressures on our emergency departments and hospitals, helping to end hallway medicine. Properly implemented, OHTs will bring health-care providers together to provide quality, co-ordinated care, enabling patients to easily navigate the system. Working together to find system-level solutions to physician burnout will benefit Ontario patients, doctors and the entire health-care system.

Introduction

The Ontario Medical Association (OMA) represents Ontario's 31,500 practising physicians, as well as 12,500 medical students and retired physicians. In addition to supporting doctors and strengthening their role in caring for patients, the OMA is also a trusted voice in transforming Ontario's health-care system.

The OMA has been working with the government over the past 18 months on measures to improve Ontario's health-care system, including putting an end to hallway medicine, investing in front-line care and supporting those struggling with mental illness and addiction.

The OMA welcomes this opportunity to provide input to the 2020 Budget. Our submission focuses on investments in four areas:

- Increasing access to palliative care
- Enhancing timely access to mental health and addiction services
- Enabling Ontario Health Teams (OHTs)
- Addressing physician burnout

We understand the serious fiscal issues facing the province and the need to spend taxpayers' dollars wisely. Our submission focuses on how the OMA can work with the government to improve access to care and enhance integration across the health-care system. Enhanced access to palliative care and mental health and addiction services will lower costs by reducing pressures on our emergency departments and hospitals, helping to end hallway medicine. Properly implemented, OHTs will bring health-care providers together to provide quality, co-ordinated care, enabling patients to easily navigate the system. Working together to find system-level solutions to physician burnout will benefit Ontario patients, doctors and the entire health-care system.

Ontarians have confidence in their doctors. As front-line health-care workers, Ontario physicians have unique insights into the challenges facing our health-care system. The OMA looks forward to continuing to work with the government on measures to increase access to integrated, high-quality health care across our province.

Increasing Access to Palliative Care

Background

According to Health Quality Ontario, by 2041 the Ontario population of those aged 65 and up is projected to increase by 92 per cent — from 2.36 million to 4.56 million.

With the elderly population growing, the number of people requiring palliative care in Ontario is projected to double, putting increased pressure on physicians and an already burdened health-care system.

Of the 103,213 people who died in Ontario in 2017-18, only a small fraction died from accidents or other sudden causes. The majority of people spend their final months in a palliative state, where they would benefit from specialized medical care, including pain management and other supports. Proper palliative care does not require a hospital setting, yet unfortunately too many remain in a hospital bed. For those who remain at home, they and their families go without support from a palliative-care physician and a care team. Other options, such as care at a hospice, are few and far between. In fact, only 61.4 per cent of patients received proper palliative care in their final year. An expansion of palliative-care services is necessary to provide these patients with the care they need.

The OMA believes improving access to palliative care supports the government's initiatives to reduce unnecessary health costs, end hallway health care and integrate health care through the new OHTs. Improved access to palliative-care services also provides a better and more compassionate experience for patients and their families.

Lack of palliative-care resources puts more pressure on ERs and hospitals

Among those who died in 2017-18 and did not spend their final 30 days in hospital, more than half (54.1 per cent) made an unplanned visit to the emergency department during their final month of life. The Institute for Clinical Evaluative Services reports that the vast majority of palliative care occurs in hospitals, despite overwhelming evidence of the benefits of community-based palliative care. This contributes to hallway medicine. In its 2019 Pre-Budget submission to the provincial government, the Ontario Hospital Association also recognized the need to shift palliative care resources to the community

According to the Canadian Society of Palliative-Care Physicians, palliative care can result in an approximately 30 per cent reduction in spending through reduction in emergency room and intensive care unit visits and hospital admissions. Strong palliative-care programs can also shorten patient stays in hospitals and help to eliminate unnecessary diagnostic tests and interventions. Earlier access to palliative-care supports and services lowers costs and can improve quality of life for patients, allowing them to die with dignity.

Investments in community-based and hospice palliative care will see patients cared for outside a hospital setting, supporting the government's priorities of reducing wait times and hallway medicine.

Issues

1. Shortage of palliative care physicians

Ontario has a chronic shortage of palliative care physicians. As of December 1, 2019, only 236 physicians self-described as being palliative-medicine specialists. This represents just 0.7 per cent of all practising physicians in Ontario, or approximately one dedicated palliative-care physician for every 59,000 people. Another 2,150 physicians, mostly family practitioners, devote at least 10 per cent of their practice to palliative work. This often means these physicians are caring for palliative patients in the evenings and on weekends, after seeing other patients. This is not sustainable.

2. Freeze of the Community Palliative Care On-Call Program

During negotiations for the 2008 Physician Services Agreement, the OMA called for a mechanism that would provide better, faster and more reliable availability of palliative care in the community. In 2013, the Community Palliative Care On-Call (CPOC) Program was established. CPOC provides 24-hour, 365-days-a-year on-call coverage for community-based palliative-care patients. CPOC was open to groups of at least three physicians who primarily provide palliative care, and who:

- Would respond by telephone within a half hour and respond in-person as medically necessary
- Have a minimum of 175 palliative patients or carry out at least 1,250 palliative-care services per year
- Are a community resource for palliative care, including communicating with other physicians, taking referrals, managing patients, providing advice, etc.

Through CPOC, palliative patients and their families can easily access care when it is needed most. Many of these patients are in acute distress, so booking an appointment or speaking to a doctor during regular clinic hours is not an option. Without CPOC, the only other option is a visit to the emergency department, putting unnecessary pressures on this service and increasing the prevalence of hallway medicine.

Even though the demand for palliative-care services is expanding, the Ministry of Health has frozen applications to the CPOC. In 2018-19, only 63 physicians were able to provide services through CPOC. Additionally, CPOC is not equally available around the province, resulting in regional disparities in access to this timely care.

3. Lack of access to palliative care in rural and remote communities

Rural and remote communities have much less access to palliative care than other parts of Ontario. Communities in rural and remote areas, including parts of northern Ontario, have limited access to local supports and services. There is a significant need to ensure equal distribution of hospice care beds, palliative-care providers and resources in these communities.

4. Lack of integration of palliative care services from hospital to home

When patients are nearing the end of life, publicly funded home care services can help ease the financial and mental health burden on family and allow patients to die at home if they wish. In addition to home visits from doctors, registered nurses and nurse practitioners, these services should include personal support, occupational and physical therapy, counselling and other services.

The new OHT model provides an opportunity to integrate enhanced palliative services. Once fully developed, OHTs will consist of groups of health-care organizations, physicians and other health-care providers, working together as a team to provide the full continuum of care for patients in their community.

Recommendations

To increase access to palliative care, which will reduce overall costs of and pressures on Ontario's health-care system, the OMA recommends that the government:

1. **Build capacity through palliative education and training to ensure physicians and health-care providers have basic competencies through medical education and continued education programs.**
2. **Lift the freeze on the number of palliative medicine physicians able to provide services through CPOC, which will increase availability of urgently required care.**
3. **Develop, in partnership with the OMA, a provincial strategy for palliative care in rural and remote communities, which would improve equitable and sustainable access to palliative care.**
4. **Ensure enhanced palliative care is included as part of the integrated health services offered through OHTs.**

Enhancing Timely Access to Mental Health and Addiction Services

Background

The government's 2018 Throne Speech committed \$3.8 billion toward mental health and addiction care over five years. This significant investment demonstrates the government's growing recognition that mental health needs to be considered on a par with physical health.

An OMA survey of physicians identified timely access to services as the greatest opportunity to improve the delivery of mental health and addiction care.

Improving mental health and addiction support and investing in early intervention programs will help reduce wait times by getting people the care they need before a crisis occurs. It would also ease the burden on hospital emergency departments, as individuals with mental health concerns and/or addictions unfortunately experience more frequent visits to emergency departments.

The OMA supported Schedule 1 of Bill 116, *The Mental Health and Addictions Centre of Excellence Act, 2019* and was pleased it received all-party support when it passed in December 2019.

The OMA believes the province needs a core set of consistent, high-quality and connected mental health and addiction services for Ontarians.

Issues

1. Stigma around mental health and addiction

Stigma continues to be a significant barrier to the diagnosis and treatment of mental illness and addiction. It can stop people from seeking help and negatively affect them while they are receiving care. The province has a great opportunity to directly and indirectly champion stigma reduction efforts.

2. Lack of consistent, province-wide service standards

The first step toward developing Ontario's renewed mental health and addiction strategy should be to establish service standards. In other words, we need to determine the minimum timelines and types of care that those experiencing mental health and addiction issues can expect to access, regardless where in Ontario they live. These standards would provide a roadmap on how to best allocate resources, including long-term, sustainable and sufficient funding. We believe the creation of the Mental Health and Addictions Centre of Excellence within the new Ontario Health Agency would be the proper venue for this discussion. However, the OMA and Ministry must be involved as any service standard must be adequately reflected in the context of the Physician Services Agreement (PSA).

3. Lack of information

To ensure resources are allocated appropriately, we need better information on what services currently exist, where there are gaps and what can be done to address these gaps.

4. Opportunities for physician leadership

In 2017, at least 15,700 Ontario physicians — half the total number of practising physicians in the province — provided some form of mental health and addiction care to more than 1.12 million Ontarians.

Physicians understand that mental health and addiction service delivery has been delayed and fragmented and is inequitable in different parts of the province. These factors limit the type and quality of care that can be delivered to patients.

Ontario doctors are on the front lines of mental health and addiction care. They understand the issues and can play a leadership role as the government transforms mental health and addiction services.

5. Increasing access to psychotherapy

Mental illnesses are often multi-faceted and complex, and patients may require treatment for extended periods of time or throughout their entire illness. Evidence-based psychotherapy treatments are often successful in treating a number of challenging, and sometimes debilitating, conditions including the most commonly diagnosed mental illnesses in Canada.

Untreated or undertreated mental illness increases other medical costs and is a barrier to patients regaining a meaningful personal life and returning to work. Today, many patients must wait to receive mental health services.

Recommendations

To improve timely access to mental health and addiction services in Ontario, the OMA recommends that the government and/or Mental Health and Addictions Centre of Excellence:

- 1. Partner with doctors to define consistent, reasonable service standards that would apply to all Ontarians accessing mental health and addiction care. The service standards**

should reflect the real world of the physician's practice, local hospital and community-based providers.

- 2. Conduct a provincial capacity assessment for mental health and addictions care and investments in areas with unmet needs.**
- 3. Provide opportunities for physician leadership as it develops its mental health and addiction strategy, beginning in the planning and development stages.**
- 4. Develop a strategy that combats stigma and encourages all Ontarians to be comfortable openly discussing their mental health at home, in the community and with their doctor.**
- 5. Expand and enhance the availability of publicly funded and evidence-based psychotherapy services.**

Enabling Ontario Health Teams

Background

Physicians and their patients have long championed a more integrated health-care system and look forward to continuing to work with the government on the creation of OHTs. The OMA supports the quadruple aim of the OHT model:

- Better patient and population health outcomes
- Better patient, family and caregiver experience
- Better provider experience
- Better value.

If implemented effectively, one of the most significant results of this new model of care will be to allow physicians to spend more time caring for patients.

Issues

1. Physician leadership

Physician leadership will help ensure the success of OHTs, a health system reform that is intended to lead to cost savings, efficiencies and positive outcomes. Physician leadership means that physicians are meaningfully engaged in all aspects of OHTs, from their development to implementation and evaluation.

Physician leadership can take many forms. For example, physicians may lead the design and structure of a new OHT, shepherd the process of applying to become an OHT, act as administrative leaders, function as clinical leaders within OHTs and assume formal leadership roles as key decision makers within the governance structure of OHTs.

Ontario's physicians want to be involved and to shape this significant health system transformation. However, it is simply not sustainable for them to run their clinical practices and lead OHTs without support for engagement and leadership. Risk of increased physician burnout may result from a variety of factors, including increased workloads and demands on clinical time, growing patient demands, rising costs and the increasing demands of new technology. Therefore, it is important to eliminate barriers to physician participation. Providing opportunities for physician leadership training is also important. Formal physician roles within OHTs need to be established and physician contributions and leadership roles within OHTs should be recognized.

2. Integration of information-sharing systems

The integration of patient care envisioned by OHTs will require deeper integration of health information-sharing systems so that physicians and other health-care providers can access and exchange patient health information, allowing them to provide better patient care.

Better integration of information-sharing systems will also reduce the administrative burden on health-care providers obtaining patient information and will reduce patients' frustration with being repeatedly asked to provide the same information. This would increase efficiency in the delivery of care and help alleviate burnout.

Physicians and other health-care providers who are integrating as part of a single OHT are each likely to have their own electronic medical record (EMR) systems, which may not be compatible. Developing a single system within a sector may not work for all OHTs, due to the effort and costs associated with switching EMR systems. Frustration with electronic tools is one of the leading contributors to provider burnout. Therefore, it will be important to ensure that the transition to integrated electronic information-sharing does not add complexity, unnecessary variation or administrative burdens. We also need to do a better job of connecting with and exchanging information with patients along their care journey, through such things as patient portals and virtual care.

The OMA believes physicians should be involved in the design and development of integrated information-sharing systems. Physicians need to be supported by implementation/change management expertise and by governance and legal expertise to ensure that designs will fit into their workflows and that the technology complies with government legislation and regulations.

3. Patient care co-ordination and navigation

Ontario's doctors value the role of the more than 4,000 care co-ordinators formerly employed by Local Health Integration Networks (LHINs) and see tremendous opportunity to leverage their role and maximize their potential in OHTs. Care co-ordinators help patients access home care, community supports and long-term care and, together with physicians, are often tireless advocates for their patients' needs.

Transitioning care co-ordinators

At a mature state, OHTs are expected to offer patients around-the-clock access to care co-ordination and system navigation services. The OMA recognizes that this reality is still several years away and welcomes the opportunity to co-design how this vision can be realized, including how to best transition care co-ordinators from LHINs and develop their role in a renewed health-care system.

Given that family doctors and primary care teams now provide the bulk of care co-ordination, it may make sense to locate care co-ordinators physically or virtually within primary care settings. Doing so provides an element of medical oversight; promotes continuity of care; supports communication among the health-care team and makes care co-ordinators accessible to patients and providers in their communities.

Attention to the availability (or lack) of space and appropriate reimbursement for overhead costs (e.g., rent for occupied space) will be required.

It should be noted family doctors do not see themselves employing care co-ordinators. However, this may be within the purview of the lead organization within an OHT. Where co-location is not possible or not feasible, OHTs may wish to consider virtual technologies to connect patients with care co-ordinators, either from the primary care clinic or from the patient's home.

Patient navigation

To support continuity in primary care and follow-up of patients' holistic and complex needs, the role of care co-ordinator in primary care within OHTs should be expanded to include patient navigation of the broad range of the services across the health-care continuum. This could include navigating access to physiotherapy, rehabilitation, mental health and addictions services, specialist referrals, agencies and other needs related to the social determinants of health (i.e., income and housing supports).

It will be important to:

- Ensure access to care co-ordinators throughout the week, including setting up a system to address information exchange after hours
- Provide digital exchanges of information whenever possible
- Provide clear and succinct updates with relevant patient information on a regular basis
- Minimize paperwork, forms and other red tape that gets in the way of patients and families getting timely access to needed services and supports.

At minimum, care co-ordinators should be made available virtually to the care team. Key to this is the availability of IT infrastructures that allow the care co-ordinators and care providers to exchange information.

Ultimately, the ability to provide more seamless and integrated care within primary care will affect the success of OHTs and will be a key line of defence against hallway medicine.

Recommendations

To help create the OHTs and enable them in the areas of integrated election information-sharing and patient care and navigation, the OMA recommends the government:

1. **Invest in physician leadership at all levels and stages of OHTs.**
2. **Work to prioritize the exchange and integration of health information across all sectors, and especially to support patient transitions in care.**
3. **Work to achieve integration between different provider EMRs within OHTs; this is expected to require standards-based integration.**
4. **Provide cybersecurity support for physicians to protect physician practices and reduce system vulnerabilities so that providers can focus on care delivery instead of securing technology.**
5. **Locate existing care co-ordinators within primary care settings whenever possible on a voluntary basis and with the support of primary care leadership involved. Additional funding/reimbursement to support overhead costs is an important consideration.**
6. **Ensure that the role of care co-ordinator is expanded to include co-ordination and patient/system navigation, which would address patient needs and the broader social determinants of health.**
7. **Ensure that the role of care co-ordinators/system navigators be co-designed with physicians, patients, families and other health-care providers, to avoid a one-size-fits-all approach.**
8. **Establish the necessary IT infrastructure to support patient access and information exchange with care co-ordinators.**

Addressing Physician Burnout

Background

Burnout has been recognized as a crisis in health care around the world and Ontario is no exception. As defined by the World Health Organization, “burnout is a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed. It is characterized by three dimensions: 1) feelings of energy depletion or exhaustion; 2) increased mental distance from one’s job, or feelings of negativism or cynicism related to one’s job; and, 3) reduced professional efficacy. Within our increasingly resource-constrained health-care system, physicians are facing pressures that affect their own physical and mental health, as well as their ability to do their jobs.

Changes in clinical work (e.g., more complex patients, rising patient numbers etc.), longer work hours, increased administrative requirements and non-integrated technology solutions all contribute to rising levels of physician burnout. This, in turn, leads to higher turnover and increased likelihood of early retirement, further straining the health-care system. Burnout can also have serious implications for physicians and their families; suicide rates for physicians are six times higher than for the general population.

The wide array of factors that contribute to burnout indicate system-wide problems. The OMA believes we need to move away from looking at burnout as a matter of individual resilience and instead promote

a model of shared responsibility. We need to focus on finding system-level solutions so we can create an enabling and supportive environment that promotes physician wellness and burnout prevention. Such a focus will benefit Ontario's patients, physicians, and ultimately the whole health-care system.

Issues

1. OMA Burnout Task Force

The OMA has taken a leadership role by striking a Burnout Task Force in 2019 to understand the system-level causes and effects of physician burnout in our province.

In 2020, the Burnout Task Force will make recommendations to address physician burnout, based on the contributors and solutions that are identified as most significant by front-line Ontario doctors.

The government and the OMA need to work together to implement solutions to physician burnout and other health-care system issues. Experience in health reform efforts around the world has shown that physicians are crucial to health systems transformation and that health transformation fails if physicians are not at the table as active participants.

Recommendation

To address the growing problem of physician burnout, the OMA recommends that the government:

- 1. Look to the OMA for leadership on this issue and partner with the OMA to implement the recommendations of the Burnout Task Force.**

Conclusion

The OMA welcomes the government's commitment to streamline the health-care system and provide timely access to improved and integrated health care across our province. We appreciate this opportunity to provide input into the 2020 Budget on behalf of Ontario's 31,500 practising physicians.

Our recommendations are designed to support the government's measures to improve access, end hallway medicine and strengthen front-line care. Increased access to palliative care and mental health and addiction service will help Ontario families and reduce pressure on our hospitals and emergency departments. Giving OHTs the tools they need to be most effective will help patients navigate the system and increase access to integrated, quality care. Supporting Ontario doctors by exploring system-level solutions to burnout will benefit the entire system.

Ontario's doctors look forward to continuing to work with the government on improvements to our health-care system that will lead to improved, timely, integrated care for the people of Ontario.