

**Patient Care Groups:  
A new model of population based  
primary health care  
for Ontario**

**A report on behalf of the Primary Health Care Expert Advisory Committee**

**By David Price, Elizabeth Baker,  
Brian Golden and Rosemary Hannam**

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## **Patient Care Groups: A new model of population based primary health care for Ontario**

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This paper is in final format and was authored by David Price, Elizabeth Baker, Brian Golden, and Rosemary Hannam on behalf of the Primary Health Care Expert Advisory Committee [members listed below]. While this report has achieved general consensus amongst the Committee, membership on the Expert Advisory Committee does not necessarily indicate full endorsement of every recommendation. While the authors were guided by the critically important input of the members of the Committee, this document was also influenced by a review of the literature and the authors' understanding of selected primary care models in other jurisdictions.

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Matthew Anderson, Elizabeth Baker, Mike Bell, Michelle Clifford-Middel, Dr. Rick Glazier, Brian Golden, Paul Huras, Ross Kirkconnell, Dr. Danielle Martin, Dr. Sarah Newbery, Dr. Harry O'Halloran, Dr. David Price, Dr. David Schieck, Dr. Joshua Tepper, Carol Timmings, Ruta Valaitis.

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## Table of Contents

<b>Executive Summary</b> .....	3
1.1. <i>A short history of primary health care reform</i> .....	7
<i>Definition of Primary Health Care</i> .....	7
<i>Primary Health Care is the Cornerstone</i> .....	7
<i>Recent Progress in Primary Health Care Delivery</i> .....	8
<i>Opportunities for improvement in Primary Health Care Delivery</i> .....	10
1.2 <i>Ministry Policy Questions to the Committee</i> .....	11
1.3 <i>About the Expert Advisory Committee on Strengthening Primary Health Care in Ontario</i> .....	11
<b>2.0 Advice from the Expert Panel on Strengthening Primary Health Care in Ontario</b> .....	13
2.1 <i>Introduction</i> .....	13
2.2 <i>Effective system design should be built on a clearly articulated vision with internally consistent principles</i> .....	14
<b>3.0 Patient Care Groups: A Redesign of Primary Health Care in Ontario</b> .....	16
3.1 <i>Recommended Design</i> .....	16
<i>Patient Assignment</i> .....	17
<i>PCG Organization and Management</i> .....	18
<i>Accountability and Governance</i> .....	19
<i>Funding, Contracting, and Service Delivery</i> .....	19
<i>Health Human Resources</i> .....	21
<i>Information Technology</i> .....	22
<i>System Collaboration, Coordination and Scale Economies</i> .....	22
3.2 <i>Strategic Alignment</i> .....	23
<i>Mandate Letter</i> .....	23
<i>Health Care Transformation</i> .....	23
<i>Integration with Health Links</i> .....	24
3.3 <i>Model Summary</i> .....	24
3.4 <i>Diagram</i> .....	25
<b>4.0 Issues requiring further discussion and investigation</b> .....	26
<b>5.0 Proposed Implementation</b> .....	28
5.1 <i>An incremental approach is recommended for implementation, building on the strengths of the current system.</i> .....	28
<b>Appendix 1: Terms of Reference</b> .....	29
<b>Appendix 2: Bios for members of the Expert Advisory Committee</b> .....	33
<b>Appendix 3: Summary of Recommendations of the Five Working Groups, September 2011</b> .....	38
<b>Appendix 4: Primary Care Models</b> .....	38

## Executive Summary

In late 2013 the Ministry of Health and Long-Term Care (the “ministry”) convened the *Expert Advisory Committee on Strengthening Primary Health Care in Ontario* to address current challenges in Ontario’s primary care system. The ministry identified four policy questions of particular interest:

1. How can we ensure all Ontarians are attached to a regular primary care provider?
2. How can we ensure that Ontarians who need the services of an inter-professional care team can obtain them?
3. How can we improve integration in primary care, both among primary care providers and between primary care and other parts of the system?
4. How can we ensure Ontarians can access primary care after business hours and on weekends when needed?

In response, the Committee has proposed a vision for an integrated primary health care system for Ontario, based on a redesign of the province’s existing primary care sector. The foundation of the redesign is a population-based model of integrated primary health care delivery, designed around **Patient Care Groups (PCGs)**; which are fund-holding organizations that are accountable to the ministry through the Local Health Integration Networks (LHINs). Features of the PCG model include<sup>5</sup>:

### *Patient Assignment*

1. Groupings of Ontarians will be formed based on geography<sup>6</sup>, akin to the assignment of students within the public school system. Citizens within each grouping are assigned to a PCG, and then rostered to a primary care provider (physician or nurse practitioner) contracted by the PCG. In most cases, patients will retain their ability to choose their provider.
2. Each PCG will develop a system of coordinating the capacity of the delivery models in their region to ensure unattached patients are connected to a provider, thus ensuring universal access.
3. A system for managing exceptions will be developed. For example, patients with pre-existing relationships with providers who reside outside the PCG catchment area could be included in a neighbouring PCG allocation through PCG to PCG transfer payment agreements. Such a system could also be used to address commuters, seasonal vacationers, and patients accessing specialized primary care services (e.g., a falls prevention clinic, primary care of the elderly) in a neighboring PCG, or patients needing particular culturally sensitive care delivery.
4. Patients difficult to assign (e.g., those without permanent housing or without health cards) will be identified and assigned to the PCG in collaboration with Public Health, community health centres and the local municipal services. The funding formula would reflect the needs of this patient group; however, it is recognized that supplemental funding may be required.

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<sup>5</sup> Additional features are described in the body of the report.

<sup>6</sup> Partially based on analysis of natural groupings of primary care entities by ICES.

### *PCG Organization and Management*

5. Roles specific to each PCG include executive director, clinical leads (physician and/or nurse practitioner), care coordinator, and community representative (patient). Functions at the PCG level include contracting and contract oversight, finance and accounting, health human resource planning, and care coordination.
6. Services shared by all PCGs could be managed at the LHIN level and include population needs assessments, information technology, contracting, purchasing, indicator development and monitoring, quality improvement planning, health human resource (HHR) planning, and training. Collaboration with Public Health, Health Quality Ontario (HQO) and others would ensure appropriate service planning and monitoring.

### *Accountability and Governance*

7. Similar to accountability agreements between hospitals and LHINs, each PCG holds an accountability agreement with the LHIN, renewed annually. These accountability agreements include patient-level and population-level indicators, which will be determined by the ministry in partnership with the LHIN, HQO and Public Health. Some indicators may be common across LHINS and PCGs while others may be specific to the unique needs of a population.
8. A PCG is identified as the “most responsible organization” (MRO) for their assignment group. In turn, each primary care provider who is contracted with the PCG will be the “most responsible provider” (MRP) for the individual patient.

### *Funding, Contracting and Service Delivery*

9. Funding to each PCG is determined on a per capita basis, reflecting the demographics, geographic rurality of the population, socio-economic status, and projected health needs of its catchment population<sup>7</sup>. The PCG then contracts with its local primary care providers, honouring existing relationships and agreements currently in place, to deliver primary care services to its citizens. Primary care providers, along with the local Public Health Unit and municipal services, are collectively responsible for the health of the population within their catchment area.
10. Each PCG contracts with and holds accountable current delivery models (CHCs, FHGs, FHOs, AHACs and NPLCs) or other providers such as Public Health and hospitals however organized. Contracts would specify service delivery expectations for patients and consequences to the provider if not met (including provision of performance improvement support). Monitoring would occur on a regular basis to ensure appropriate volumes and continuous high quality service delivery, defined by quality benchmarks articulated in the contract.
11. Physicians are paid through the contract between the PCG and their existing delivery model (FHG, FHO, etc.).

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<sup>7</sup> Funding levels will be determined in partnership with Public Health and others involved in epidemiological analysis and research.

12. Each PCG ensures its patient population has appropriate access to primary care services – both “Regular” and “After Hours” – and may choose to coordinate multiple clinics, provider teams, urgent care centres and emergency department services to achieve this.
13. Clinics that are currently not part of a primary care delivery model (e.g., walk-in clinics, travel clinics, etc.) would be required to contract with at least one PCG and meet service delivery criteria and quality performance standards in order to receive funding at full OHIP levels; clinics not contracted by a PCG would be unable to bill at current OHIP rates.

#### *Health Human Resources*

14. Each PCG ensures the availability of inter-professional primary health care services to primary care providers and their patients, either directly (in which case services are delivered by the PCG) or indirectly (whereby the PCG contracts with a FHT, a CHC, or a hospital, for example).
15. Some regions may have a surplus of certain types of providers and many will have gaps. The PCG’s contracting mechanism is expected to address this issue as PCGs determine and contract for the health human resources needed to satisfy their accountabilities to patients. This is anticipated to result in a more equitable distribution of HHR as it will encourage the movement of health care providers to currently underserved regions and away from regions in which there is a surplus.

#### *Information Technology*

16. Each PCG enables collaboration, integration and enhanced patient safety by providing and supporting an integrated, cross-platform, shared database with an integrated/connected Electronic Medical Record (EMR) that is accessible from any point of care within the PCG.

#### *System Collaboration, Coordination and Scale Economies*

17. The focus is on the functions of a PCG necessary for effective primary health care delivery, not on who performs them. Current structures and organizations will be leveraged wherever possible, and when new structures are required they will replace an existing entity, not add a new one. It is also possible that PCGs could share services and staff with nearby PCGs.
18. Each PCG ensures coordinated care for patients through collaborative relationships with the local hospital, long term care facility, CCAC, and other community-based providers, achieving horizontal (coordination between primary health care practice settings) and vertical (coordination between primary health care and other parts of the system) integration.
19. Each PCG coordinates with other services beyond the traditional health sector to create communities and environments that promote the health of its patient population.
20. Each LHIN has a Primary Health Care Council to provide a forum to disseminate best practices, address common problems and opportunities, and achieve economies of scale for common interests such as contracting, IT, etc.

Given the variety of care delivery settings in the province, the Committee noted the need to develop variations of the PCG model: (1) “Standard” PCG with a roster of patients scaled to meet the needs of a logical population group, (2) “Rural” PCG (aligned with Rural Hub model), and (3) “Urban” PCG for large urban centres.

Possible scenarios, but not limited to these, include:

1. An existing, high functioning suburban Health Links organization expands its functions, scope and responsibilities, as described in this report, and establishes a PCG as part of its operations. (“Standard” PCG)
2. A small, rural hospital assumes the functions and responsibilities of the PCG for primary care in its region. (“Rural” PCG)
3. A large urban Family Health Team (FHT) leverages its management resources while maintaining and expanding its inter-professional services and assumes the functions and responsibilities of a PCG. (“Urban” PCG)

This approach to primary care has been designed with an acute awareness of the full spectrum of structures and services in the Ontario health system, and allows for a variety of forms to meet the primary care needs of Ontarians. The new design will be aligned with and complement, not duplicate, existing structures such as LHINs and Health Links, and support the ministry’s health system transformation agenda. For example, the Committee noted that aligning the PCG model with Health Links has the potential to accelerate advances in primary care and use existing system resources.

Finally, the Committee recognizes that key stakeholder and Ministry of Health and Long-Term Care support are required to fully develop the individual components of this innovative model and has begun to identify a number of issues that need further attention, described at the end of the report. These include, but are not limited to, financial and labour resourcing, implications for current contracting relationships, and population-based needs assessment methodologies (see Section 4.0 for the full set of issues).

The PCG model promises to provide numerous benefits to Ontarians by ensuring integrated, comprehensive care with consistent provider relationships. Primary health care providers will be given the opportunity to work within a system that rewards high quality care, provides opportunities for innovative care delivery, increased integration with other primary health care providers and the broader system, shared resources, and increased quality of work-life, all while recognizing and functioning within current fiscal constraints.

## 1.0 Introduction

### 1.1 *A short history of primary health care reform*

#### *Definition of Primary Health Care*

The 2003 World Health Report states that “no uniform, universally applicable definition of primary health care exists...” but it is generally understood to mean the first level of care in developed countries, including the services of family physicians, nurse practitioners, nurses, pharmacists, and others. The activities included in primary health care delivery vary according to location; it is the core principles that are most relevant and worth noting:

- Universal access to care and coverage on the basis of need;
- Commitment to health equity as part of development oriented to social justice;
- Community participation in defining and implementing health agendas;
- Intersectoral approaches to health.

The report also emphasized the need to integrate the values of primary health care within the context of the broader health system in any given country, noting that health of the population requires both upstream health promotion and effective disease management throughout the continuum:

“A health system based on primary health care will:

- build on the principles of equity, universal access, community participation, and intersectoral approaches;
- take account of broader population health issues, reflecting and reinforcing public health functions;
- create the conditions for effective provision of services to poor and excluded groups;
- organize integrated and seamless care, linking prevention, acute care and chronic care across all components of the health system;
- continuously evaluate and strive to improve performance.”<sup>8</sup>

#### *Primary Health Care is the Cornerstone*

Primary health care is considered the cornerstone of any health care system and as such must be an area of focus when addressing broader health system challenges. In what many regard as seminal research into the impact that primary care has on overall health system performance, Starfield, Shi and Macinko concluded that “a greater emphasis on primary care can be expected to lower the costs of care, improve health through access to more appropriate services and reduce inequities in the population’s overall health.” Their research identified six characteristics of primary care associated with positive impacts on population health. These include: greater access to needed services; greater quality of care; greater focus on health prevention; earlier management of health problems, a focus on appropriate whole person care, and a reduction in inappropriate use of specialists.<sup>9</sup>

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<sup>8</sup> The World Health Organization Report 2003, p 108

<http://www.who.int/whr/2003/en/Chapter7.pdf>

<sup>9</sup> Starfield et al, “Contribution of Primary Care to Health Systems and Health”, Millbank Quarterly, 83(3), 2005

[http://www.commonwealthfund.org/usr\\_doc/Starfield\\_Milbank.pdf](http://www.commonwealthfund.org/usr_doc/Starfield_Milbank.pdf)



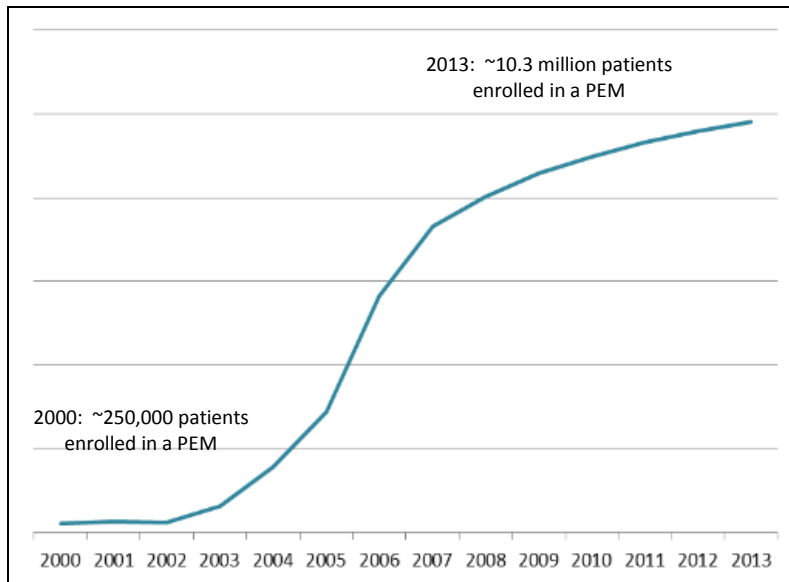
Prior to the work by Starfield et al, the province of Ontario embarked on a journey to reform its primary care sector. A 1994 Special Report in *Canadian Family Physician*<sup>10</sup> laid out nine (9) principles that should drive this reform. These include: (i) practice registration (patient enrolment); (ii) a system of blended funding (salary, capitation, incentives); (iii) local authority with fiscal responsibility for coordinating care; (iv) primary care through interprofessional teams; (v) use of health targets; (vi) central health records; (vii) computerized databases; (viii) a managed system, and; (ix) a balance between preventative, curative and palliative services.

### *Recent Progress in Primary Health Care Delivery*

Reforms put in place in Ontario since the First Ministers' Health Accord in 2003 (which announced targeted funding for primary health care) have resulted in improvements along a number of dimensions:

**Access.** As of 2013, over 10.3M Ontarians are formally enrolled to a family physician and approximately 500,000 are registered to non-enrolment models such as Community Health Centres (CHCs), Aboriginal Health Access Centres (AHACs) and Nurse Practitioner-Led Clinics (NPLCs). Unattachment, defined here as citizens who lack an ongoing provider relationship through a Patient Enrolment Model (PEM), CHC, AHAC, NPLC or Rural and Northern Physician Group Agreement (RNPGE), has dropped by an estimated 1.5M Ontarians since 2003 to approximately 3M.<sup>11</sup>

Ontario: Enrolment in a Patient Enrolment Model, 2000-2013

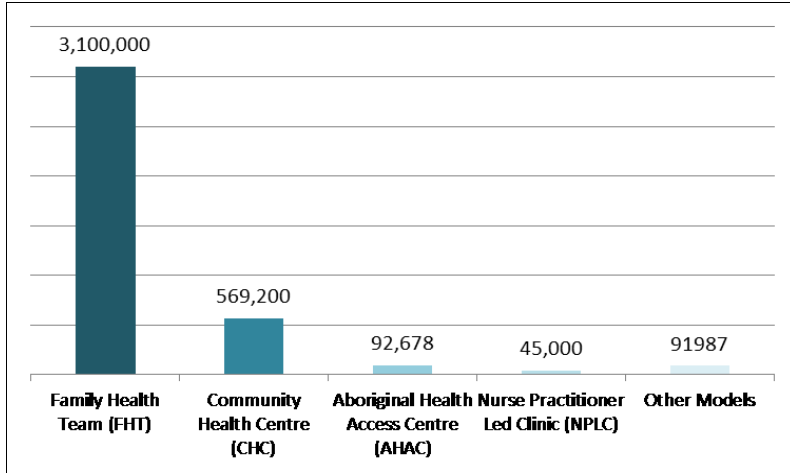


<sup>10</sup> Forster et al, "New Approach to Primary Medical Care", *Canadian Family Physician*, 40, Sept 1994  
[http://www.researchgate.net/publication/15279277\\_New\\_approach\\_to\\_primary\\_medical\\_care\\_Nine-point\\_plan\\_for\\_a\\_family\\_practice\\_service?ev=prf\\_cit](http://www.researchgate.net/publication/15279277_New_approach_to_primary_medical_care_Nine-point_plan_for_a_family_practice_service?ev=prf_cit)

<sup>11</sup> Primary Health Care Branch, Ministry of Health and Long-Term Care

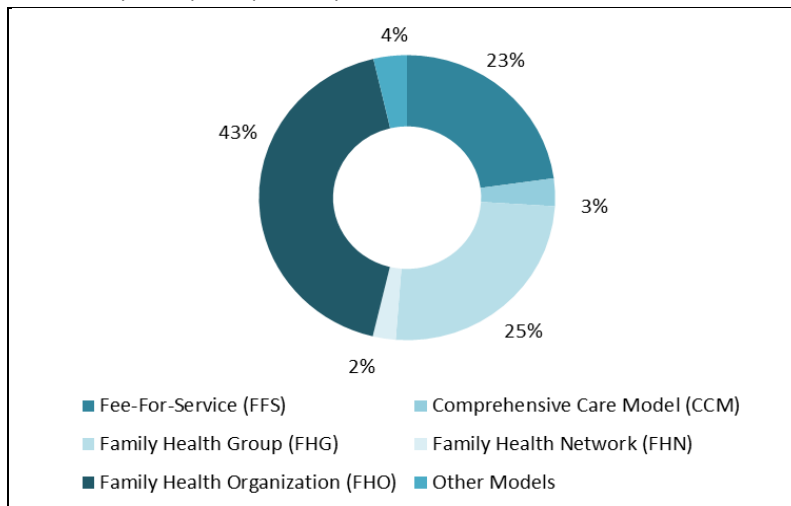
**Interprofessional Care.** Nearly 4M Ontarians have access to comprehensive, interprofessional care teams. Patients receive interprofessional care through four main models: Family Health Teams (FHTs), CHCs, AHACs and NPLCs, which were created or expanded over this decade of reform.

Ontario: Patients served by Interprofessional primary care teams



**Provider Participation.** Between 2005 and 2010 there has been a 17% increase in RNs and RPNs practising in primary care and a 95% increase for NPs.<sup>12</sup> Between 2003 and 2012 there was a 26% increase in the number of family physicians practising in Ontario, the majority of which (over 70%) practise in comprehensive care patient enrolment models that include blended payments.

Ontario: Physician participation by model



<sup>12</sup> Nursing Policy and Implementation Branch, Ministry of Health and Long-Term Care

**EMR Adoption.** There are currently more than 11,600 primary care providers enrolled in an EMR adoption program, representing coverage for more than 10 million Ontarians.<sup>13</sup>

### *Opportunities for improvement in Primary Health Care Delivery*

Primary care practice-level reforms were essential to address the immediate challenges that Ontario was facing over ten years ago, particularly related to poor access, insufficient focus on disease prevention and chronic disease management and inadequate provider supply. However, a decade later there remain considerable gaps in both primary health care delivery and overall health system performance.

A variety of reports and journal articles have reviewed the progress of the reforms and made efforts to describe and understand the areas for improvement at both levels. Those focused on primary health care include the 2011 Auditor General's report which noted that despite large investments, the reforms have had limited impact in certain areas, particularly access to care. Although many Ontarians were connected to a family physician through the patient enrolment models, wait times to see their physician within two days had remained unchanged.<sup>14</sup> The 2013 Health Quality Ontario report pointed to the same wait time challenge, and highlighted the need to improve screening rates and reduce the rates of hospitalization for diseases that could be treated in the community.<sup>15</sup> A 2010 article in JAMA also noted gaps in access to the new models for vulnerable groups, limited progress on availability of after-hours care and unnecessary emergency room visits.<sup>16</sup>

In terms of the health system beyond primary care, the 2012 report from The Commission on the Reform of Ontario's Public Services (The "Drummond Commission") highlights the broader context in which we need to address these gaps. It commented on:

1. Constraints on the public purse, noting both that health care expenditures account for nearly 50% of every Ontario tax dollar and that the province has a \$12.5B deficit;
2. Ontario's aging population and the implications of that for health care spending and access.

With regards to international comparison, the 2014 Commonwealth Fund report on the health system performance of 11 countries ranked Canada 10<sup>th</sup> overall, indicated particularly low scores in quality, safety, access, timeliness, efficiency and equity.<sup>17</sup>

In light of these observations, the opportunities to improve health system performance can, in part, be addressed through system-level reforms and redesign of a currently disjointed system made up of largely independent and generally siloed organizations. The aim of this system reform therefore is to ensure access to appropriate, timely, high quality, cost effective primary health care for all Ontarians in order to improve the health of citizens and value overall.

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<sup>13</sup> eHealth Liaison Branch, Ministry of Health and Long-Term Care

<sup>14</sup> 2011 Annual Report to the Office of the Auditor General of Ontario, p 152

<sup>15</sup> Health Quality Ontario, Yearly Report on Ontario's Health System, 2013

<sup>16</sup> Glazier, R & Redelmeier, D, Building the Patient-Centred Medical Home in Ontario, JAMA, June 2, 2010 – 303(21)

<sup>17</sup> Commonwealth Fund, Mirror, Mirror on the Wall: How the Performance of the US Health Care System Compares Internationally, 2014 Update

## 1.2 Ministry Policy Questions to the Committee

In the fall of 2013 the Ministry of Health and Long-Term Care (the “ministry”) convened an Expert Advisory Committee on Primary Health Care to address the opportunities above. Specifically, the ministry formulated the following four policy questions for discussion and recommendations.

<b>Policy Question</b>	<b>Description</b>
<b>1. How can we ensure all Ontarians are attached to a regular primary care provider?</b>	<p>Increase access to primary care for the three million Ontarians who lack a provider relationship through a Patient Enrolment Model (PEM) or Rural and Northern Physician Group Agreement (RNPGA) while being mindful of :</p> <ul style="list-style-type: none"> <li>• The choice-based model of enrolment for both patients and clinicians;</li> <li>• Varied local contexts and challenges that exist related to access across the province, e.g., rural/northern communities, City of Toronto, fast growing urban centres, etc.;</li> <li>• Differing needs of specific patients groups, e.g., unattached, complex, high users, ethnic groups, very young and very old; and</li> <li>• The difference between “access” to care and meaningful access to comprehensive, high quality primary care.</li> </ul>
<b>2. How can we ensure those Ontarians that need the services of an interprofessional care team can obtain them?</b>	<p>Expand appropriate access to high quality, comprehensive interprofessional teams, while being mindful of:</p> <ul style="list-style-type: none"> <li>• current interprofessional models;</li> <li>• local/regional barriers to developing or expanding interprofessional care teams.</li> </ul>
<b>3. How can we improve Integration in Primary Care?</b>	<p>Increase horizontal and vertical integration in the health system:</p> <ul style="list-style-type: none"> <li>• among primary care providers</li> <li>• between primary care and other parts of the health care system (e.g., acute care, long-term care, etc.).</li> </ul>
<b>4. How can we ensure Ontarians can access primary care after business hours and on weekends when needed?</b>	<p>Increase access to after-hours primary care, while being mindful of:</p> <ul style="list-style-type: none"> <li>• The choice-based model of enrolment for both patients and clinicians;</li> <li>• The role of personal choice in both accessing primary care and in the delivery of primary care services by clinicians;</li> <li>• Varied local contexts and challenges that exist related to access across the province, e.g., rural/northern communities, City of Toronto, fast growing urban centres, etc.;</li> <li>• Differing needs of specific patients groups, e.g., unattached, complex, high users, ethnic groups, very young and very old; and</li> <li>• Trade-offs between providing access to care and ensuring that primary care is coordinated and continuous (e.g., walk-in clinics).</li> </ul>

## 1.3 About the Expert Advisory Committee on Strengthening Primary Health Care in Ontario

The Expert Advisory Committee has its origins in the 2009 McMaster Health Forum that had a similar mandate which was to review the shortcomings in primary health care and consider opportunities for reform. Two years later over 100 individuals representing academia and providers continued the

discussion in an initiative called Strengthening Primary Health Care in Ontario which led to five papers on: Quality, Access, Efficiency, Accountability and Governance and over 100 recommendations (see summary in Appendix 3) in the fall of 2011.

Acknowledging the complexity of the challenges and the need for more focused, evidence-based and expert advice to address the recommendations, the ministry asked individuals from a broad cross-section of both disciplines and geography to sit on the Expert Advisory Committee. Members were invited to participate based on their expertise, and were expected not to act as advocates for their organizations or professional body.

It is recognized that the recommendations provided by the Committee in response to the questions are not binding on government but rather, reflect the general discussion of the Committee. The goal of the Committee is to reach consensus, with no requirement of unanimity, in its advice.

The formal mandate<sup>18</sup> of the Committee is to provide advice to the ministry to assist in the advancement of the primary health care transformation agenda. The Committee is co-chaired by Dr. David Price and by Elizabeth Baker, NP and reports, through the co-chairs, to the Assistant Deputy Minister (ADM), Negotiations and Accountability Management Division (NAMD) of the ministry, who serves as the executive lead for primary care within the ministry.

Members are listed below, with their biographies in Appendix 2:

<b>Expert Advisory Committee Membership</b>
Co-Chair: Dr. David Price
Co-Chair: Elizabeth Baker
Matthew Anderson
Mike Bell
Michelle Clifford-Middel
Dr. Rick Glazier
Brian Golden
Paul Huras
Ross Kirkconnell
Dr. Danielle Martin
Dr. Sarah Newbery
Dr. Harry O'Halloran
Dr. David Shieck
Dr. Joshua Tepper
Carol Timmings
Ruta Valaitis

<sup>18</sup> See Appendix 1 for Terms of Reference

## 2.0 Advice from the Expert Panel on Strengthening Primary Health Care in Ontario

### 2.1 Introduction

To quote Dr. Paul Batalden, Dartmouth pediatrician and former Chair of the Institute for Healthcare Improvement, “Every system is perfectly designed to obtain the results it gets”<sup>19</sup> – many intended, and some unintended. The root causes behind the four policy questions above are found in the design of the Ontario health system. “Design” refers not only to structural relationships and governance, but also to reward systems, human resources, and information and decision support systems. To address the four policy questions – and achieve additional improvements – the design of the often disjointed primary care sector needs to be refined, and also requires more effective linkages with other parts of the Ontario health and social system (e.g., acute care, mental health care, long term care, home and community care, and also public health and its non-health sector partners such as the Ministries of Education, Transportation, and Environment). Improved system design involves the ‘what’ (what system are we working towards?) and ‘how’ (how will we implement needed changes?)

The Committee began meeting in late 2013 to first characterize the current state of primary health care in Ontario and then to develop a refined vision for primary health care in the province. In addition to the observations noted above and the four questions posed by the ministry, the Committee also reviewed the five papers written in 2011 and identified key areas for improvement in the current system. Among these:

- The need to ensure clear accountability for providers and consumers of health care beyond regulatory requirements;

- The need to ensure optimal function of our interprofessional teams, both in terms of ensuring each member is working to his or her full scope of practice and in distributing the services equitably;

- The lack of a governing system to ensure effective integration between primary care providers, and between providers and other parts of the health sector and beyond, including public health;

- The need to consider indicators of the overall health care needs of communities in planning and provision of services;

- The high number of models of care (see Appendix 4) contracts, funders and funding models leading to challenges for integration and effective management, variation in efficacy, and duplication of services with associated costs;

- The need for greater attention to elements of quality such as patient safety and commitment to continuous quality improvement.

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<sup>19</sup> This quote is widely attributed to Dr. Paul Batalden, 2004 e.g., [http://www.clinicalmicrosystem.org/assets/materials/presentations/pdf/2004\\_03\\_diagnosing\\_treating.pdf](http://www.clinicalmicrosystem.org/assets/materials/presentations/pdf/2004_03_diagnosing_treating.pdf)

The Committee observed that Ontario has over a decade of experience launching discrete initiatives including new delivery models, new incentive systems and payment schedules that only partly address primary health care challenges. It has taken the position that instead of a similarly fragmented approach, the province should pursue a redesign in the primary care sector that will, among other things, address persistent issues related to the topics above leading to an eventual fundamental redesign.

It must be noted that as of the writing of this document, the deliberations had not yet moved beyond the Committee; stakeholders will be engaged when appropriate to refine the initial model described below and help set the stage for implementation.

## *2.2 Effective system design should be built on a clearly articulated vision with internally consistent principles.*

### **Vision**

The Committee developed the following vision to guide its focus:

In three years the design elements necessary for Ontario to have an effective primary care system to improve population health outcomes will be in place. Every Ontarian will identify with a primary care provider from whom he or she receives high quality care. That care will be:

- timely,
- comprehensive and coordinated,
- person-centred and community-based,
- interprofessional team-based,
- safe, with a commitment to continuous quality improvement, and
- of good value both financially and in improved health outcomes.

### **Principles**

Building on the principles articulated in the 1994 Special Report in *Canadian Family Physician*, the Committee identified the following principles to guide its work:

1. The primary care system supports engaged, empowered citizens and their circle of care.
2. The primary care system is equitable. Every citizen is provided access to a primary care provider, either family physician and/or nurse practitioner. The primary care provider works in conjunction with an inter-professional team to provide comprehensive and continuous care.
3. The system is built on joint accountability: Each primary care provider group is responsible for a given population and their primary health care needs. Both provider groups and citizens are expected to use the system responsibly.

4. Each primary care provider group is responsible for the care of their patients within their community and in other parts of the system, acting as the centre or home for their care throughout the health sector.<sup>20</sup>
5. The primary care system accommodates variation due to geography and builds on existing infrastructure.
6. Linkages and connections with the broader health and social system are strengthened and support horizontal and vertical integration while minimizing fragmentation of care.
7. The system recognizes and functions within current fiscal constraints.
8. The focus is on the functions necessary for effective primary care delivery, not on who performs them. Current structures and organizations will be leveraged wherever possible, and when new structures are required they will replace an existing entity, not add a new one.
9. The recommendations are implementable in the short to medium term and with a reasonable expectation of success.
10. The recommendations support local governance and accountability, and ensure alignment with ministry provincial policy priorities.

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<sup>20</sup> See for instance the College of Family Physicians of Canada's discussion paper "Patient-Centred Primary Care in Canada: Bring it on Home" October 2009  
[http://www.cfpc.ca/uploadedFiles/Resources/Resource\\_Items/Bring20it20on20Home20FINAL20ENGLISH.pdf](http://www.cfpc.ca/uploadedFiles/Resources/Resource_Items/Bring20it20on20Home20FINAL20ENGLISH.pdf)



## 3.0 Patient Care Groups: A Redesign of Primary Health Care in Ontario

### 3.1 Recommended Design

**Note: The following design features require elaboration post consultation with key stakeholders. Section 4.0 articulates a partial list of issues requiring further discussion and investigation.**

With the joint goals of realizing the ministry's policy priorities and designing a principles-based primary care system, the Committee assessed the current state of primary health care and identified possible reforms. Over the course of several meetings the Committee arrived at a model based on **Patient Care Groups**.

Patient Care Groups (PCGs) are population based fund-holding organizations that are accountable to the ministry through the Local Health Integration Networks (LHINs). More important than the type of organization is the organization's ability to provide the **functions** of the PCG described below. PCGs may take many forms, including newly created organizations or existing providers (e.g., Family Health Teams, Health Links, Hospitals, Community Health Centres, etc.).

While several PCG functions are reflected in current primary care structures in Ontario, many key features are particularly innovative or extend strategies that have proven to be successful:

Funding to each PCG is determined on a per capita basis, reflecting the demographics, socio-economic status, and projected health needs of its catchment population.<sup>21</sup> Primary care providers, along with the local Public Health Unit and municipal services, are responsible for the health of the population within their catchment area.

The model ensures clear lines of accountability between primary care providers and patients, and between primary care providers and the broader system.

The model ensures universal access to primary care by all Ontarians; there are no unattached patients.

The model aligns with the goal of equity of access to inter-professional resources by all Ontarians.

The model leverages existing organizations and capabilities to provide better integrated care, both horizontally (coordination between primary health care practice settings) and vertically (coordination between primary health care and other parts of the system).

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<sup>21</sup> Funding levels will be determined in partnership with Public Health and others involved in epidemiological analysis and research.

The model ensures that quality and fiscal responsibility are rewarded. Provider groups and individual providers, who may be subcontracted to provider groups, are contracted with based on their ability to achieve quality benchmarks and any additional criteria/metrics captured in their accountability agreement. Contract granting and renewal will be performance based, and support may be available to providers when performance does not meet standards.

The model offers the benefits of economies of scale through the PCG central functions but also allows and rewards adaptation to local needs.

Underpinning the model is a requirement for robust performance measurement to ensure programs and services are meeting the needs of the population, and to provide the foundation for ongoing quality improvement.

### *Patient Assignment*

- Groupings of Ontarians<sup>22</sup> will be formed based on geography. The number of Ontarians in each grouping will vary according to local circumstance, following the principle that groupings should be sufficiently small to have effective governance and accountability mechanisms, but large enough to achieve economies of scale. The Institute for Evaluative Sciences (ICES) research<sup>23</sup> has shown that current primary care delivery patterns generally match geographic areas in most parts of the province, however certain regions (mainly urban centres) are more complex and may be better served by a combination of geography, needs, and current referral patterns. Every Ontarian in a grouping region will be assigned to a PCG which will be accountable for the care of those individuals.
- Given the variety of care delivery settings in the province, the Committee noted the need to develop variations of the PCG model: (1) “Standard” PCG with a roster of patients scaled to meet the needs of a logical population group (exact size of the patient roster to be determined by further analysis), (2) “Rural” PCG (aligned with Rural Hub model), and (3) “Urban” PCG for large urban centres.

Possible scenarios, but not limited to these, include:

1. An existing, high functioning suburban Health Links organization expands its functions, scope and responsibilities, as described in this report, and establishes a PCG as part of its operations. (“Standard” PCG)
  2. A small, rural hospital assumes the functions and responsibilities of the PCG for primary care in its region. (“Rural” PCG)
  3. A large urban Family Health Team (FHT) leverages its management resources while maintaining and expanding its interprofessional services and assumes the functions and responsibilities of a PCG. (“Urban” PCG)
- An analogy to this approach is found in the publicly-funded provincial school system whereby students are assigned to a public school based on home address. “Special cases” (e.g., specialized

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<sup>22</sup> Precise number of citizens per grouping to be determined during the implementation stage.

<sup>23</sup> Stukel et al, Multispecialty Physician Networks in Ontario, *Open Medicine*, 7(2), 2013

educational needs) are accommodated, and result in a small number of students enrolled in “out of district” specialized schools. These situations are the exception however, and typically patients would be assigned locally.

- Every patient within the PCG’s region is assigned to the PCG, and then rostered to a primary care provider (physician or nurse practitioner) contracted by the PCG. In most cases, patients will retain their ability to choose their provider.
- Each PCG will be responsible for ensuring all patients assigned to them have a relationship with a primary care provider; and will develop a system of coordinating the capacity of the delivery models in their region to ensure unattached patients are connected to a provider. This feature will address the issue of unattached patients.
- A system for managing exceptions will be developed. For example, patients with pre-existing relationships with providers (which will generally be maintained) who reside outside the PCG catchment area could be included in a neighbouring PCG allocation through PCG to PCG transfer payment agreements. Such a system could also be used to address commuters, seasonal vacationers, and patients accessing specialized primary care services (e.g. a falls prevention clinic, a Family Health Team with special expertise in mental illness, a clinic specializing in primary care of the elderly) in a neighboring PCG, or patients needing particular culturally sensitive care delivery. Exceptions will be tracked and monitored to ensure appropriate use and funding.
- Patients difficult to assign (e.g., those without permanent housing or without health cards) will be identified and assigned to the PCG in collaboration with Public Health, community health centres and the local municipal services. The funding formula would reflect the needs of this patient group, however it is recognized that supplemental funding may be required. The shelter health models in Toronto, Hamilton and Ottawa offer examples of possible alternatives.

### *PCG Organization and Management*

- Roles specific to each PCG include executive director, clinical leads (physician and/or nurse practitioner), care coordinator, and community representative (patient) – see diagram on page 25. The PCG team can be made up of members of existing organizations (e.g., local community hospital, Health Links, Family Health Organizations, etc.).
- Depending on the size of the PCG catchment area and local circumstance, some PCG management teams may have roles at less than one FTE (e.g., the clinical leads may work two or three days a week in that role, not full time).
- Functions at the PCG level include contracting and contract oversight, finance and accounting, health human resource planning, and care coordination.
- Services shared by all PCGs could be managed at the LHIN level and include population needs assessments, information technology, contracting, purchasing, indicator development and monitoring, quality improvement planning, health human resource (HHR) planning, and training. Collaboration with Public Health, Health Quality Ontario (HQO) and others would ensure appropriate service planning and monitoring.

### *Accountability and Governance*

- Each PCG has a community-based board of directors which includes patient representation. The PCG boards may require different solutions in urban and rural areas due to local circumstance (e.g., a small rural population may only be able to support a limited number of boards).
- Similar to accountability agreements between hospitals and Local Health Integration Networks (LHINs), each PCG holds an accountability agreement with the LHIN, renewed annually and monitored by the PCG's Board.
- The accountability agreement describes the population of the PCG and expected service needs, and also sets expectations regarding patient-level and population-based indicators.
- The accountability agreement specifies progress expected on patient-level and population-level indicators<sup>24</sup>, including specific obligations related to access, coordination, quality, patient experience and costs. For example:
  - Percentage of residents in catchment are registered (confirming no, or minimal, unattached)
  - Percentage of residents in catchment who can access their provider on the same day or next day
  - Percentage of avoidable ED usage
  - Percentage reporting after-hours access to primary care and weekend access difficult or somewhat difficult
- Indicators and expected progress are determined by the ministry in partnership with the LHIN, HQO, and Public Health and would be aligned with the obligations of other providers in the region. For example, PCGs would work with their local hospital and Health Link(s) to reduce inappropriate ED visits.
- A PCG is designated as the "most responsible organization" (MRO) for their assignment group. In turn, each primary care provider who is contracted with the PCG will be "the most responsible provider" (MRP) for the individual patient.

### *Funding, Contracting, and Service Delivery*

- Each PCG is funded to provide primary care as currently understood by the ministry<sup>25</sup> and includes activities designed to reduce the burden of illness in the future. Each PCG receives a base budget from the LHIN to deliver this basket of services to the citizens in the PCG catchment area, taking into account their demographic characteristics and predicted health care needs. The base budget is

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<sup>24</sup> Indicators would be aligned with Health Quality Ontario's Primary Care Performance Measurement Framework <http://www.hqontario.ca/public-reporting/primary-care>

<sup>25</sup> The starting point is the current basket of services included in the primary care agreements (health assessments, diagnosis and treatment, primary reproductive care, primary mental health care, primary palliative care, support for hospital, home and long term care facilities, service coordination and referral, patient education and preventative care, in-hospital newborn care, arrangements for 24/7 response) but can be expanded depending on local community circumstances.

reviewed approximately every three years to adjust for changes in expected health needs while also allowing for some stability in the delivery model of the PCG.

- The service delivery model(s) are determined by the PCG leadership according to the needs of the patient population served. Specifically:
  - The PCG determines the health human resource requirements to meet the needs of patients in its catchment area.
  - The PCG determines which provider payment mechanisms are most appropriate, and can use more than one as needed – fee-for-service<sup>26</sup> capitation, salary, etc. (within the pre-identified total budget).
- Each PCG contracts with and holds accountable current delivery models (e.g., CHCs, FHGs, FHOs, AHACs and NPLCs, hospitals). Current models of care and other primary care providers (including fee for service physicians) need not be disbanded.
- Contracts would specify service delivery expectations for patients and consequences to the provider if not met (including provision of performance improvement support). Monitoring would occur on a regular basis, ideally quarterly, to ensure continuous high quality service delivery, defined by quality benchmarks articulated in the contract.
- Specifically, physicians would be paid through the contract between the PCG and their existing delivery model (FHG, FHO, etc.). Similar to the process to implement Alternative Funding Agreements for hospital-based physician groups (e.g., emergency departments), funds would be transferred to the PCG by the Ontario Health Insurance Plan (OHIP) then allocated to each physician group/NPLC according to the terms of the contract. These would likely follow the existing terms of the model agreement but then could evolve over time.
- Each PCG ensures its patient population has appropriate access to primary care services – both “Regular” and “After Hours” – and may choose to coordinate multiple clinics/teams and/or with Urgent Care and emergency department services to achieve this. Specifically:
  - All practices would be expected to achieve a targeted level of same-day/next-day appointment availability (included in their contract with the PCG and monitored).
  - Absent unique circumstances approved by the LHIN, all practices (or groups of practices) would be expected to offer evening and weekend clinics to ensure all patients could reasonably access their primary care provider team after hours (also included in their contract and monitored).
  - Optimal use of phone and other technology will be encouraged and facilitated.
- Patients rostered to the PCG can therefore access all PCG-contracted services (as described above) within the catchment area and others outside the catchment as organized by the PCG in reciprocal

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<sup>26</sup> As the PCG will have knowledge of the local community and how best to serve patients, no one payment model is recommended.

agreements, similar to interprovincial processes. Patients would access services outside of those areas covered by PCG contracts and reciprocal agreements only in rare, clearly defined circumstances.

- Clinics that are currently not part of a primary care delivery model (e.g., walk-in clinics, travel clinics, etc.) would be required to contract with at least one PCG and meet service delivery criteria and quality performance standards in order to receive funding at full OHIP levels; clinics not contracted by a PCG would be unable to bill at current OHIP rates.
- Among other services, the local acute care hospital or other appropriate facility would provide diagnostic services after hours and on weekends with results available to PCG providers on a timely basis, for example, through interoperability of hospital and community provider Electronic Medical Record (EMR) systems.
- Funding for CHCs, FHTs, AHACs and NPLCs would be used to support the features above.
- In addition, it is understood that the large selection of primary care delivery models currently in place could be harmonized into a smaller number over time.

### *Health Human Resources*

- Each PCG ensures the availability of inter-professional primary health care services to primary care providers and their patients, either directly (in which case services are delivered by the PCG) or indirectly (whereby the PCG contracts with a FHT, a CHC, or a hospital, for example).
- Current relationships between FHTs and FHNs/FHOs would be maintained. The interprofessional teams would expand their service capacity (determined according to population needs analysis and experience) to accommodate the patients referred by other primary care providers within the PCG. Similarly, CHCs would continue to provide services to their rostered patients, and also accept PCG patients referred to them.
- The payment mechanism by which the interprofessional team provides its services to the other primary care providers would be determined by the PCG (e.g., a capitated rate, individual service prices, etc.).
- Some regions may have a surplus of certain types of providers and many will have gaps. The PCG's contracting mechanism is expected to address this issue as PCGs determine and contract for the health human resources needed to satisfy their accountabilities to patients. This is anticipated to result in a more equitable distribution of HHR as it will encourage the movement of health care providers to currently underserved regions and away from regions in which there is a surplus.
- Moving to the PCG model will require time for appropriate phasing and sufficient planning to ensure the necessary HHR is available to reflect the population assigned to the PCG. Where HHR is a concern, recruitment and retention strategies need to be engaged and supported in collaboration with HealthForceOntario.

### *Information Technology*

- Each PCG will enable collaboration, integration and enhanced patient safety by providing and supporting an integrated, cross-platform, shared database with an integrated/connected EMR that is accessible from any point of care within the PCG.
- Each PCG is also connected to specialist, acute, and long term care services in its geographic region and each contracted provider maintains a comprehensive record of their patients' interactions with the health system.
- Such a comprehensive record relies on EMR interoperability. All EMR systems within the PCG, and throughout the LHIN, would be expected to establish and maintain interoperability.
- OntarioMD will have an important role to play in coordinating EMR adoption and interoperability. Ontario is now at the point where the vast majority of family physicians and nurse practitioners have an EMR and attention can be turned towards optimal use (including quality based reporting). Resources will need to be directed towards EMR interoperability both amongst primary care providers and tertiary care providers/hospitals and patient personal health records.
  - In close liaison with Community Care Access Centres (CCACs) and the primary care providers with which it holds contracts, the PCG ensures the coordination of community-based services for the patient, including home care and other community support services. The PCG would also link to community-based mental health through the relevant local agency, e.g., CMHA.

### *System Collaboration, Coordination and Scale Economies*

- Each PCG coordinates care for patients through collaborative relationships with the local hospital, long term care facility, CCAC, and other community-based providers (see Section 3.2 regarding the relationship with Health Links).
- Each PCG coordinates with other services beyond the traditional health sector to create communities and environments that promote the health of its patient population. Depending on local circumstance the PCG may wish to contract with Public Health directly to deliver services to meet patient needs (e.g., diabetes care, smoking cessation, methadone clinics etc.).
- Each PCG will have a close association with at least one acute care facility.
- Each LHIN has a Primary Health Care Council to provide a forum to disseminate best practices, address common problems and opportunities, and achieve economies of scale for common interests such as contracting, IT, etc.
- Ideally each Primary Health Care Council would include representation from each PCG and other organizations delivering primary health care in the LHIN. In certain cases this would result in an unmanageable number of seats around a table, in which case efforts would be made to bring the number down to a manageable level (for example, Public Health could act as a representative for the municipal services to which it is connected (housing, recreation, etc.), and make appropriate connections to primary care as needed).

- As mentioned above, services shared by all PCGs could be managed at the LHIN level and include population needs assessments, IT, contracting, purchasing, indicator development and monitoring, quality improvement planning and implementation, health human resource planning and training. In certain cases it may be more practical for the PCG to manage such services, or for two or three PCGs to coordinate at a sub-LHIN level. Public Health, HQO and others would assist in these areas, collaborating with the LHIN to ensure appropriate service planning and monitoring and consistency where needed throughout the province.
- PCGs are not duplicative of LHIN functions; they are complementary. Given the highly localized nature of effective primary care, they focus on organizing primary care service delivery within their catchment (currently quite fragmented).

### 3.2 Strategic Alignment

The PCG model and features have been designed to operate within and support the broader Ontario health system. Particular attention has been paid to the alignment of the PCG model with other system improvement priorities, initiatives, and goals, notably those listed in the Premier’s mandate letter to the Minister of Health and Long- Term Care, the Health care Transformation priorities, and the Health Links initiative.

#### *Mandate Letter*

In September 2014 the Ontario Premier sent a public letter to the Minister of Health and Long-Term Care outlining her priorities for the health system in Ontario over the next four years<sup>27</sup>. The PCG model will directly support all three goals and many of the objectives contained in the letter, as follows:

Goal	PCG Model Features
Putting patients at the centre, right care, right place, right time	Patient-centred care with a focus on health and community wellness Seamless local integration Coordinated, population-based care
Accountability and Transparency	Contract management and performance monitoring Predictable, accountable funding Economies of scale
Access	No unattached patients Specific obligations to all contracted providers to ensure access, such as regular and after-hours care, appointments, and access to interprofessional care.

#### *Health Care Transformation*

In January 2012 the ministry announced Ontario’s Action Plan for Health with the goal to “make Ontario the healthiest place in North America to grow up and grow old”. As noted earlier in this paper, after two

<sup>27</sup> <https://www.ontario.ca/government/2014-mandate-letter-health-and-long-term-care>



years progress has been made but more work is needed to spread from areas of excellence to optimal performance province-wide. To move forward the ministry has put in place a Framework for Strategic Action with four pillars – 1) Modernize Home and Community Care, 2) Improve System Integration and Accessibility, 3) Increase the Health and Wellness of Ontarians, and 4) Ensure Sustainability and Quality. Spanning all four pillars is the need to maintain a person-centred perspective and set up mechanisms to ensure accountability and evidence-based care.

The PCG model supports the features of this agenda, particularly in the areas of system integration and accessibility, increasing the health and wellness of Ontarians and ensuring sustainability and quality. The system of contracting and monitoring between providers, PCGs, and the LHIN sets up strong accountability relationships, and by taking a population health perspective and opening the door to partnerships beyond the traditional health system, the model enables a whole-person perspective of health and wellness.

### *Integration with Health Links*

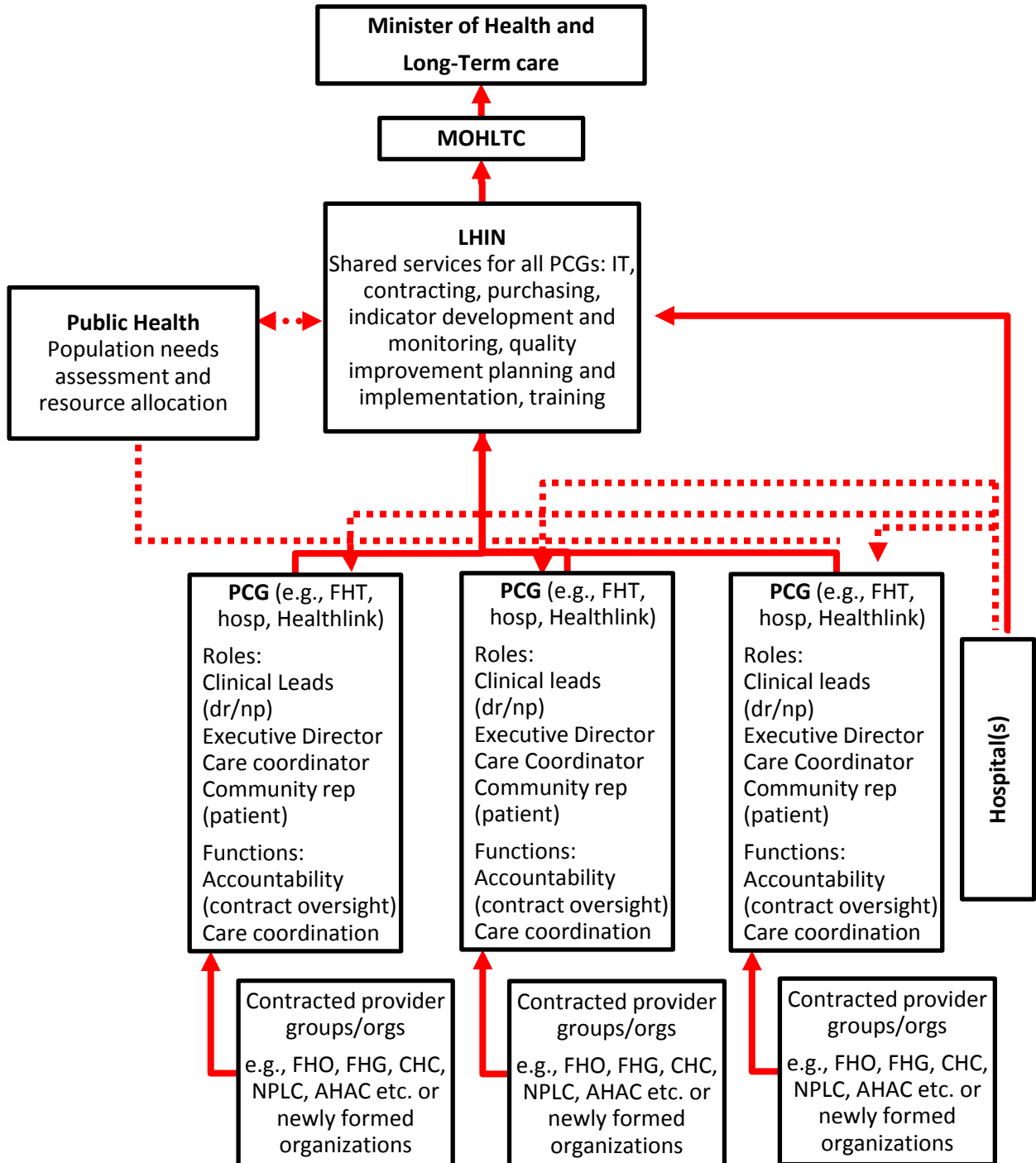
- Health Links are now moving beyond the early implementation stage as part of an expanded provincial strategy.
- As the two models share *some* common goals (but for different patient populations), one possible scenario -in some regions-would involve leveraging the existing Health Links infrastructure and further developing their scope and capabilities to take on the form and functions of the PCG model, resulting in "Health Links 3.0". Required enhancements to Health Links would include standardized governance, administrative functions, geographically based assigned populations, contracting, and accountability agreements, among others features.
- In order to avoid administrative and functional duplication, we recommend all efforts be made to avoid redundant or overlapping Health Links and PCGs in a region. Where future Health Links are willing and able to take on the features of the proposed PCG model, they can assume the functions of the PCG, under the Health Links name. This would require a Health Link's taking responsibility for all citizens in region. In such a case, PCGs and HLLs could become one in the same and be referred to as either Health Links or PCGs.
- The integration of Health Links and PCGs, where possible, is expected to accelerate implementation of the changes proposed in this document by leveraging existing resources and engendering greater support in the field.

### *3.3 Model Summary*

The PCG model promises to provide numerous benefits to Ontarians by ensuring integrated, comprehensive care with consistent provider relationships. Primary health care providers will be given the opportunity to work within a system that rewards high quality care, provides opportunities for innovative care delivery, increased integration with other primary health care providers and the broader system, shared resources, and increased quality of work-life, all while recognizing and functioning within current fiscal constraints.

3.4 Diagram

**Patient Care Groups**



## 4.0 Issues requiring further discussion and investigation

The Advisory Committee has begun to identify a number of issues that need further attention with the support of the MOH and key stakeholders:

**Business Case:** Experiences in other jurisdictions suggest that effective primary health care service delivery for all Ontarians will ease the burden of care delivery on other parts of the system (e.g., unattached patients will be receiving preventative care, etc.). Further work is needed to demonstrate and evaluate the business case for the implementation of the PCG model – i.e., improved value for health system investments.

**Resources Required:** The proposed PCG model is intended to leverage existing system resources wherever possible. However, some new or reallocated investments may be required to ensure equitable access to interprofessional team-based caregivers across the province.

**Contract environment:** Changes recommended by the PCG model to enable local, innovative solutions for care delivery will have implications for current contracts held by primary care delivery models. A review of the current landscape of contracts and incentives and possible options for the new PCG model would assist in decision-making. For example, how would possible conflict of interest situations be avoided (such as when an FHT becomes the PCG for an area)? What should happen to the current access bonus? How can a Health Link become a fund-holding organization in order to contract with the LHIN to perform PCG functions?

**Aligning payment and incentives:** PCGs will be held accountable to the LHIN and this will have implications for the current network of agreements between the LHIN and its service providers. The PCG accountability agreement with the LHIN should support and align, and not detract from the existing agreements to ensure overall health system improvement. To ensure this is the case, current accountability agreements between LHINs and its health service providers will require review.

**Population-based needs assessment:** There is a need to leverage existing skills and datasets in public health to refine the understanding of population-based needs at a local level, including the corresponding health human resources and services required to meet those needs. Further work is needed to fully explore and utilize this skill-set and to develop joint processes for sharing the data and capabilities.

**Aligning care resources with population needs:** Based on the needs of their catchment population, PCGs need to develop and refine their capacity to effectively and equitably distribute resources (funding for physicians/NPs, interprofessional teams, etc.). Work is needed to capture current successful strategies and develop innovative approaches to respond to challenges such as how interprofessional teams can extend to serve almost quadruple their population along with what tools they would need to measure their progress and make timely adjustments. Similarly, upholding the principle of equity, there is a need to ensure that small and isolated populations have sufficient funding to sustain a critical mass of providers.

**Patient assignment in major urban centres:** Existing patterns of referral in major urban centres do not currently follow geographic boundaries. Further work is needed to determine appropriate guidelines for assigning patients to PCGs.

**Home and community care:** This integrated model for delivering home and community primary health care must develop in close liaison with the local CCAC, other community providers and public health services. In addition, the most similar experience with contracting as described in the PCG model is in home care albeit with several key differences. Learnings from the Expert Panel on Community Services and Home Care, in addition to other key stakeholders, is needed to guide planning.

**Quality Improvement:** Experts in quality improvement such as Health Quality Ontario and others will be needed to identify and/or develop quality measurement and support capacity.

**Collaborative Learning:** Additional work is required to gather and optimize successful strategies to build capacity in the primary care management sector. Moreover, key strategies and approaches that develop and support true inter-disciplinary governance, communication, collaboration, integration and change management must also be considered.

**Review of other jurisdictions' experiences relevant to PCG features and implementation:** Additional work is required to explore recent experiences outside Ontario implementing population-based models of primary care delivery to extract lessons learned. Possible settings to review include other provinces, Intermountain Healthcare, Kaiser Permanente, Geisinger Health System, and publicly administered primary care systems in Sweden and New Zealand, etc.

## 5.0 Proposed Implementation

*5.1 An incremental approach is recommended for implementation, building on the strengths of the current system.*

Development of a **Systematic Change Management** strategy and implementation plan which includes:

- Engagement and consultation with citizens, providers and other stakeholders in design development.
- Articulation of clear benefits to citizens, providers and communities (reflecting process of engagement above).
- Determination of optimal legal entity formation for PCGs, which could vary depending on local circumstance.
- Articulation of PCG Board structure and role for each type of PCG, and acceptable variations to accommodate local circumstances.
- The combining of interprofessional funding into one local portfolio.
- Determination of patient assignment guidelines.
- Development of appropriate clinical and economic indicators; development of key metrics.
- Ensure adequate measurement capacity and information technology inter-operability.
- Perform inventory of current governance/HR/management capacity in primary care, determine leadership gaps and develop strategy to address them.
- Identification of a small number of communities that reflect the range of settings and challenges likely to be experienced when introducing the PCGs. These could include those with a high proportion of group comprehensive care practices, interprofessional care, and strong inter-organizational relationships.
- Identify and share learning through rapid cycle evaluation.
- Proceed with phased implementation across all geographic boundaries.

## Appendix 1: Terms of Reference

### Expert Advisory Committee on Primary Health Care

#### Terms of Reference

#### **Membership:**

Expert Advisory Committee	
ADM Executive Sponsor	ADM, Ministry of Health and Long-Term Care
Co-Chair: Dr. David Price	Provincial Primary Care Lead
Co-Chair: Elizabeth Baker	Provincial Nursing Lead
Matthew Anderson	CEO, William Osler Health System
Mike Bell	Director of Primary Health Care, Rideau Community Health Services
Michelle Clifford-Middel	Nurse Practitioner Lead, Georgian Nurse Practitioner Led Clinic
Dr. Rick Glazier	Researcher, Institute for Clinical Evaluative Sciences
Brian Golden	Sandra Rotman Chair in Health Sector Strategy at The University of Toronto and The University Health Network; Professor of Strategic Management, Rotman School of Management, U of T
Paul Huras	CEO, South East Local Health Integration Network
Ross Kirkconnell	Executive Director, Guelph Family Health Team
Dr. Danielle Martin	Physician, Women’s College Family Health Team
Dr. Sarah Newbery	Physician, Marathon FHT
Dr. Harry O’Halloran	PC LHIN Lead, North Simcoe Muskoka LHIN
Dr. David Shieck	Physician, Guelph FHT
Dr. Josh Tepper	CEO, Health Quality Ontario
Carol Timmings	Registered Nurse, Toronto Public Health
Ruta Valaitis	Associate Professor, McMaster University, School of Nursing

**Note:**

*Members have been selected for their ability to contribute to the mandate; not as representatives of a region or constituency.*

## Introduction

Ontario's primary health care sector has undergone significant reforms over the past fifteen years. Over this period, primary health care in Ontario has evolved from a predominantly fee for service system of independent practitioners to more advanced group-based practices premised on patient enrolment and comprehensive care. Much attention has been given lately to the importance of integrated primary health care services and evidenced-based care as key to achieving a sustainable and affordable health care system. Through this lens, Ontario has made good progress on both fronts with the recent introduction of Health Links and Quality Improvement Plans (QIPs) in the primary health care sector.

Significant improvements in how Ontarians receive primary health care services have been achieved as a result of these reforms. These include:

- 10.1M patients enrolled to their own primary care provider;
- Three quarters of all family physicians are now part of a group practice;
- New and increased interdisciplinary models of care, including: 200 Family Health Teams (FHTs) serving 2.8M patients; 26 Health Links, 25 Nurse Practitioner-Led Clinics (NPLCs), and 73 Community Health Centres (CHCs);
- Negotiated agreements that promote the delivery of comprehensive primary health care;
- Family medicine now a desired specialty, resulting in an increasing number of family physicians and interdisciplinary providers delivering primary health care services.

Although these mark significant achievements in Ontario's health system, the process of reform is not over and there is a continued need for improvement. Primary health care still remains a significant part of the government's transformation agenda for health care.

In order to support the ministry's primary health care transformation agenda, the Government of Ontario has established the Expert Advisory Committee on Strengthening Primary Health Care in Ontario (hereto referred to as the "Expert Advisory Committee").

## Mandate of the Expert Advisory Committee

With reference to the recommendations made through the Strengthening Primary Health Care in Ontario initiative (2011) in the areas of primary health care access, accountability, efficiency, governance and quality, the Expert Advisory Committee will provide advice to the Ministry of Health and Long-Term Care to assist in the advancement of the primary health care transformation agenda. Understood throughout this process is a commitment to incorporating patient-focused care and supporting effective patient engagement.

Specifically, during its deliberations the Expert Advisory Committee will:

1. Define a future strategic vision, goals and objectives to advance Ontario's primary health care sector and make recommendations around the design of the PHC system.
2. Build on existing work in primary health care ensuring alignment of the vision to the outcome measurement framework\* developed through Health Quality Ontario.
3. Draw on the work of the Primary Health Care Planning Group papers on Accountability, Efficiency, Organization and Governance, Access and Quality, and ensure that interconnected measurable outcomes for a select number of priorities are embedded within the vision, focused on improving:

- a. Access for patients to the right care at the right time in the right place and by the right provider. Included in this domain are the following:
  - i. Equitability of access to primary care teams and resources across the province
  - ii. After-hours access to specific clinical services at the time of need
  - iii. Distribution of primary care providers and services across the province
- b. Integration across the health system
- c. Quality improvement methodology

In determining and describing the above, the Committee will consider governance structures to support accountability within primary care and will also consider efficiency of practice.

4. Propose the next evolution of primary health care in Ontario through examination of existing (primary health care) models. Additional steps will include: recommending changes to the existing models, with consideration to both outcomes and sustainability in order to achieve the overarching vision of primary care.
5. Provide guidance and direction\* on approaches to improve primary health care integration, bringing more rigour to the practice of primary health care and ensuring both horizontal and vertical integration within the system. This will include:
  - a. An understanding of current primary health care integration work;
  - b. An analysis of current reports and recommendations about primary health care system improvement

\*Denotes areas that may be addressed through sub-groups of the Committee.

6. Finally, periodically the MOHLTC may ask the Expert Advisory Committee to consider and provide timely feedback on policies and tools in evolution that relate indirectly to the mandate above.

## Authority

Decisions within the framework of the Expert Advisory Committee's Terms of Reference are the responsibility of the Expert Advisory Committee.

Decisions about purpose, mandate, roles, responsibilities, duration and timelines are the responsibility of Executive Sponsor in consultation with the Co-Chairs.

## Role of Expert Advisory Committee Members

The individual members of the Committee will:

- Use their knowledge and expertise to guide recommendations and decision-making;
- Consult with Reference Groups and others (as deemed appropriate) throughout the development of recommendations;
- Be responsive to the project team and beneficiaries of the Expert Advisory Committee's outputs;



- Objectively consider ideas and issues raised against their contribution to the Expert Advisory Committee's outputs.

## **Expert Advisory Committee Logistics and Process**

### **1.0 Role of the Co-Chairs.**

The Co-Chairs are responsible for:

- a. convening and chairing scheduled meetings;
- b. facilitating consensus building;
- c. timely achievement of the Committee's mandate; and
- d. ensuring the Executive Sponsor and MOHLTC are made aware of any requirements for the Committee.

### **1.1 Frequency of Meetings**

The Committee will meet regularly starting December 2013 and will continue meeting until October 2014, at which time continuation will be reviewed.

### **1.2 Decision-Making Process**

The Committee will adopt a consensus model of decision-making for recommendations and advice. Deliberations of the working groups will seek to build consensus on the most acceptable advice/direction.

Where consensus cannot be reached, the Committee will present a summary of the deliberations to the Executive Sponsor.

### **1.3 Quorum Requirements**

Quorum will be one of the two co-chairs and 50 percent of the appointed members of the Committee.

### **1.4 Proxies to Meetings**

Committee members cannot send proxies to participate in his or her stead.

### **1.5 Agenda Items**

Agenda items may be suggested by any member of the Committee, and by the Executive Sponsor. Determination of the agenda is the responsibility of the Co-Chairs.

### **1.6 Committee Supports**

The MOHLTC will provide secretariat support to the group/sub-groups and will provide support for data analysis, writing, etc., either directly or indirectly.

Expenses, including travel and accommodations, will be paid through the MOHLTC.

## Appendix 2: Bios for members of the Expert Advisory Committee

### Member Description

#### **Dr. David Price, Co-Chair (Academic/Family Physician, Hamilton)**

Dr. David Price is Professor and Chair of the Department of Family Medicine at McMaster University, and has been Chief of Family Medicine at Hamilton Health Sciences since 2004.

Dr. Price is the founding director of the Maternity Centre of Hamilton, a multidisciplinary centre caring for prenatal and intrapartum patients. The model of care developed at the Maternity Centre has been replicated across the country and has been the subject of national presentations and publications.

Dr. Price is also the Medical Director and co-investigator of the Quality in Family Practice program; a six year undertaking of four concurrent projects, focusing on the development and implementation of continuous quality improvement initiatives.

Dr. Price is the administrative lead for OSCAR (Open Source Clinical Application Resource), an Electronic Medical Record (EMR), and MyOSCAR Personal Health Record. OSCAR was developed at McMaster and is now utilized across Canada by more than 1,500 family physicians and is the fastest growing EMR in Ontario.

Locally, Dr. Price was instrumental in helping to create the academic Family Health Team at McMaster University, an interprofessional team consisting of physicians, nurse practitioners, social workers, dietitians, occupational therapists, physician assistants, pharmacists, and psychiatrists. The McMaster Family Health Team currently serves over 29,000 patients in the Hamilton area.

#### **Elizabeth Baker, Co-Chair (Nurse Practitioner, Ottawa)**

Elizabeth Baker, RN(EC), MHS, BScN, is a Primary Health Care Nurse Practitioner in active practice and a Legal Nurse Consultant in Ontario. She has worked in acute care, rural, northern and community settings. As the former National Director of Nurse Practitioner Professional Practice at VON Canada, Elizabeth developed the VON Nurse Practitioner Centre of Excellence, two Nurse Practitioner-Led Clinics and chaired the Research Ethics Committee for the organization at large. She served seven years with the College of Nurses of Ontario as an elected Council and Disciplinary Committee member and regularly serves on various professional committees. Elizabeth is the Provincial Nursing Lead for the Ministry of Health and Long-Term Care.

**Mike Bell (Administrator, Kingston)**

Mike Bell has been a health care administrator for over 15 years in both public and private settings. Formerly the Director of Primary Health Care in the Community Health Centre sector, he was highly involved in driving Quality Improvement and Patient Safety initiatives in both urban and rural CHCs. His other interests include health equity, primary health care reform and regional integration.

Mike has a BA in Health Studies, a MA in Canadian Policy Studies and an MSc in Quality Improvement and Patient Safety. Mike is currently the Program Operational Director for the Cancer Centre of South East Ontario and the South East Regional Cancer Program.

**Dr. Richard Glazier (Academic/Family Physician, Toronto)**

Dr. Glazier first joined ICES in 2001 and is a Senior Scientist and Primary Care Program Leader. He is a Family Physician at St. Michael's Hospital in Toronto and a Scientist in its Centre for Research on Inner City Health. Dr. Glazier is a Professor and a Research Scholar in the Department of Family and Community Medicine at the University of Toronto and is cross-appointed at the Dalla Lana School of Public Health, with additional graduate department appointments in Health Policy, Management and Evaluation; Institute of Medical Science; and Sociology.

Dr. Glazier is past Chair of the Section of Researchers of the College of Family Physicians of Canada (CFPC). In 2005, he was named Family Medicine Researcher of the Year by the CFPC. He received his medical degree from the University of Western Ontario and completed training in public health and preventive medicine at Johns Hopkins University and the World Health Organization.

**Matthew Anderson (Hospital CEO, Peel Region)**

Matthew Anderson is the CEO of William Osler Health System. He has served as the Chief Executive Officer at the Toronto Central Local Health Integrated Network for two years. Prior to joining the Toronto Central LHIN, Mr. Anderson was at the University Health Network for ten years where he held the positions of Senior Vice President, Performance and Technology, Vice President and Chief Information Officer.

Mr. Anderson has a BA from the University of New Brunswick as well as a MHS (Administration) from the University of Toronto.

**Dr. Brian Golden (Academic, Toronto)**

Brian Golden is the Vice-Dean of Professional Programs; the Sandra Rotman Chair in Health Sector Strategy at the University of Toronto and the University Health Network (joint appointment Faculty of Medicine); Professor of Strategic Management at Rotman; and Executive Director, Collaborative For Health Sector Strategy. Brian has been a faculty member at Insead (France), the Richard Ivey School of Business, University of Western Ontario (Canada), the University of Texas (USA), and Northwestern University's Kellogg Graduate School of Management (USA). He conducts research and teaches in the areas of strategic change and implementation, health system integration and funding, governance, organizational strategy and leadership.

**Ross Kirkconnell (Administrator, Guelph)**

Ross Kirkconnell is the Executive Director of the Guelph Family Health Team, working with 50 family physicians and numerous other clinicians to advance collaborative primary care in Guelph. Previously, Ross was Executive Director of the CCAC of Wellington-Dufferin, Program Manager with the Long-Term Care Division of the Ministry of Health and Long-Term Care, and Program Associate with the Office for Senior Citizens' Affairs. Ross has a BA from McMaster University and MSc from the University of Guelph.

Ross participates on a number of volunteer and community Boards including: Chair of the Board of the Quality Improvement and Innovation Partnership, the Guelph-Wellington Physician Recruitment Committee, the United Way Social Planning Council of Guelph-Wellington, the Waterloo-Wellington Palliative Care Advisory Committee, and the Royal City Ambassadors.

**Michelle Clifford Middel (Nurse Practitioner, Barrie)**

Michelle is a multi-skilled advanced practical nurse with proven ability to lead nurse practitioner and team based health service projects. She is an expert in leading successful requests for funding projects, conducting health service needs assessments, developing and evaluating population and resource based programs and services. Her clinical specialties developed over 24 years advanced practice nursing including 17 years as a nurse practitioner in primary health care, wellness, illness prevention, chronic disease detection and management, teaching, counseling, gerontology, palliative care and emergency outreach. Michelle earned her Nursing Diploma at Georgian College in 1990, her BScN at Ryerson University in 1997 and a Master's Degree from Western University in 2008.

Michelle currently practices in the Nurse Practitioner Long-Term Care Outreach (NLOT) program at the Royal Victoria Regional Health Centre in Barrie.

**Dr. Sarah Newbery (Family Physician, Marathon)**

Dr. Newbery is a physician at Marathon Family Health Team and has worked in Marathon for over 10 years. During her time as a physician at MFHT, Sarah has worked on some of the administrative and program development aspects of MFHT as a member of the Board of Directors. In addition to these office duties, Sarah has hospital inpatient, emergency, and obstetrical duties.

Dr. Newbery has taken a special interest in obstetrics and chemotherapy services at Wilson Memorial General Hospital, as well as helping the MFHT Nursing Committee develop their current and future services.

**Carol Timmings (Registered Nurse, Toronto Public Health, Toronto)**

Carol Timmings is the Chief Nursing Officer and Best Practice Spotlight Organization Sponsor at Toronto Public Health. She has an extensive history of work on issues related to public health and primary care, has won awards for her contributions to the public health sector.

**Dr. Danielle Martin (Family Physician, Toronto)**

Dr. Danielle Martin is a family physician and Board Chair of Canadian Doctors for Medicare. She is clinical staff at Women's College Hospital and lecturer in the Department of Family and Community Medicine at the University of Toronto. She served on the Health Council of Canada from 2005-2011.

Dr. Martin is an active student of public policy, serving on the Advisory Board of the Mowat Centre for Policy Innovation and enrolled in the Master of Public Policy program at the School of Public Policy and Governance, University of Toronto. Dr. Martin has been recognized for contributions to improving Canadian health care: in 2005, she received the Canadian Medical Association Award for Young Leaders; in 2006, the Ontario College of Family Physicians named her one of three physicians who received a Certificate of Recognition in 2006 for their exemplary contribution to family medicine during their first five years of practice. Dr. Martin helped launch Canadian Doctors for Medicare in May 2006, as the voice for Canadian physicians who believe in "a high quality, equitable, sustainable health system built on the best available evidence as the highest expression of Canadians caring for one another."

**Paul Huras (LHIN CEO, South East LHIN)**

Paul Huras is the founding CEO of the South East Local Health Integration Network in Belleville where he provides the leadership for the LHIN's responsibilities of local health system planning, community engagement, and allocating the funds and monitoring the performance of the one billion dollar SE Health System. Since the beginning of the LHINs, in 2005, Paul has taken on expanding roles locally and provincially, including Co-Chairing the provincial Physician LHIN Tri-Partite Committee (PLTC).

He has over 25 years of health system leadership experience, including 14 years as CEO of the Thames Valley District Health Council and previously 5 years as Vice President of Planning and Information Services at Peel Memorial Hospital, where he also served as Acting Executive Vice President.

Paul is a Fellow with the School of Policy Studies, Queen's University and holds an adjunct appointment with Queen's in the Department of Community Health & Epidemiology, Faculty of Health Sciences. He formerly held the position of Assistant Professor in the Department of Epidemiology at the University of Western Ontario where he also taught courses in health management and strategic management.

Paul is a past Board Member of the Institute of Clinical Evaluative Sciences (ICES) and a past Vice Chair of the provincial Association of Colleges of Applied Arts and Technology (ACAATO). He is also past Chair of both The Michener Institute in Toronto and Fanshawe College in London.

Paul holds a MBA and a MSc (Epidemiology), as well as the CHE designation with the Canadian College of Health Service Executives and a FACHE designation with the American College of Healthcare Executives.

**Dr. Harry O'Halloran (Physician, Collingwood)**

Dr. O'Halloran has been a family physician in Collingwood since 1986, on staff at Collingwood General and Marine Hospital. Over the years he has held various positions within the CGMH including medical staff executive, board member, Chief of Obstetrics, Co-Chief of Family Practice.

Since 2002 Dr. O'Halloran has been the lead physician for the various physician PEM groups including the FHG, FHN and now FHO in Collingwood. He is also on the Board of the local FHT.

He has been the Primary Care Lead Physician for North Simcoe Muskoka LHIN since 2012.

**Ruta Valaitis (Academic/Nurse, Hamilton)**

Ruta Valaitis joined McMaster University in 1987 as a part-time Lecturer in the School of Nursing. She is presently an Associate Professor in the School and the Dorothy C. Hall Chair in Primary Health Care Nursing.

Ruta has a BA in Psychology and a BScN from the University of Windsor; a MHS from McMaster University; and a PhD from the University of Toronto.

Her primary research interests are in health services research; primary health care; public health nursing (youth health and school health); interprofessional and intersectoral collaboration; computer applications in health promotion; participatory research; e-health and health promotion; e-learning in health sciences education; qualitative research methods; Photovoice; Q-methodology; case study; and use of NVIVO 8 and 9 for cross case comparisons. Currently, Ruta is a Principal Investigator for a CHSRF funded multisite program of research exploring collaborations between primary care and public health. She is also the Ontario academic lead on a Canadian Institutes of Health Research (CIHR) funded Emerging Team exploring public health services renewal in BC and ON. This program of research aims to use novel research methodologies, such as social network analysis and concept mapping, to explore the processes and impact of public health policy renewal.

**Dr. David Schieck (Physician, Guelph)**

Dr. Schieck is a family physician with the Guelph Family Health Team, where he has practised comprehensive family medicine since 2003. He participates actively in his region as member of the Primary Care Advisory Committee of the Waterloo-Wellington LHIN and has previously served as the Chief of the Department of Family Practice at Guelph General Hospital.

Dr. Schieck has served as a district representative with the Section on General and Family Practice of the Ontario Medical Association since 2009 and currently sits on its Executive Committee as Chair of the Health Policy Committee.

**Dr. Joshua Tepper, Member (Physician, Toronto)**

Dr. Tepper is a family physician and the President and Chief Executive Officer of Health Quality Ontario (HQO).

Previously, Dr. Tepper served as the first Assistant Deputy Minister (ADM) at the Ministry of Health and Long-Term Care, Health Human Resources Strategy Division. He was also the inaugural Vice President of Education at Sunnybrook Health Sciences Centre, a senior medical officer for Health Canada, an adjunct scientist at the Institute for Clinical Evaluative Sciences (ICES), and a research consultant for the Canadian Institute of Health Information (CIHI).

Dr. Tepper has a degree in Public Policy from Duke University, a MPH from Harvard University, and an MBA from the Richard Ivey School of Business.

## Appendix 3: Summary of Recommendations of the Five Working Groups, September 2011

“This report is available in English only at:

[http://www.trilliumresearchday.com/documents/2012\\_PHPG\\_Summary%20of%20Recommendations\\_Final.pdf](http://www.trilliumresearchday.com/documents/2012_PHPG_Summary%20of%20Recommendations_Final.pdf)

## Appendix 4: Primary Care Models

Provider	Primary Care Model (examples)	Description
Physician	Comprehensive Care Model (CCM)	Solo physician providing comprehensive primary care services to enrolled patients and some after hours care.
	Family Health Group (FHG)	Groups of physicians (3 or more) providing comprehensive primary care to enrolled patients on a 24/7 basis (through office hours and Telephone Health Advisory Services).
	Family Health Network (FHN)	Groups of physicians (3 or more) providing comprehensive care to enrolled patients on a 24/7 basis (through office hours and Telephone Health Advisory Services), compensated through capitated payments and fee-for-service.  Main differences between FHN and FHO are the base rate payment and the basket of core services.
	Family Health Organization (FHO)	
	Fee for Service (FFS)	Physicians compensated for services performed according to the Schedule of Benefits.

Interdisciplinary	Family Health Team (FHT)	Teams of physicians, nurses, social workers, dieticians and other interdisciplinary health providers (IHPs) providing comprehensive primary care to enrolled patients. Governed by a Board of Directors. IHP and operational funding established through agreement between FHT Board and ministry; physician funding through separate agreements in most cases.
	Nurse Practitioner-Led Clinics	Teams led by Nurse Practitioners and consisting of RNs, RPNs, collaborating physicians and other IHPs to provide comprehensive primary care services to unattached patients. Governed by a Board of Directors. NP, IHP and operational funding established through agreement between NPLC Board and ministry.
	Community Health Centres/ Aboriginal Health Access Centres	Interdisciplinary teams in a non-enrolment model serving unique population groups. CHCs are governed by a Community Board of Directors and funded by the LHINs.
Specialized	First Nations Agreements	Special arrangements with providers delivering primary care in unique circumstances, such as rural and northern Ontario and/or high needs populations, etc.
	GP Focused Practice Models	
	Homeless Shelter Agreements	
	Rural Northern Physician Group Agreement (RNPGA)	



