

PROPOSED IMPLEMENTATION PLAN

<i>Year One</i>	RESPONSIBILITY
<p>1. Communicate support for the concept of PCGs.</p> <p>a) Announce that PCGs will be established. (R3) PCGs will be responsible for providing comprehensive primary health care to a defined population.</p> <p>b) Make commitment to develop groups over the next six years in Ontario. (R29)</p>	<p>Ministry of Health</p>
<p>2. Put a structure in place to support implementation activities.</p> <p>a) Appoint a champion to affect the change in primary health care. (R27) The champion will be responsible for leading the transition in primary health care, and ensuring that primary health care receives a high priority in government and with provider groups.</p> <p>b) Establish an Implementation and Monitoring Committee of external representatives supported with a secretariat, and reporting directly to the Minister of Health. (R28)</p> <p>c) Commit funds for PCG development. Funding for PCGs incorporate: population-based funding or capitation, and funding for special programs. Other services outside of group funding supported with additional funds, and paid as sessionals. (R8)</p> <p>d) Invest stable and ongoing funding immediately to support the education of nurse practitioners in Ontario. (R10)</p>	<p>Ministry of Health</p>
<p>3. Do the groundwork for PCG development.</p> <p>a) Establish an education task force to address education issues. (R9, R11, R12)</p> <p>b) Develop criteria for selecting PCGs.</p>	<p>Implementation and Monitoring Committee, and Secretariat</p>

<i>Year One con't</i>	RESPONSIBILITY
<p>4. Start PCG development.</p> <p>a) Solicit expressions of interest to establish PCGs, and establish mechanisms that will assist sites to establish their operations.</p> <p>b) Prepare contracts between PCGs and consumers. Registration contracts clearly outlining the relationships, rights and responsibilities of the participants of a PCG. (R20)</p> <p>5. Prepare contracts between PCGs and the Ministry of Health. The contract between the PCG and the MOH will set out the expectations and operational standards of PCGs. (R22) The contracts will include PCGs monitoring the extent to which their enrolled consumers seek primary health care outside the group, and evaluating and addressing the reasons why this is occurring. In the second year of operation, PCGs should be negated for 100% of the cost of care if any of their consumers seek their primary health care outside the group. (R5)</p> <p>6. Develop and implement a system to monitor performance and activities of PCGs.</p>	<p>Implementation and Monitoring Committee, Secretariat</p> <p>Implementation and Monitoring Committee, Secretariat</p> <p>Implementation and Monitoring Committee, Secretariat</p>
<p><i>Year Two</i></p> <p>1. Develop directories of community resources to support PCGs. (R15)</p> <p>2. Initiate the development of systems so that each PCG has electronic access to drug and laboratory information. (R14)</p> <p>3. Choose the sites to become PCGs from expressions of interest: 50% underserved and 50% established group practices (HSOs and others)</p>	<p>Local Community Care Access Centres and District Health Councils</p> <p>Ministry of Health</p> <p>Implementation and Monitoring Committee, and Secretariat</p>

PRIMARY HEALTH CARE STRATEGY

<i>Year Three</i>	RESPONSIBILITY
1. Develop guidelines for inter-professional quality management in primary health care settings. (R26)	Implementation and Monitoring Committee, and Secretariat
2. Choose the sites to become PCGs in Year 3: remaining 50% underserved and remaining 50% established group practices (HSOs and others)	Ministry of Health
<i>Year Four</i>	RESPONSIBILITY
1. Choose the sites to become PCGs from expressions of interest: 33% of the remaining population	Implementation and Monitoring Committee, and Secretariat
<i>Year Five</i>	RESPONSIBILITY
1. Choose the sites to become PCGs from expressions of interest: remaining 50% the population	Implementation and Monitoring Committee, and Secretariat
<i>Year Six</i>	RESPONSIBILITY
1. Establish final sites for PCGs: 100% of the remaining population.	Implementation and Monitoring Committee, and Secretariat

Summary of Implementation, and Annual and Cumulative Rollout of PCGs

	Activities		Cost (mil)	
Year 1	Planning for Implementation. Committing funds for nurse practitioner education, and six year implementation activities.		\$5	
	Annual Rollout	Cumulative Rollout	Annual Capitation (mil) (cumulative)*	Start-up capital (millions) *
Year 2	50% of underserved and 50% of established group practices (HSOs and other group practices)	50% of underserved and 50% established group practices (HSOs and other group practices)	\$169	\$154
Year 3	Remaining underserved and established group practices (HSOs and other group practices)	100% of underserved and 100% established group practices (HSOs and other group practices)	338	154
Year 4	33% of the remaining population	100% of underserved and established group practices (HSOs and other group practices) + 33% of the remaining population	842	476
Year 5	50% of the remaining population	100% of underserved and established group practices (HSOs other group practices) + 66% of the remaining population	1,345	476
Year 6	100% of the remaining population	100% of underserved and established group practices (HSOs other group practices) + 100% of the remaining population	1,849	476

* Cost estimates use current dollars. No allowances are made for inflation and cost increases. Capitation amounts include an amount to repay start up capital costs

PRIMARY HEALTH CARE STRATEGY

When Established, Each PCG Will Incorporate The Following:

Key elements	<ul style="list-style-type: none"> • Provide a defined range of primary health care services. (R1) • Arrange for 24 hours-a-day, 7 days-a-week response and extended office hours. (R2) • Enroll consumers with a primary care physician or primary care nurse practitioner. (R4) • Incorporate inter-professional primary care providers, with primary care physicians and primary care nurse practitioners forming the core team and other professionals added to meet the needs of the enrolled population. (R6)
Funding	<ul style="list-style-type: none"> • Determine how providers will be remunerated within the group. (R7)
Information Management	<ul style="list-style-type: none"> • Incorporate clinical management systems in PCGs. (R13)
Coordination of Care	<ul style="list-style-type: none"> • Compile, as well as be the custodian of a health record for each enrolled consumer. (R16) • Develop agreements with organizations and health care providers offering different levels of care (e.g., between PCGs and local hospitals, which includes hospital privileges for primary care physicians). (R17) • Establish standard communication and transfer protocols with other referral organizations, health care providers and sectors (R18). • Develop care paths with local health care providers for common medical conditions, paying special attention to hand-off points. (R19).
Accountability Mechanisms	<ul style="list-style-type: none"> • Identify indicators and develop mechanisms to report to the public on an ongoing basis, the performance of the group. (R21) • In the short-term, establish arrangements for supporting the development of policies and strategic directions to guide their operations, including obtaining input from the enrolled population. In the longer-term, PCGs consider establishing more formal mechanisms such as governing boards made up of the enrolled population. (R23) • Establish a management structure that includes two key functions: a group administrator and a clinical director. (R24) • Establish mechanisms to monitor and evaluate their effectiveness and efficiency on an ongoing basis. (R25)

Challenges to Achieving Primary Health Care's Potential

There is Little Appreciation for the Pivotal Role of Primary Health Care

- Health and health maintenance tend to be equated with high technological medical care and hospitals.
- There is little appreciation of the pivotal role primary health care can play in keeping people well, advocating on their behalf, guiding them through the system, and coordinating their care.
- This lack of appreciation usually translates into less commitment to support the changes that are required to develop a strong system of primary health care.

The Effectiveness of Primary Care Funded Through Alternate Arrangements is Unclear

- Currently, community health centres (CHCs) and health service organizations (HSO) are not widely accepted as effective alternatives to fee-for-service (FFS) for primary health care.
- The potential of alternate funding arrangements for primary health care is difficult to assess because of the limitations of performance measures and accountabilities of CHCs and HSOs.
- e.g., CHCs are not required to provide a full range of primary care services, their hours of operation and arrangements for after-hours coverage vary, and there is a lack of accountability for CHC services.
- e.g., In HSOs, the use of non-physician primary care providers varies, there are difficulties maintaining an accurate record of enrolled patients, and mechanisms to ensure that HSOs are meeting the terms of their contracts are spotty, at best. It was expected that HSOs would improve access to care and thereby decrease reliance on institutions for emergency and inpatient care. This has not happened.*

*B.G. Hutchinson et al., iDo physician-payment mechanisms affect hospital utilization? A study of Health Service Organizations in Ontario,î Canadian Medical Association Journal 154 (1996): 653-661.

There are Inadequate Information Systems to Support Primary Health Care

- Information systems used by primary health care providers tend to be limited to systems that are used mostly for submitting claims to the Ministry of Health. These systems are not used to monitor a patient's health care, assist in accessing information on the range of services available in the community, or transmit health record information among providers.

There is a Maldistribution of Primary Care Physicians in Ontario and Limited Use of Non-Physicians to Help Provide Care

- Factors such as aging physicians, the lack of desire to practise in smaller and more remote communities, and physicians changing their work patterns to fit lifestyle choices, directly impact on the feasibility of every Ontarian having a primary care physician.
- Low population density, geography and distances between towns exacerbate the problem of insufficient numbers of primary care physicians in some areas of the province.
- Physicians in remote areas find it difficult to provide care over large areas. It is also difficult for physicians to be supported professionally when there are few if any peers to consult with, and to obtain consults with specialists who are far away.
- Recent legislation recognizes midwives and an extended class of nurses who practise as community nurse practitioners. One study estimated that nurse practitioners can perform 80% of tasks performed by physicians.* There has been little concerted effort to date to use these practitioners optimally in an integrated primary health care system. Limitations in funding and lack of acceptance of these professionals are barriers.

*M.A. Fitzgerald et al., iThe Midlevel Provider: Colleague or Competitor,î Patient Care 33 (1995): 20-37.

There are Limitations Inherent in Fee-For-Service Funding

- FFS breaks down the provision of primary health care into its component parts. Since each part is associated with a billing code and a fee, the FFS structure is not able to consider integrated primary health care as a total, comprehensive picture.
- Physicians who conduct more detailed assessments, and in-depth disease prevention, health promotion and client education activities are either funded inadequately for these activities or not at all.
- FFS physicians wanting to establish inter-professional group practices must find alternate sources of funding, since most non-physicians cannot bill for their services nor can physicians bill for services provided to their patients by non-physicians.
- FFS is an incentive for physicians to practise in more densely populated areas, since FFS pays physicians for the volume of work they do.
- The OMA-MOH agreement does not allow FFS funds to be transferred to alternate payment program funding, which could be used to support comprehensive primary health care.

Enabling Legislation to Support a System of Primary Health Care is Limited

- Current legislation limits the ability to establish innovative primary care arrangements since it: limits the ability of health care providers generally to amalgamate with other health care providers not operating under the same statute; and neither permits nor facilitates the formation of alliances or partnership arrangements between similar types of health care providers.

Professional Autonomy Can Impact on Efforts to Collaborate

- Most primary care physicians are solo practitioners. This impacts on their willingness to enter into more collaborative arrangements, especially if they anticipate a loss of personal autonomy or feel they must manage other health care providers.
- Fee-for-service reinforces autonomy and solo practice. Physicians wanting to establish inter-professional group practices must find alternate sources of funding, or pool their billings to finance other care providers.

APPENDIX B: COMPARISON OF PRIMARY CARE REFORM MODELS AND ESSENTIAL ELEMENTS

Organization/ Report	Enrollment	Inter- professional Group Practices	Defined Range of Service and 24-7	Co-ordination and Communication Mechanisms	Information Management	Quality Improvement and Accountability	Funding
Federal/ Provincial/ Territorial Advisory Committee on Health Services ³⁵	Yes	Yes	Yes Core services with contractual requirements. 24-hour coverage.	Yes Primary care organizations to establish relationships with community organizations and government.	Promoted. Each primary care organization to maintain ongoing patient medical records.	Yes Through contractual agreement.	Capitation based funding. Explore GP fund holding system.
Ontario Chairs of Family Medicine ³⁶	Yes	Yes Solo practices possible within a network.	Yes Comprehensive services including coordination, 24- hour coverage, referrals	Yes Core service. Primary care physicians to provide in-hospital care.	Yes, to provide information on patient and population health status/ needs assessment.	System for continuous quality improvement.	Support blended funding Option for fee-for-service (amount no to exceed what would be earned under blended approach).
Canadian Medical Association ³⁷		Multidisciplinary care encouraged but not required.	Primary care physician should provide: • General care • Maternal & child • Psychosocial care • Rehabilitative and palliative care • Advocacy		Yes including clinical patient management software.	Yes Enhance information systems for practice management.	Payment for health promotion. Incentives to recruit physicians to under- served areas.

³⁵ The Federal/Provincial/Territorial Advisory Committee on Health Services, *The Victoria Report on Physician Remuneration* (1995).

³⁶ J. Forester et al., "New approach to primary medical care: nine-point plan for a family practice service", *Canadian Family Physician* 40 (1994): 1523-30.

³⁷ Canadian Medical Association, *Strengthening the Foundation: The Role of the Physician In Primary Health Care in Canada* (1994).

Organization/ Report	Enrollment	Inter- professional Group Practices	Defined Range of Service and 24-7	Co-ordination and Communication Mechanisms	Information Management	Quality Improvement and Accountability	Funding
College of Family Physicians of Canada ³⁸	Client rostering for purpose of records, not a basis for payment.	Yes	Yes, including 24-hour availability.	Yes	Yes National family physician computerized network. Clinical practice management tools designed around practice guidelines.	Yes	Support blended funding mechanism.
Ontario Medical Association ³⁹	Rostering on a voluntary basis for providers and public.	MD as principal coordinator of care and collaborative relationships with other providers.	24-hour response. No core services defined. Health maintenance activities.		Provider-based patient database to promote screenings and ongoing care.	Yes	Range of payment plans needed to achieve goals. Support a reformed FFS funding plan.
PCCCAR ⁴⁰	Yes	Financial incentives to encourage group practice and multidisciplinary team based care.	Yes Including defined services, 24-hour triage.	Yes Access to medical specialists only with referral from primary care provider.	Yes, move to electronic health record.	Develop comprehensive set of practice guidelines. Develop an infrastructure for CQI.	Streams: 1. Capitation funding for mandatory functions 2. Fund for excluded services 3. Funds for enhanced services Methods of provider payment determined by individual primary care agencies.

³⁸ Canadian College of Family Physicians, *Managing Change: The Family Medicine Group Practice Model* (1995).

³⁹ Ontario Medical Association, *Primary Care Reform: A Strategy for Stability* (1996).

⁴⁰ Subcommittee on Primary Health Care of the Provincial Co-ordinating Committee for Community and Academic Health Sciences Centre Relations (PCCCAR), *New Directions for Primary Health Care* (1996).

Organization/ Report	Enrollment	Inter- professional Group Practices	Defined Range of Service and 24-7	Co-ordination and Communication Mechanisms	Information Management	Quality Improvement and Accountability	Funding
Task Force on the Funding and Delivery of Medical Care in Ontario ⁴¹	Yes				Enhanced clinical information	System-wide quality improvement.	Capitation, fee-for-service and CHC funding models with funding pools for each model determined on a capitation basis.
Centre of Health Economics and Policy Analysis ⁴²	Yes	Promising but not essential.	Yes Including minimum weekly operating hours, 24-hour coverage, defined range of services.	Yes Access to medical specialists only with referral from primary care provider. Includes minimum communication requirements.	Yes Additional information required for all levels of decision making. Initial focus on clinical practice management.	Yes Practice audits with rewards for "good" performance.	Capitation funding allocated to each model with a range of provider payment mechanisms.
OMA, Primary Care Reform Physician Advisory Group ⁴³	Yes	Encouraged by offering program funding arrangements to rostered practices.	Yes Defined services. 24-hour coverage.	Yes Primary care MD as coordinator of care.	Yes Incremental development of information systems based on electronic patient record.	Implementation of evidence-based clinical practice. Guidelines and decision tools.	two models: Reformed fee-for-service, and Blended funding model.
Ontario College of Family Physicians ⁴⁴	Yes	Group practices or practice networks with enhanced role for nurses.	Yes 24-hour coverage.	Yes Access to all levels of health care through family physicians. Every family	Yes Family physician responsible for managing comprehensive electronic	Yes Community report cards. Peer assessment through physician groups.	No one funding model should be imposed. Blended funding mechanism promotes principles of family practice more appropriately than others. Blended

⁴¹ Task Force on the Funding and Delivery of Medical Care in Ontario, *Report of the Task Force on the Funding and Delivery of Medical Care in Ontario* (1996).

⁴² B. Hutchison and J. Abelson, *Models of Primary Health Care Delivery: Building Excellence through Planned Diversity and Continuous Evaluation*. McMaster University Centre for Health Economics and Policy Commentary C96-3 (1996).

⁴³ Ontario Medical Association Primary Care Reform Physician Advisory Group, *Primary Care Reform: A strategy for stability* (1996).

⁴⁴ Ontario College of Family Physicians, *Family Medicine in the 21st Century: A prescription for excellence in health care* (1999).

 PRIMARY HEALTH CARE STRATEGY

Organization/ Report	Enrollment	Inter- professional Group Practices	Defined Range of Service and 24-7	Co-ordination and Communication Mechanisms	Information Management	Quality Improvement and Accountability	Funding
				Physician to be an active member of medical staff of a hospital. Formal networks.	health record.		funding includes a base salary, overhead costs, no-volume modifiers and volume modifiers.

APPENDIX E: COMPARISON OF PRIMARY HEALTH CARE DELIVERY SYSTEMS AND STRATEGIES

Essential elements	Fee-for-service practices (FFS)	Health Service Organizations (HSO)	Community Health Centres (CHC)	OMA Primary Care Pilots (PCN)	Ontario College of Family Physicians (OCFP)	HSRC Primary Health Care Groups (PCG)
Enrollment	Not required	Required for most individuals	Not required	Voluntary enrolment with physician	Enrolment with family physician required	All consumers to be enrolled with primary care physician or nurse practitioner. Those enrolled with a nurse practitioner will co-enroll with a physician in the group
Handling of non-enrolled patients, exclusion of patients	Not Applicable	For non-enrolled consumers, Ministry of Health allows FFS billing of up to \$50K per FTE physician & maximum average of all physicians in an HSO of \$30K of FFS billings to non-members. No person refused enrolment or terminated on basis of health status Person can be removed from roster for any bona fide reason consistent with proper & ethical medical practice	No person refused care, even those without health insurance	No person refused the opportunity to enroll with a PCN Physician and no person terminated from Enrolled membership on account of his or her health status or need for health services.	No clear policy outlined	No person to be refused enrolment or terminated on basis of health status Person can be removed from roster for any bona fide reason consistent with proper & ethical medical practice
Enrolment with whom?	Not applicable	Roster to HSO but	Not Applicable	With physician	With family physician	With primary care physician or nurse practitioner. Enrolment with nurse practitioner requires co-enrolment with family physician.

Essential elements	Fee-for-service practices (FFS)	Health Service Organizations (HSO)	Community Health Centres (CHC)	OMA Primary Care Pilots (PCN)	Ontario College of Family Physicians (OCFP)	HSRC Primary Health Care Groups (PCG)
Defined range of services	Not defined	<p>Services are not specifically defined, however the objectives are to:</p> <ol style="list-style-type: none"> 1. Allow the flexibility to respond to the health needs of population serviced. 2. Develop a co-ordinated system of health care delivery. 3. Focus on health maintenance & illness prevention. 4. Decrease institutional care. <p>* 24-7 considered a feature of an HSO</p>	<p>No mandatory services defined, however, a strong emphasis on the determinants of health. CHC's have a wide range of services depending on the population being served including diagnosis and treatment</p>	<p>Required services:</p> <ul style="list-style-type: none"> • Health assessment • Diagnosis & treatment • Primary reproductive care • Primary mental health care • Access to obstetrical & newborn care • Service coordination where possible • Patient education & preventive health care • Appropriate periodic health assessments • On-call coverage/ after-hours coverage 	<p>PCCCAR basket of services:</p> <ol style="list-style-type: none"> 1. Health assessment 2. Illness prevention and health promotion 3. Diagnosis and treatment of episodic illness 4. Primary reproductive care 5. Palliative care 6. Primary mental health care 7. Coordination and access to rehabilitation (i.e. referral or direct provision of rehabilitation services) 8. Service coordination and referral (e.g. long term care, home care, specialists etc.) 9. Access to hospital care and coordination 10. Patient education and support for self-care 11. Advocacy 	<p>With primary care physician basket of services:</p> <ol style="list-style-type: none"> 1. Health assessment 2. Illness prevention and health promotion 3. Education and support for self-care 4. Diagnosis and treatment of episodic and chronic illness and injuries 5. Primary reproductive care 6. Palliative care 7. Primary mental health care 8. Coordination and provision of rehabilitation services 9. Coordination of and referral to other health care services 10. Supportive care in hospital, at home and in long-term care facilities

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24-hours-a-day, 7-days-a-week coverage and extended hours	Not required	Required but may take many forms including contracting FFS physicians.	Arrangements for 24/7 required but these are inconsistent. i.e. may mean access to PC through emergency departments after hours.	Weeknight coverage must be available in at least one PCN location from 5 p.m. to 9 p.m. Weekend hours determined by practice type & population need. After hours telephone triage to achieve 24-hour access to health care	Required for urgent care	Access to PC services 24-7. Tele-triage system available 24-7 for advice and to direct calls to most appropriate service.
Inter-professional provider groups	FFS funding does not lend itself to the inclusion of other professions. Employing other health professionals may only be feasible in large group practices with pooling of incomes.	Institutional Substitution Program (ISP) grants available to fund PC services not already funded in MD cap. These may include non-MD provider programs such as nutrition counselling and chiropody services.	Inter-professional care providers are a key feature of CHCs. (e.g. MDs, NPs, social workers etc.)	No stated role for other providers except MDs. Opportunities for NPs in globally funded groups if allowed enrolment size is increased from 2,200 per MD to 3,000.	OCFP endorses a collaborative practice model between physicians and nurse practitioners. The OCFP recognizes that other professionals have a role in the delivery of primary care as well.	Enhanced role for nurses and nurse practitioners since consumers can enroll with an NP. Minimum of one NP required within the Core Team. Additional professionals will be determined by the defined range of primary care services. These will include RNs, probably social workers and midwives, and possibly professionals such as physiotherapists, dieticians or psychologists.

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Group practices (networks)	Not required. Approx. 40% of PC MDs are in solo practice. Many MDs in group practice are organized as office sharing arrangements rather than true group practices. ⁴⁷	Not required.	True group practices	Primary care reform pilots are either organized as group practices in a single site or as electronically linked networks. Size of group varies.	PCNs comprised of 7 to 30 family physicians. Allow for formal group practices or practice networks (virtual groups). Integration of PC groups or networks with the use of Family Practice facilitator (1 per 50-60 MDs). The facilitator would integrate groups with the broader health care system, encourage QI & collaborative relationships. Facilitators may be chief of staff in local hospital. Facilitator may be part of a regional network.	Encourages true group practices through location on a single site. Only for remote PCGs where co-location may not be feasible due to low population density and distance, will groups be located at different sites.

⁴⁷ P.A. Williams et al., "Autonomy in Ontario Medical Group Practice". *Health Services Management Research* 3(2) (1990): 87-97.

PRIMARY HEALTH CARE STRATEGY

Essential elements	Fee-for-service practices (FFS)	Health Service Organizations (HSO)	Community Health Centres (CHC)	OMA Primary Care Pilots (PCN)	Ontario College of Family Physicians (OCFP)	HSRC Primary Health Care Groups (PCG)
Quality improvement mechanisms	Not formally required.	Negation is an incentive to provide full range of high quality care.	CHCs in the process of installing an information system which will facilitate quality improvement efforts	Financial rewards to individual MDs for achieving health targets.	OCFP recommends a “report card” to the community on its health status as method of assessing effectiveness of care being delivered by group.	<ul style="list-style-type: none"> • Implementation & use of clinical pathways, protocols and guidelines • Identify indicators and develop mechanisms to report to the public on an ongoing basis • Continuing education PCGs required to monitor and evaluate their effectiveness and efficiency on an ongoing basis • Establishment of mechanisms for continuous quality improvement and participation in external quality assurance programs and audits
Accountability mechanisms	Reporting on patients and procedures necessary for reimbursement.	Required to submit monthly service encounter reports to MOH (failure to do so may result in financial penalty). Monthly roster change information is also required.	Standard reporting to MOH.	<p>Contractual arrangement between PCN & MOH.</p> <p>Reports on client-based encounters submitted to MOH monthly. Failure to report may result in financial penalty.</p> <p>Registration contract between PCN and consumer.</p>	<p>Accountability to community through report cards.</p> <p>“Patient choice” (registration) outlines responsibilities of MD & consumer.</p>	<p>Accountability of PCGs to:</p> <ul style="list-style-type: none"> • Payor through defined reporting requirements re: costs, utilization, quality of services, population health outcomes. • Registered population for provision of contractual services, health outcomes & satisfaction. <p>Reports on client-based encounters submitted to MOH monthly.</p>

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Governance and organization	<p>No specific governance arrangements required.</p> <p>A number of organizational models possible.</p>	<p>71 HSOs are physician-sponsored (i.e. Owned & operated by MDs)</p> <p>2 HSOs have community boards, i.e. are sponsored by non-profit corporations</p> <p>4 HSOs are sponsored by health science centres and are therefore accountable to the hospital board</p>	<p>CHCs are non-profit organizations governed by community boards.</p>	<p>All PCNs to establish and maintain a written governance structure.</p> <p>Possible organization models include corporations, partnerships and unincorporated associations.</p>	<p>Primary care groups to be part of larger regional health care delivery networks.</p> <p>No specific recommendations for governance.</p>	<p>In short term, PCGs establish arrangements to support the development of policies & strategic directions to guide the operations of the PCGs, including mechanisms to obtain input from the enrolled population.</p> <p>In long-term, PCGs should consider establishing more formal mechanisms such as governing boards that are made up of members of the enrolled population.</p> <p>PCGs to be organized as non-profit organizations.</p>
Information management	<p>Not required but some solo MDs & group practices have set up their own systems.</p>	<p>Not required but large HSOs have information systems (e.g. SSM Group Health)</p>	<p>Currently limited but being improved through standard electronic information system.</p>	<p>Each pilot site to have a Clinical Management System which includes:</p> <ul style="list-style-type: none"> • Electronic patient record • Medication mgmt • Lab test results delivery • Preventive screening • Enrolment • Payment • Practice mgmt functions • Linkages to telephone health advisory system • LAN/communications security 	<p>All members of group to share an electronic health records system which would include a record of any health care received (e.g. LTC, ER, specialists, community-based)</p>	<p>Basic information required for determining health status & the health care requirements of the registered population.</p> <p>Eventually, participants in PCGs should have access to:</p> <ul style="list-style-type: none"> • On-line consumer-specific drug & lab info (for providers) • Tele-triage • Tele-health (consumer information) <p>Local CCACs and DHCs to develop directories of community resources to enable PCGs to arrange the best services for their enrolled population.</p>

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Communication & co-ordination	No formal requirements	No formal requirements	No formal requirements	PC reform to provide incentives for coordination. For example: <ul style="list-style-type: none"> • Team consultation & home care supervision fees • Institutional Substitution Program funding (similar to HSOs) to be explored • Co-location of funded services • Electronic communication links & networking 	MD to provide co-ordination for LTC, ER, specialists etc.	<ul style="list-style-type: none"> • PCG maintains comprehensive medical record • Agreements be developed for full continuum of services • Standard communication & transfer protocols • Clinical pathways & care maps.
Hospital appointments for MDs	Not required	Not required	Not required	Not required	MDs need to be an active or associate member of the medical staff of local hospital	Recommended
Size of practice	Not limited Average patients per GP/FP: 1,036	Maximum 2,500 per FTE M.D. Average: 1,900 rostered per MD	Variable No solo practice CHCs, however, one CHC in province with no MDs.	Maximum 2,200 per FTE M.D.. With the addition of a nurse practitioner, roster can be increased to 3,000. Exceptions include rosters rolled over from HSOs & FFS MDs who have had more patients in their current practice. MOH planned for PC networks of 15 to 20 MDs but have approved smaller groups.	PC practice networks with 7 to 30 physicians. No discussion of enrolled population size.	Number of enrolled individuals per provider depends on practice setting: Urban 1,874 Rural 1,331 Remote 1,178 Core teams of 4 to 8 providers.

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Essential elements	Fee-for-service practices (FFS)	Health Service Organizations (HSO)	Community Health Centres (CHC)	OMA Primary Care Pilots (PCN)	Ontario College of Family Physicians (OCFP)	HSRC Primary Health Care Groups (PCG)
Funding	FFS Sessional payments	Capitation funding (average \$137 per person). Institutional Substitution Program Grants available as well Each MD can bill max. of \$30K FFS	Globally funded Providers are salaried employees of CHC.	2 Funding methods: 1. Global capitation Similar to HSOs 2. Reformed FFS including 5 additional fee codes.	Allow for a variety of MD payment methods but recommend Blended Funding. Blended funding includes 4 components (base, overhead costs, non-volume modifiers, volume modifiers)	Funding is provided to the PCG and can include three components: <ul style="list-style-type: none"> • population-based funding to pay for mandatory primary health care functions; • funds for services that are not included in population-based funding, specifically obstetrical deliveries, emergency department work, anaesthetic services, surgery assists, and visits to homes, hospitals and long-term care facilities; and • funding for enhanced services and program beyond the mandatory functions, that address services for priority groups or those difficult to register (e.g., the socially and economically disadvantaged).
Incentives	Service volumes	Incentive for keeping rostered patients out of hospital were provided Ambulatory Substitution Care Plans (ACIPs) by MOH. These were discontinued	None	Allowance for computer systems. Incentives for achieving health targets.	None specifically recommended.	Maximum incentives of 20% to the group for achieving performance targets. The group will be responsible for allocating the incentive to the team.

PRIMARY HEALTH CARE STRATEGY

Essential elements	Fee-for-service practices (FFS)	Health Service Organizations (HSO)	Community Health Centres (CHC)	OMA Primary Care Pilots (PCN)	Ontario College of Family Physicians (OCFP)	HSRC Primary Health Care Groups (PCG)
Negation	Not applicable	<p>Yes for use of FFS services outside HSO</p> <p>Negation is equal to 50% of actual cost of care.</p>	Not applicable	<p>Negation included in Global Capitation funded groups for outside PCN use of medical services.</p> <p>Negation is equivalent to 100% of the actual cost of the service. Use of primary care services through hospital emergency departments and outside the geographic region is not negated.</p>	Nothing recommended. OCFPs allows for a variety of funding models.	<p>Negation to be equivalent to 100% of the actual cost of the service. Use of primary care services through hospital emergency departments and outside the geographic region is not negated.</p> <p>PCGs will be provided with feedback regarding outside use of primary care services by the enrolled population. PCGs will not be negated until 12 months after they have been established.</p>
Scope of implementation	<p>FFS is the most common system</p> <p>Accounts for 86% of income for MDs</p>	<p>77 HSOs in existence.</p> <p>No new HSOs approved since 1990</p> <p>Approximately 4% of PC physicians practice in HSOs</p>	<p>57 CHCs in the province.</p> <p>Since April 1999 new CHCs have been announced for Waterloo, Grand Bend, Crysler and Ottawa.</p> <p>6% of PC physicians practice in CHCs.</p>	<p>Very limited 8 sites approved. To date, 2 up and running.</p> <p>OMA's strategy is to wait for full evaluation before recommending broader implementation.</p>	Province-wide implementation.	Provincial. Staged with 5-year implementation plan.