The Care by FHO Physicians is not Captured by OHIP Billings
Nor is Care Improved by Mandated Draconian Quotas

A FHO that Models Quality and Accessibility

I am the Lead Physician of the Central Hastings Family Health Organization (FHO). I am certain that our group emulates a model of care that offers the quality and accessibility that exceeds the MOHLTC's expectations for FHOs. We provide quality comprehensive primary care to our surrounding rural communities with superior accessibility.

I personally care for a roster of over 1500 patients. In my nine years of practice, I have always made it a priority to balance the size of my roster with my availability in order to always allow appropriate accessibility for my patients. A detailed description of my availability can be found on my website. Through the combination of Advanced Access appointments, my "Same Day/Next Day" protocol, as well as our FHO's After-Hours Clinics, I am proud to offer accessibility to my patients that is second to none in the Province. Every one of my patients can be seen within 24 hours, most typically on the very same day, of requesting an appointment. All of the physicians in our FHO practice similarly, so the same can be said for all of our 8000 patients.

With respect to After-Hours Clinics, our FHO diligently adheres to our contractual obligations. For the last several years, our FHO has been comprised of five physicians. We offer evening clinics from 5pm to 8pm every weeknight Monday to Thursday, and then an additional clinic on the weekend. Because our daytime access is balanced, there is relatively small demand for the evening clinics. The average number patients who attend an After-Hour Clinic is 10, meaning we often have unused appointment slots in our After-Hours Clinics. In fact, we intermittently have After-Hours clinics where five or less patients show up, and occasionally none at all.

When a physician in our FHO is away on vacation, we have internal agreements and protocols in place where we cover each other's patients, messages, prescription renewals, test results. Thus, our patients are never without care, even when one's primary physician may be away.

My practice and our FHO offer more than sufficient accessibility versus the demands of our roster sizes.

Not only that, but despite having a relatively high proportion of elderly and complex patients, and despite practicing in an impoverished region with low socioeconomic determinants of health, the quality of my care exceeds the LHIN and Provincial averages. I have published my Health Quality Ontario metrics on my website for everyone to see.

Again, I am certain that our FHO is a model of quality and accessibility that exceeds the MOHTLC expectations.

The Work by FHO Physicians is Not Captured by OHIP Billings

As in the nature of FHOs, much of the work and the care that we provide our patients is not captured by OHIP billings, though. OHIP billings only capture face-to-face billable encounters with patients. I email and call my patients, even after hours, on weekends, holidays, and vacations. Where appropriate, I have my staff telephone or email patients in order to spare them a visit to the clinic and thus free up appointment time for other patients in need. I invest in virtual care technologies such as Ocean and Health Myself in order to provide superior care and accessibility to my patients. I use my Electronic Medical Record (EMR) to manage my roster's population health and preventative care issues – again, using staff, email, letters, and phone calls to notify and recall patients as needed. None of this is captured nor reflected by OHIP billings.

For years, I have built, funded, and maintained my own website to help empower and educate my patients for their own self-management. None of this is captured by OHIP billings.

All of these efforts allows me to spend more quality face-to-face time with patients who are truly in need. My standard clinic visit is 20 minutes. The nature of the FHO model is that it economically incentivizes physicians to address multiple complex issues all in a single visit, rather than recalling a patient multiple times for multiple shorter visits. Accordingly, I typically see about 20 to 23 patients per day, including occasional squeeze-in appointments. This has always been sufficient for the care and accessibility demands of my roster of over 1500 patients (who are complex, impoverished and thus generally require higher health care needs than the average population).

The "flat rate" payment model of FHOs also incentives family physicians to provide services even on days when they are away from clinic or not seeing patients in person, thus not submitting OHIP billings on those days. Most FHO family physicians like myself are metaphorically joined at the hip to their EMRs. We write notes, check on test results, read consult notes, fax prescriptions, respond to patient messages and emails - in the evenings, on the weekends, on stat holidays, and even stay connected during our vacations (See Appendix for supporting data). Such is the nature and commitment of working within a FHO model. In a sense, many FHO family physicians like myself are 'on call' and available for our patients up to 365 days per year. None of this gets captured by OHIP billings, though, because OHIP (even the shadow billings) can only be billed for face-to-face in clinic encounters.

The Government's Draconian Proposal

Having just illustrated a FHO that models the type of care and accessibility the government's Ministry of Health and Long Term Care (MOHLTC) would surely wish for all, it is shocking to see the MOHLTC's Arbitration Position for Primary Care that was published on October 11th, 2018. Amongst its demands, the MOHTLC aims to oblige mandatory hours in clinic, mandatory numbers of patients seen face-to-face, and additional After-Hours clinics that are excessive to the needs required to optimally care for efficiently managed roster sizes.

The MOHLTC is demanding that for a roster size of 1300 patients, that the physician be in clinic seeing patients face-to-face for 36 hours (9 four-hour blocks) per week. Further, the government seeks to mandate that 12 patients will be seen face-to-face every four hours. As above, though, our FHO has demonstrated that this is excessive to the needs of a 1500 patient roster, let alone 1300 patients. For my roster of 1500 patients, I am generally in clinic seeing patients from 8:30am until 4pm Monday to Thursday, including one hour of lunch to catch up on non-face-to-face work. Then on Fridays, I see patients face-to-face from 8:30am until noon. Friday afternoons I catch up on non-face-to-face work. This amounts to "only" seeing patients face-to-face for about 29 daytime hours per week (excluding after-hours clinics), but again, this has always been sufficient to meet the needs of my practice. If physicians start to be mandated quotas of hours to be in clinic and mandated numbers of patients seen patients face-to-face, then this will take away from the amount of time we are able to spend providing care and accessibility via *non*-face-to-face methods. Ultimately, as I explained above, non-face-to-face care is the essence of a FHO's effectiveness, so this will dramatically *reduce* the efficiency and capacity of FHOs.

Similarly, the MOHLTC is demanding that for a roster size of 1300 patients, that FHOs will provide a minimum of one three-hour evening clinic Monday to Friday and then and additional clinic every third Saturday or Sunday. Our current FHO has nearly 8000 rostered. We offer 4 weeknight clinics and one weekend clinic, which equals 5 three-hour clinics per week. This averages out to 1 clinic per week per 1600 patients. Even then, our clinics rarely ever fill up and there are generally unused appointments every clinic. The MOHLTC's demands equate to our FHO needing to offer 6.5 three-hour clinics per week (a 30% increase). Again, as explained above, this is excessive to meet the needs.

These mandated quotas for unnecessary daytime clinic hours and after-hours clinics will pull physicians away from other valuable services we provide to our communities. If FHO physicians are forced to spend all their time in clinic, we will no longer have the time to work in Emergency Rooms, take care of Nursing Homes, take care of patients in hospitals, nor home visits. There will not be enough time to offer additional specialized services like Palliative Care, Obstetrical Care, Anesthesia, etc. The entire health system will thus collapse.

The MOHLTC is demanding that a FHO must be comprised of a minimum of six physicians. For the last several years, our FHO only had five physicians, although we recently expanded to include seven physicians. (For what it is worth, it took years to finally recruit these two additional physicians, and it will be impossibly more difficult to do so if these government proposals are awarded because Ontario will become a horrendously unappealing place in which to practice family medicine). In any case, our group of five physicians was always able to exceed expectations and offer superior quality care and accessibility. Thus, the requirement for a minimum of six physicians is too much.

The MOHLTC is demanding that FHO physicians be able to offer appointments for acute concerns within one day. This is not unreasonable request, however, it lacks any accountability on behalf of patients. The government further proposes to penalize FHO physicians if their patients visit walk-in clinics or even the Emergency Room. If a patient attends an Emergency Department, and the ER physician bills OHIP $32 for the visit, then the government proposes that patient's family doctor should be docked the $32 in pay. Again, this lacks any element of patient accountability. Our FHO has accessibility such that any patient has the option of seeing a physician within 24 hours. Our staff track and document any patient who requests an appointment, but there are no spaces available that *same* day with the patient's *own* physician. We are proud to say this number is usually minimal. At our clinic in Madoc, which has four physicians caring for 5000 patients, the number of patients who are not able to be offered a *same* day appointment with their *own* physician typically ranges from zero to ten at maximum. Even for such cases, those patients always have the option of attending our nightly after-hours clinics. Nevertheless, we still see that some of our patients *choose* to *inappropriately* go the Emergency Department for minor and non-urgent concerns for which we would have gladly seen them. To be clear, even despite having the option of appointments at our clinic the very same day, some patients still choose to go to the Emergency Department or a Walk-In Clinic. This is totally due to patient choice. Patient choice is not within the control of the physicians. Thus, physicians must not be penalized for this.

For all of these excessive demands, for all of the mandated longer hours of work, the government is also proposing they would like to pay these doctors *less*. The MOHLTC is proposing a massive cut, slashing up to 25% of the capitation rates that FHO physicians are paid to care for patients year round. This would be *in additional* to the 10-22% that has already been cut from FHO physicians since 2012. (All the while overhead, inflation, staff wages, and taxes have continued to rise).

Undoubtedly, if the MOHLTC's arbitration proposal for Primary Care is awarded, it will destroy primary care in Ontario. Since primary care is the foundation of the health care system, Ontario's health care will consequently crumble and collapse.

Respectfully,
Dr. Adam Stewart
Madoc, Ontario

APPENDIX – Practice Statistics

Physician: Dr. Adam Stewart

Date: January 1st to Dec 31st, 2017

** The following statistics apply to the work the Dr. Stewart personally performed in 2017. It does not include all of the additional delegated work performed by his staff nor FHO colleagues.*

Roster Size: approx. 1575

Number of days worked on EMR: 310

Number of Emails Sent: 3,672

Number of EMR Searches: 423 (i.e. for population health, preventative care, targeted patient recalls, etc).

Prescriptions Faxed or Printed: 4,631

EMR Messages initiated or tended to: 11,533

Progress Notes: 37,125 (includes new notes, annotations, and updates)

Letters Sent: 11,621 (i.e. referrals to specialists and letters to patients)

Medical Reports Reviewed: 5,564

EMR Forms Completed: 21,296 (not including paper forms not in the EMR)

Lab Reports Reviewed: 12,179

Updates to Patients Cumulative Patient Profiles: 5,297