# Connecting the Dots for Patients

## Family Doctors' Views on Coordinating Patient Care in Ontario's Health System

**Results from the 2015 Commonwealth Fund International Health Policy Survey of Primary Care Doctors**

Ontario
Health Quality Ontario

Health Quality Ontario is the provincial advisor on the quality of health care. We are motivated by this single-minded purpose: better health for all Ontarians.

## Who We Are

We are a scientifically rigorous group with diverse areas of expertise. We strive for complete objectivity, and look at things from a vantage point that allows us to see the forest and the trees. We work in partnership with health care providers and organizations across the system, and engage with patients themselves, to help initiate substantial and sustainable change to the province's complex health system.

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We define the meaning of quality as it pertains to health care, and provide strategic advice so all the parts of the system can improve. We also analyze virtually all aspects of Ontario's health care. This includes looking at the overall health of Ontarians, how well different areas of the system are working together, and most importantly, patient experience. We then produce comprehensive, objective reports based on data, facts and the voices of patients, caregivers and those who work each day in the health system. As well, we make recommendations on how to improve care using the best evidence. Finally, we support large scale quality improvements by working with our partners to facilitate ways for health care providers to learn from each other and share innovative approaches.

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## The Common Quality Agenda

The Common Quality Agenda is the name for a set of measures or indicators selected by Health Quality Ontario in collaboration with health system partners to focus performance reporting. Health Quality Ontario uses the Common Quality Agenda to focus improvement efforts and to track long-term progress in meeting health system goals to make the health system more transparent and accountable. The indicators promote integrated, patient-centred care and form the foundation of our yearly report, Measuring Up. As we grow our public reporting on health system performance, the Common Quality Agenda will evolve and serve as a cornerstone for all of our public reporting products.

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**On the cover:** Dr. Pham, in her Toronto office. See page 11 for her story. We thank Dr. Pham and the other people who share with us their experiences in Ontario's health system. (Cover photo by Roger Yip)

# Table of Contents



Photo by Roger Yip

# Foreword

Dr. Joshua Tepper
President and Chief
Executive Officer

There are many reasons why I chose to become a family doctor and why I still deeply enjoy practicing family medicine: Caring for whole families; seeing patients over years; a tremendous intellectual diversity of clinical challenges; and tremendous emotional satisfaction.

My training prepared me for most aspects of family medicine, including being patient-centered, taking a good history, performing a thorough physical exam, and thinking about being a resource to my whole community. However, ensuring good care coordination is a responsibility that was not a focus of my training and which takes an increasing portion of my time as a family doctor.

Steve is a good example of this role I play as a primary care provider. Although only in his 50s, he has multiple chronic medical conditions. As part of his routine care, he interacts with more than eight doctors including an urologist, haematologist, nephrologist, endocrinologist, and two respirologists (one for asthma and one for sleep apnea). He takes 15 medications, almost none of which I prescribe, although I work closely with his pharmacist to assess risks of interaction and to help with compliance. I also follow up with several other health care providers involved with his care. Thinking about his health more broadly, Steve is on the Ontario Disability Support Program (often referred to as ODSP), and I work to coordinate his other supports, such as income support for things like transportation and food. Some visits we spend almost the whole time talking about Steve's recent journeys through the health care system – making sure we connect the dots and address the concerns he has with different members of the care team, and trying to figure out how to make this large care team work as efficiently as possible.

Care coordination is not a task I saw as integral to being a family doctor when I first applied for residency more than a decade ago. However I have learned that it is critical to my patients' care and, done right, can be as meaningful as other services I offer my patients.

Health Quality Ontario reported in 2015, in *Experiencing Integrated Care: Ontarians' views of health care coordination and communication*, that people living in Ontario generally report good experiences with the health system, and are just as likely as those in top-ranking countries to get help from their regular doctors in coordinating their care. However, that report also showed that basic patient information was often not shared between providers. In this report, *Connecting the Dots for Patients: Family doctors' views on coordinating patient care*, we find that family doctors often experience barriers coordinating care for their patients. For example, Collingwood family doctor, Dr. Harry O'Halloran, notes that if a patient "is outside of the local system, there is likely no notification" of his/her visit to a hospital. "The family doctor will find out only when the patient visits," he says.

The findings in this report speak to the challenges that I, and many other primary care providers, experience in coordinating our patients' care across all sectors, including home care and community services. Regrettably, the data does not allow us to reflect the experiences of all primary care providers in Ontario (including nurses, nurse-practitioners, pharmacists, dieticians, and social workers).

Our health system will continue to get more complex, with most patients finding themselves part of increasingly large teams often spanning many physical locations. Primary care plays a critical role in helping patients navigate across this care team. Together we need to find better ways to support primary care providers in their efforts to deliver coordinated care, as we move towards the vision of everyone living in Ontario having access to high-quality, comprehensive primary care anchored in an integrated and equitable health system.

Sincerely,

**Dr. Joshua Tepper**
President and CEO
Health Quality Ontario

# Executive Summary

*"Effective care coordination reduces duplication, increases quality of care, and facilitates access... It ensures continuity of care for patients regardless of setting, including home, community, hospital, long-term care facility, or their family practice."*

- Ontario Primary Care Council's Position Statement: Care Coordination in Primary Care, Nov. 2015

*Each health care sector has its own database – one used by the hospital, another by the family doctor's office – and they are typically not connected. The patient gets the same questions asked by different practitioners."*

- Dr. Brent Elsey

*"My biggest challenge in coordinating care is for those patients at the margins, with mental illness, chronic substance abuse, homelessness - because the affected are often unable to advocate for themselves."*

- Dr. Thuy-Nga (Tia) Pham

*"Patients have responsibilities, too… if a [medical appointment] date gets changed, this costs us family time and often money, and it can cost our employer money… [as well] it can affect later scheduled treatments."*

- Randy, caregiver

Coordinating patient care is a fundamental role of primary care[1], which is the foundation of Ontario's complex health system. Ideally, all the other types of patient care flow from, and stay linked to, primary care. Family doctors, as well as other primary care providers including nurses and nurse-practitioners, are tasked with ensuring that their patients move through multiple health sectors to get the services, supports and care they need.

However, patients do not always move through the system as smoothly as they could. Some patients in Ontario experience delays and frustrations[2] because of limitations in the system. Ensuring the timely exchange of patient information can take dedicated effort; it is not a given that family doctors have the time or staff in their practices to do this on top of the day-to-day care they provide to patients. Family doctors may encounter incompatible databases, duplication, time lags in patient information delivery, poor communication with social services, lack of integration of community case managers on the primary care team, and other challenges.

This report compares the responses of Ontario family doctors with those of family doctors in other Canadian provinces and in 11 OECD countries, as part of the 2015 *Commonwealth Fund International Health Policy Survey of Primary Care Doctors.*[3] The survey focuses on how they experience coordinating care with other health care providers and sectors of the health system. To look beyond the data we include stories about how family doctors and other primary care providers in different parts of Ontario have worked to help their patients in transition through the health system.

A picture emerges of systemic challenges faced by family doctors in their efforts to coordinate care for their patients across the health system, which, in turn, affects the experiences of patients and caregivers. *Connecting the Dots for Patients* discusses family doctors' experiences working with specialists, hospitals, home care and community services – and, in particular, challenges in the latter two areas.

Internationally, Ontario has one of the lowest reported percentages of doctors communicating with home care and community services. Less than a third of family doctors in Ontario say they, or other personnel in their practice, routinely communicate with their patient's case manager or home care provider. Slightly more than a third of Ontario family doctors say it is easy, or very easy, to coordinate their patients' care with social services or other community providers.

## Next steps

Getting patients the care they need is a priority goal and family doctors play an important role in reaching that goal. However, family doctors are experiencing systemic barriers when coordinating care for their patients. Several recommendations, from various sources within and outside the system, have been put forward in the past year highlighting ways to improve care coordination across the health system, with primary care as the foundation.

Health Quality Ontario is working with a broad range of primary care providers, patients and caregivers, to break down the barriers to care coordination, with the goal of achieving better health care for people in Ontario. At the end of this report, we provide information on the work underway by Health Quality Ontario, our partners, and other leading organizations across the province, as well as next steps.

## Key findings

- 29% of Ontario family doctors say they, or other personnel in their practice, routinely communicate with their patient's case manager or home care provider about the patient's needs and services to be provided.
- 36% of Ontario family doctors say it's easy, or very easy, to coordinate their patients' care with social services or other community providers when needed.
- 90% of Ontario family doctors say they always, or often, receive a report back from the specialist with all relevant health information.
- 25% of Ontario family doctors say that during the past month, tests or procedures for their patients had to be repeated because results were unavailable.
- 71% of Ontario family doctors say they always, or often, receive notification from the hospital when their patient is discharged; 54% say they get the notification, on average, within four days of discharge.

# 1. Why Care Coordination in Primary Care is Important

From the patients' perspective, few things are more important than how well their care is coordinated between various health care providers, services, and institutions. Lengthy delays, repeated tests, inconsistent information, and other disconnections make it difficult for patients, their families and other caregivers to navigate the health system in Ontario.[2]

The strain of dealing with a siloed health care system – where the right hand doesn't always know what the left hand is doing – can be just as difficult and frustrating for the health care providers as it is for patients, caregivers and/or family members. We all want the most timely, least stressful or intrusive care for ourselves and those we care for. This includes seamless transitions between settings; appropriate and unduplicated tests; optimized wait times for test results, specialist appointments and social services delivery; and available beds in hospitals or long-term care homes when we need them.

# Components of ideal care coordination

Patient care coordination that is effective and integrated among health care providers is an important feature of a high-performing system focused on patients.[3] Poor coordination can contribute to a host of negative outcomes, including hospital admissions that could have been prevented, unnecessary emergency department visits, medical errors, repeated tests and poor health outcomes for the patient.[5,6] Care coordination is optimal when the following components are present in a patient's care: team communications; timely information flow; and smooth transitions.[7]

## Team communications

Everyone involved in the patient's care (e.g., nurse, doctor, social worker, physiotherapist, etc.) operates as part of a team, with transparent sharing of information and good communication skills demonstrated by everyone.

## Timely information flow

Full, accurate and updated patient information needs to be transferred quickly from the last provider (e.g., nurse, doctor, social worker, physiotherapist, etc) or place of care (e.g., primary care office, hospital, emergency department, lab, clinic, specialist's office or community support agency) to the next care provider/place of care, so providers are well-prepared to engage with the patient and provide timely and effective care.

## Smooth transitions

Increasingly, often due to aging or chronic conditions, people need multiple types of care in more than one setting (e.g., primary care office, hospital, emergency department, lab, clinic, specialist's office, their own home, or community support agency). How smoothly a patient can move from one setting to another directly impacts his/her emotional and physical well-being.

# Family doctors' responses on care coordination

The 2015 *Commonwealth Fund International Health Policy Survey of Primary Care Doctors* covers numerous topics including care coordination, access to care, chronic care management, IT and office systems. Only family doctors were surveyed by the Commonwealth Fund, so our report does not capture experiences of other primary care providers. This report focused on the questions related to care coordination.

Responses do not cover all aspects of primary care, and they are not intended as an in-depth analysis of any particular system. However, these family doctors' responses provide an important starting point in understanding the quality of care coordination in Ontario. For the purposes of this report, we only note where there are statistics significantly different from Ontario's results.

To put the information in context, we compare responses from family doctors in Ontario with responses from family doctors across Canada and the other participating countries: Australia, France, Germany, Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom and the United States.

## How does Ontario compare?

Ontario is a large province with a mix of urban and rural settings, with many health care facilities and services spread across large regions, each with a unique set of characteristics and resources. Some regions face the challenge of organizing a large system with many thousands of patients. Other regions must cope with long distances that challenge the goal of accessible care. The Ministry of Health and Long-Term Care is committed to providing health care equity for every resident in Ontario. Furthermore, Ontario has a broad range of models of primary care ranging from a solo family doctor to more than 50 family doctors working with teams of other health care providers.[8]

## Survey respondents

- Family doctors in 11 countries: Canada, Australia, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom and the United States.

### Ontario respondents

- More than two-thirds (about 71%) identify themselves as primarily working in a doctor group practice or a community clinic/health centre setting.
- Less than a quarter (24%) are in private solo practice.
- About 5% practice in a different setting (e.g., hospital-based practice).
- 57% were men and 43% were women, roughly matching the gender breakdown of Ontario family doctors.
- About 57% practice in Ontario cities.
- 16% family doctors practice in Ontario suburbs.
- 26% family doctors practice in small town or rural Ontario.

Survey results are weighted to represent the primary care doctor population and account for sample design and probability of selection.

# 2. Care Coordination with Home Care and Community Services

Dr. Pham at her family practice; see her story on page 11. Photo by Roger Yip.

A key part of care coordination in primary care is linking patients with other sources of care and support in the community.[9] In Ontario, in addition to coordinating care with hospitals and specialists, primary care providers may also refer patients to home care, social services and other community providers (e.g., social workers, psychologists, physiotherapists, etc.).

Using survey data of family doctors in the 2015 *Commonwealth Fund International Health Policy Survey of Primary Care Doctors,* the specific measures we report on in this chapter are:

- The percentage of family doctors who say they, or other personnel in their practice, routinely communicate with their patient's case manager or home care provider about their patient's needs and services to be provided.
- The percentage of family doctors who say they, or other personnel in their practice, frequently coordinate care with social services or other community providers.
- The percentage of family doctors who say it is easy, or very easy, to coordinate their patients' care with social services or other community providers when needed.

## Coordination with home care

Home care is an important part of the health care system, providing medical and social care in the home or community setting.[10] It provides a wide range of services for many different care needs, including individuals with mental illness, children with special needs, people living with chronic disease(s), helping patients immediately after leaving the hospital, persons who are dying, and many others.[9]

To effectively manage their patients' care, primary care providers need to be kept up to date on changes in their patients' clinical status, needs and situation when they are receiving home care or community services.

# Dr. Pham: Dedicated case manager on the team

The practice of Dr. Thuy-Nga (Tia) Pham, a family doctor in east Toronto, sets a high bar for coordination with home care compared to the average experience in primary care in Ontario, especially for patients who wish to die at home. That's because Dr. Pham's team includes a dedicated community and home care case manager who is involved in developing and implementing treatment plans for their most gravely ill patients.

Case in point: Dr. Pham's office received a call from the daughter of Betty, an elderly patient in the practice. Betty had been receiving treatment for a chronic condition but was deteriorating rapidly; it was time to shift Betty to palliative care, and she wanted to die at home. "It took about an hour of phone calls and paperwork to make the arrangements and get a nurse in place for Betty" at her home, says Dr. Pham.

While most family doctors will try to fulfill a patient's desire to die at home, that requires having sufficient resources in their practices to coordinate home care services. Many doctors do not have Dr. Pham's success. "Once they hit a snag or delay, especially if time is a factor, they will advise the patient to call 911," says Dr. Pham.

Ontario has one of the lowest reported percentages of communication with home care services among the provinces and countries surveyed. Among family doctors in Ontario who have patients receiving home care services (e.g., nursing or personal care), fewer than three in 10 (29%) report that they, or someone in their practice, routinely communicate with their patient's home care provider regarding the needs and services of their patient (Figure 2.1). Responses vary almost threefold across Canada, from 22% in Quebec to 62% in Saskatchewan. Family doctors in four other provinces report a greater frequency in routine communication with their patients' home care providers compared to family doctors in Ontario.

Internationally, there was large variation in responses (Figure 2.1). Seven other countries report greater frequency of routine communications with their patient's case manager or home care provider about needs and services.

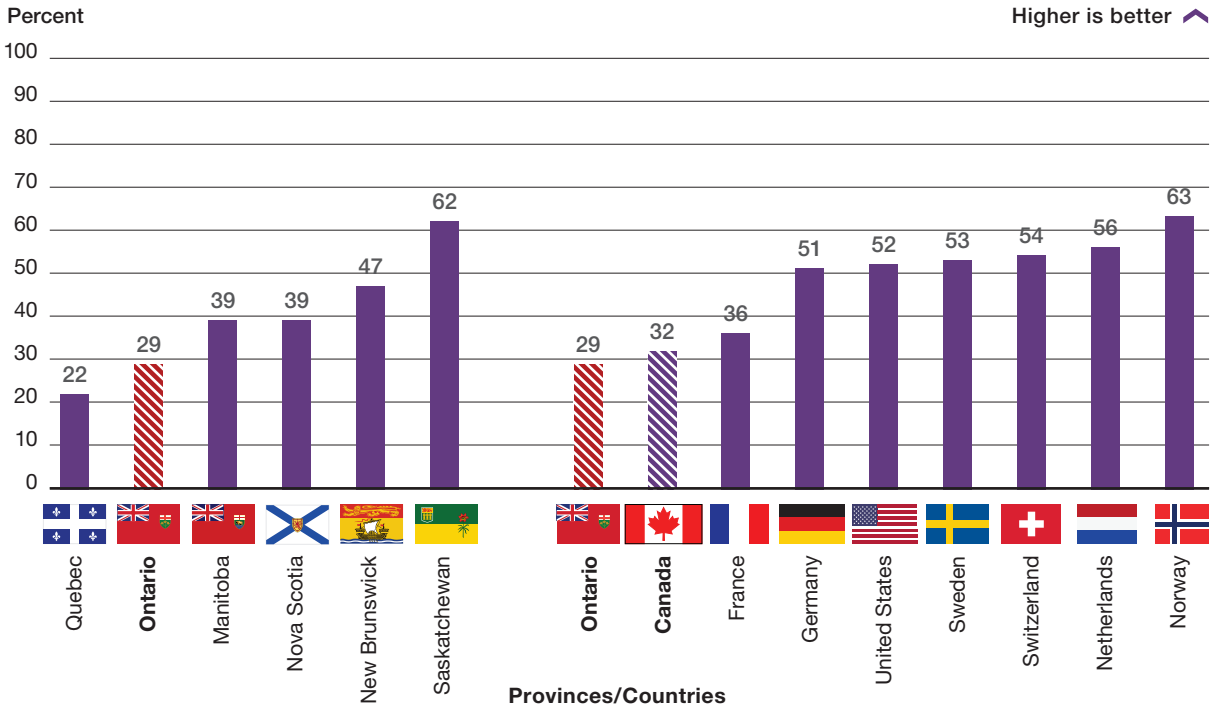
Responses vary almost threefold across Canada

**22%** in Quebec

**62%** in Saskatchewan (Higher is better)

FIGURE 2.1

**Among family doctors whose patients receive home care services, the percentage who say they, or other personnel in their practice, routinely communicate with their patient's case manager or home care provider about their patient's needs and the services to be provided, 2015**




**Notes:** Only statistically significantly different results from Ontario are shown. Within Canada, there is a statistically significant difference between Ontario, Quebec, Newfoundland and Labrador, New Brunswick, Manitoba and Canada as a whole. Internationally, there is a statistically significant difference between Ontario, France, Sweden, Switzerland, the Netherlands, the United States, Germany and New Zealand. See Methods Notes for a description of statistical significance.

# Coordination with social services and community providers

Primary care providers also play a role in coordinating care for their patients with social service providers in the community such as social workers, psychologists or physiotherapists. Most family doctors say that coordination with social services/community providers is not easy.

In Ontario, more than half of family doctors (53%) say they, or other personnel in their practice, frequently coordinate care with social services or other community providers (Figure 2.2). Fewer family doctors in British Columbia and Quebec (44% and 46%, respectively) reported frequently coordinating care with these types of services. The percentage in Saskatchewan (62%) is higher than Ontario.

Internationally, Ontario is near the middle of the pack, higher than France, the Netherlands, Sweden, the United States and Australia. Several other countries, including Switzerland, Germany and the United Kingdom, report a higher frequency of care coordination (Figure 2.2).

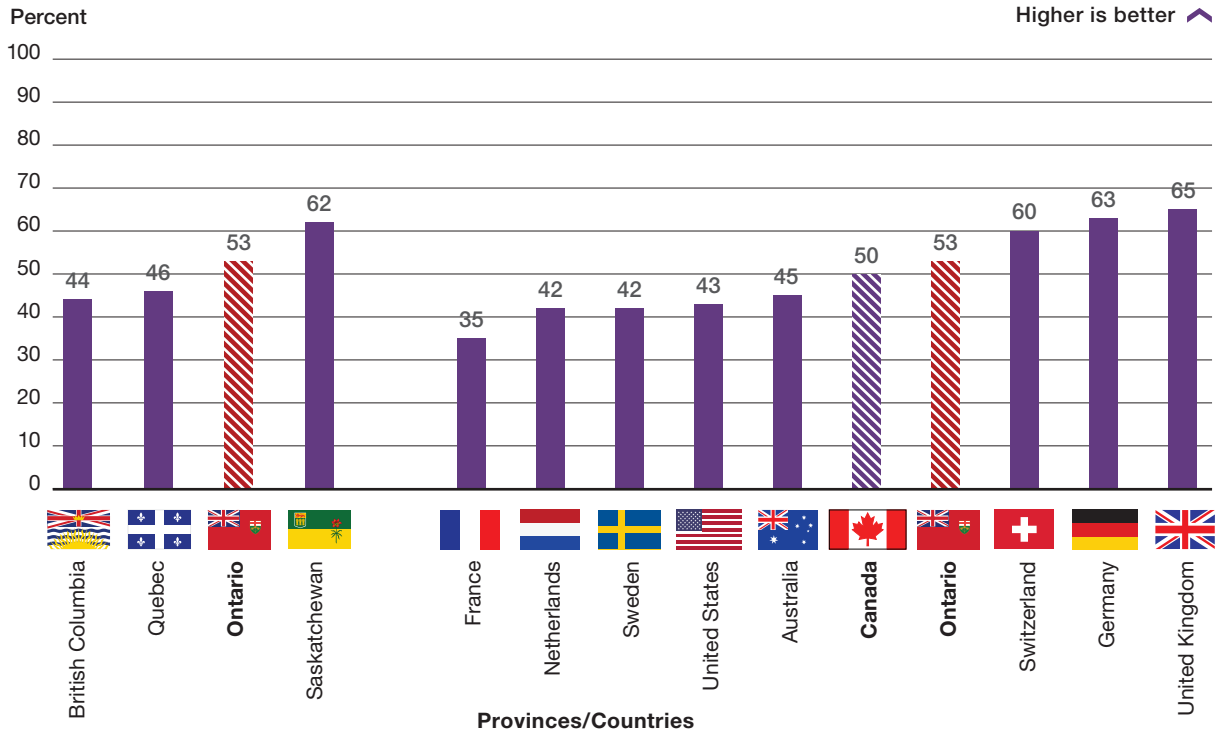
Family doctors who frequently coordinate care with social services or other community providers

**44%** in British Columbia

**62%** in Saskatchewan (Higher is better)

FIGURE 2.2

**Percentage of family doctors who say they, or other personnel in their practice, frequently coordinate care with social services or other community providers, 2015**




**Notes:** Only statistically significantly different results from Ontario are shown. Within Canada, there is a statistically significant difference between Ontario, Quebec, Newfoundland and Labrador, New Brunswick, Manitoba and Canada as a whole. Internationally, there is a statistically significant difference between Ontario, France, Sweden, Switzerland, the Netherlands, the United States, Germany and New Zealand. See Methods Notes for a description of statistical significance.

# Ease of coordination with social services, other community providers

Just over one third of family doctors in Canada (35%) report that it is easy, or very easy to coordinate their patients' care with social services and other community providers when needed (Figure 2.3). A similar proportion of family doctors in Ontario (36%) report the same ease of coordination. The top two provinces are Saskatchewan (55%) and Nova Scotia (45%).

Most family doctors in other countries also report low percentages of easy, or very easy care coordination for their patients with social services or other community providers (Figure 2.3). Results from Ontario are higher than Australia and the United Kingdom. However, family doctors in Germany, New Zealand, Norway and Switzerland report a higher frequency in the ease of coordination.

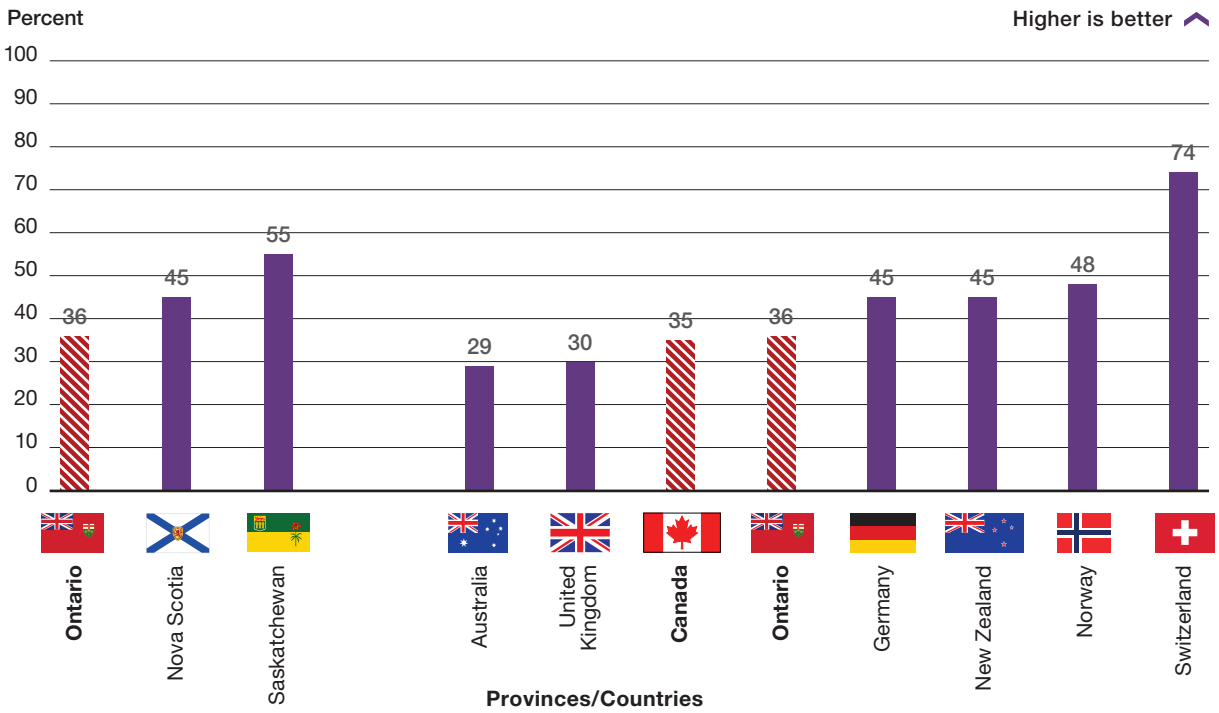
Doctors who report that it is easy, or very easy to coordinate their patients' care with social services and other community providers when needed

**36%**
in Ontario
(Higher is better)

**55%**
in Saskatchewan

FIGURE 2.3

**Percentage of family doctors who say it is easy or very easy to coordinate their patients' care with social services or other community providers when needed, 2015**

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# Nurse-practitioner led clinic: A unique primary care model integrated with mental health services

In Ontario, there are many different types of health care providers, such as pharmacists, dieticians, nurses and nurse-practitioners, involved in delivering primary care to clients. There may be other social services connected to primary care as well, such as legal aid and housing services.

The Canadian Mental Health Association (CMHA) Durham Nurse Practitioner-Led Clinic, in Oshawa, has some of these services. Clients and their family/caregivers are regularly invited to sit down with a care team that includes other service providers. Examples of service providers that have participated include an addictions counsellor, housing worker, someone from autism support, public health, the school board as well as a nurse-practitioner. These "care plan meetings" might be held at the clinic, at the client's home or at the hospital using teleconferencing technology, based on what suits the client best.

Clients participate in the meetings at least once a year, sometimes every three to six months, since many individuals face challenges such as income limitations and serious mental illness with changing needs. "It's common for me to see a person who hasn't been to a care provider for five to 10 years, has several chronic conditions, and then we identify a couple more," says nurse-practitioner and clinic lead Stephanie Skopyk. "Many clients don't really fit into a typical primary care office; they forget appointments, they have many complex problems and medications, and they require more time spent with care providers."

Stephanie and her colleagues at the clinic work regularly with two consulting doctors, both local family doctors, one of them from a psychiatric facility. "We have also been able to link with hospitals and Community Care Access Centres," says Linda Gallacher, CEO, Canadian Mental Health Durham and founder of the CMHA Durham Nurse-Practitioner Led Clinic. She takes pride that the CMHA Durham Nurse Practitioner-Led Clinic works hard to integrate primary care and community services. "Normally it is so difficult for our clients to navigate the health system because there's not an integration of mental health and primary care," says Linda.

# In summary

Among family doctors in Ontario whose patients receive home care services, just over a quarter say they routinely communicate with their patients' case manager or home care provider, while just over half say they or someone else in their practice frequently coordinate care with social services or other community supports. For the most part, family doctors in Ontario, Canada and internationally, report that it is not easy to coordinate their patients' care with social services or other community providers.

Together, these findings tell us that care coordination by family doctors with a patient's case manager or home care provider, as well as coordination of social and community supports, may not be well-supported in Ontario. Family doctors face challenges given the difficulty they report in coordinating this type of care for their patients.

# 3. Care Coordination with Specialists

When patients in Ontario and Canada need to see a specialist, such as a cardiologist, orthopedic surgeon or psychiatrist, they usually require a referral from their family doctor, or nurse-practitioner (in some provinces). While many patients have an ongoing or long-term relationship with their specialist(s), especially patients with a chronic condition that requires monitoring and management over time, their primary care providers will usually be kept up-to-date on the patients' progress and treatment(s), along with any changes in the specialist's care, or recommendations for management in the primary care setting where care is shared.

In cases where multiple specialists care for a patient, primary care providers can be the common point of contact, maintaining the completeness and accuracy of patient information coming in from multiple sources and managed from one place. Care coordination between specialists and primary care providers is especially important for providing continuity of patient information.[11]

Using survey data of family doctors, in this chapter we report on the following specific measures:

- The percentage of family doctors who say they always, or often, receive a report back from the specialist with all relevant health information.
- The percentage of family doctors who say they always, or often, receive information that is timely and available when needed, after their patient has been seen by a specialist.
- The percentage of family doctors who say that during the past month, tests or procedures had to be repeated because results were unavailable for their patients.

# Receiving patient information from specialists

In Ontario, nine in 10 family doctors (90%) say they always or often receive a report from the specialist about their patient (such as the specialist's assessment of the patient along with recommendations for follow-up care) (Figure 3.1). The results in Ontario were higher than the results in Quebec.

Internationally, the percentage of family doctors who say they always, or often, receive a report back from the specialist ranges from 56% in Sweden to 96% in France (Figure 3.1). A higher percentage of family doctors in Ontario report they always, or often, receive a report back from the specialist with relevant health information compared to several countries, including Australia, Germany, Sweden, the United Kingdom and the United States. Results from family doctors in France and Switzerland are higher than those of family doctors in Ontario.

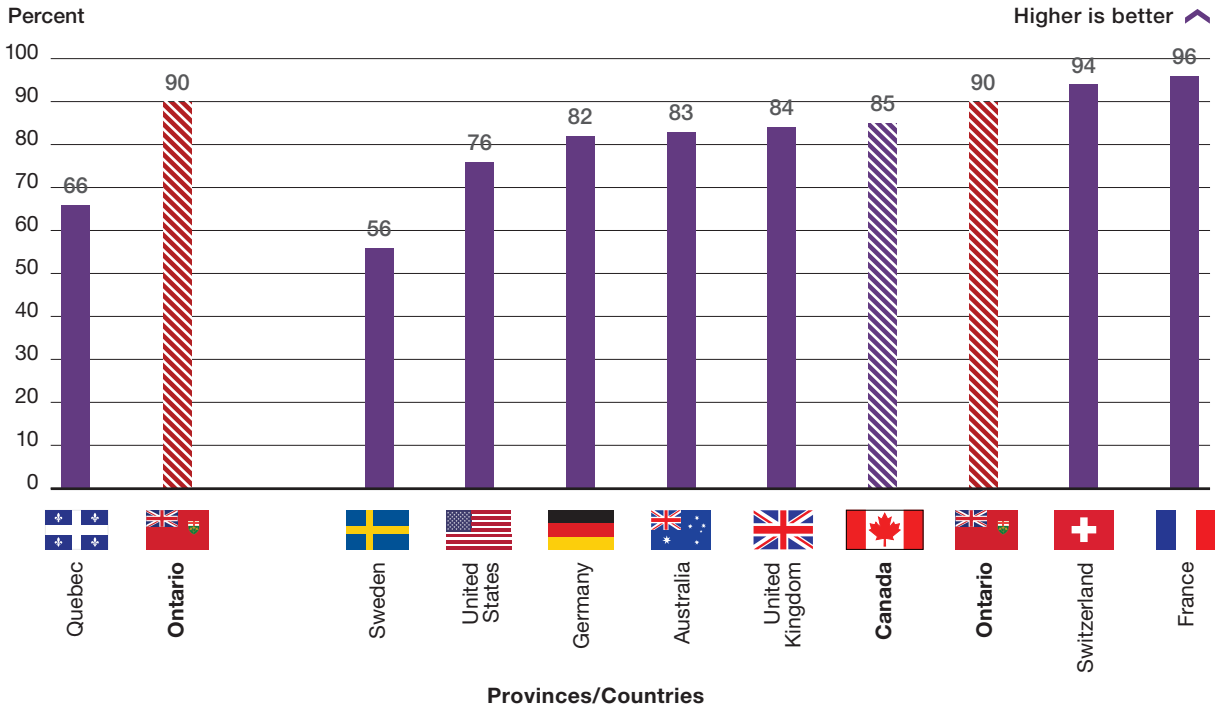
Family doctors in Ontario who say they always or often receive a report from the specialist about their patient

**90%**

Internationally it ranges from 56% in Sweden to 96% in France (Higher is better)

FIGURE 3.1

**Percentage of family doctors who say they always or often receive a report back from specialists with all relevant health information, 2015**

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# Receiving patient information from specialists when needed

Although a large percentage of family doctors in Ontario and elsewhere report receiving relevant health information after their patients visit a specialist, far fewer family doctors report the information received was available when needed. Of the provinces that are statistically different from Ontario, the percentage varies from 37% to 71% (Figure 3.2). This is higher than reported by family doctors in New Brunswick, Newfoundland and Labrador and Quebec.

Similar to results across Canada, there is a large variation in responses internationally, from 43% of family doctors in Sweden to 80% in France and Switzerland (Figure 3.2). Results from family doctors in Ontario are higher than several other countries, including Australia, Germany, the Netherlands, Sweden, the United Kingdom, and the United States. Results from France and Switzerland are higher than in Ontario.

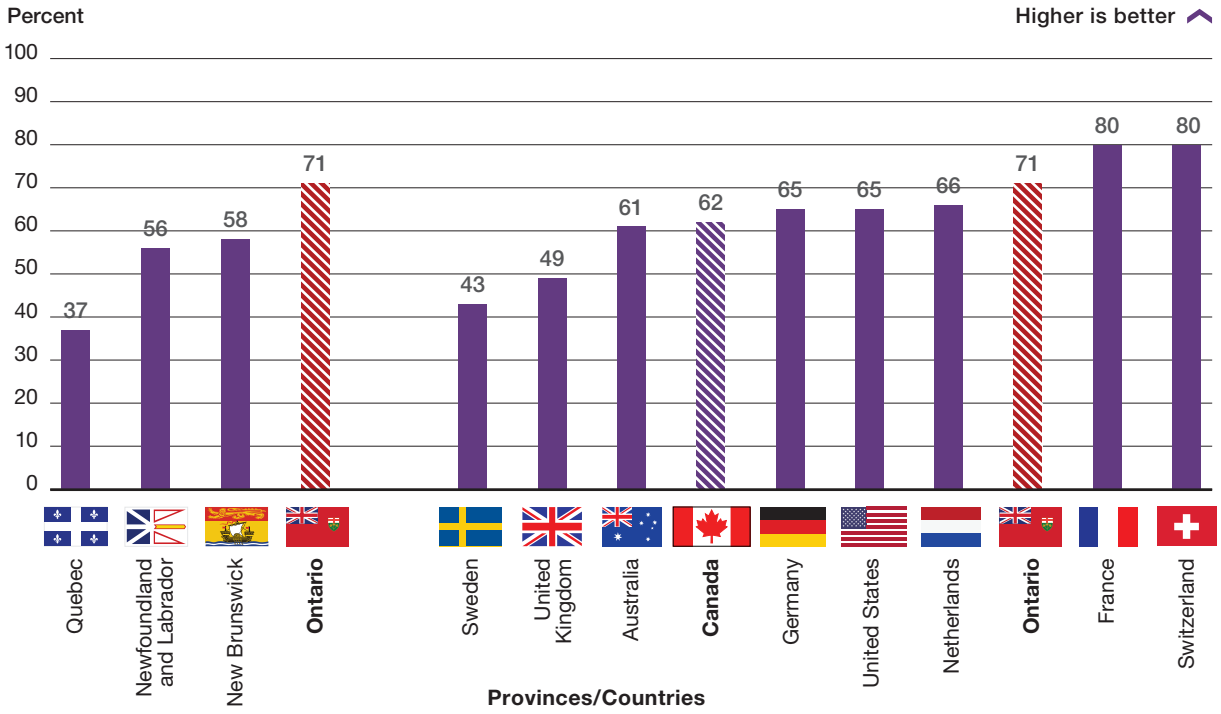
Family doctors report receiving information when needed after their patient visits a specialist

**37%** in Quebec

**71%** in Ontario (Higher is better)

FIGURE 3.2

**Percentage of family doctors who say they always or often receive information that is timely and available when needed after their patient has been seen by a specialist, 2015**

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# Repeat tests and results coordination

One consequence of poor care coordination can be unnecessarily repeated tests. Patients undergo tests and procedures for a variety of reasons. Some may be to diagnose or screen for disease, others may be to manage and monitor medications and/or chronic health problems.[12] Test results and medical records are usually available at scheduled medical appointments for patients in Ontario.[2]

On occasion, tests or procedures may need to be repeated because results are not available when they are required. In Ontario, 25% of family doctors say they have had to repeat a test or procedure due to the unavailability of results at least once during the past month.

Delays contribute not only to health care providers' inefficiencies, but can add to the patient's pain and suffering, wasted time and financial loss, and in some cases could lead to patients being harmed.[13]

Although the percentage of repeated tests and procedures in Ontario may seem high, three other provinces report even higher percentages of family doctors having to repeat at least one test in the past month — Manitoba (39%), Quebec (34%) and Saskatchewan (34%). International comparisons also show room for improvement. For example, in the United Kingdom, almost half (48%) of family doctors say that during the past month, tests and procedures had to be repeated because of unavailable results. Some doctors suggest that part of the challenge in coordinating tests and procedures performed on patients is a lack of clear communication between the ordering doctor (such as the specialist) and the doctor awaiting test results (such as the family doctor).[14]

Family doctors may not receive test results when they are performed by providers in locations other than the family doctor's office (e.g., in stand-alone labs, hospitals or walk-in clinics). This adds a further challenge to ensuring test results are received by the family doctor in a timely manner.[15]

# In summary

The vast majority of family doctors in Ontario (nine of 10), as well as family doctors internationally, receive a report back for their patients after a specialist visit. Fewer (seven of 10) report that they receive patient information from the specialist in a timely way. We are unable to tell from the data whether the numbers reflect receipt of an initial consultation report from a specialist, or reporting throughout a patient's treatment to support ongoing coordination.

When doctors don't receive information, tests often need to be repeated. One-quarter of family doctors in Ontario report having had to repeat tests and procedures for their patients in the past month, suggesting that there is room for improvement in communication of results and coordination of care.

These results tell us that the lines of communication between family doctors and specialists are fairly well established. Yet for medical tests or procedures, the coordination pathways may be less certain, inhibiting some information from getting back to the family doctor.

Family doctors who say during the past month, tests or procedures had to be repeated because results were unavailable for patients, 2015

| 25% | 34% | 34% | 39% | 48% |
|---|---|---|---|---|
| Ontario (Lower is better) | Quebec | Saskatchewan | Manitoba | United Kingdom |

# 4. Care Coordination with Hospitals

Dr. O'Halloran examines a patient; see his story on page 26. Photo by Roger Yip.

It is important for family doctors and patients to understand how to manage the patient's health after a hospital stay. The discharge process involves transferring information to other health care providers, including the patient's family doctor, and making sure that follow-up care has been arranged.[2]

Every time a patient is discharged from a hospital, a summary is prepared by doctors in the hospital to communicate information about the patient's hospital stay and the recommended follow-up care needs, such as new medications, test results or future appointments. Timely receipt of the discharge summary by the patient's family doctor may contribute to the quality and continuity of care the patient receives after a hospital stay, potentially helping avoid adverse medication reactions and, subsequently, readmissions to hospital. [16]

This chapter provides information on family doctors' experiences with the receipt and timeliness of information from hospitals when their patients have had a hospital stay. We also examine how often family doctors or others in their practices coordinate follow-up with hospitals after a patient's hospital stay.

Using survey data of family doctors, the specific measures we report on in this chapter are:

- The percentage of family doctors who say they always, or often, receive notification when their patient is discharged from the hospital.
- The percentage of family doctors who say that, on average, it takes up to four days to receive patient information for follow-up after hospital discharge.
- The percentage of family doctors who say they, or other personnel in their practice, frequently coordinate follow-up care with hospitals for patients being discharged.

# Notification of hospital discharge

In Ontario, seven in 10 (71%) family doctors say they always, or often, receive notification when their patient is discharged from hospital, higher than Alberta, Manitoba, Saskatchewan, and Quebec. (Figure 4.1).

Internationally, the notification of family doctors when their patient is discharged from hospital is much more varied than in Canada. Responses range from 35% in Sweden to 97% in the Netherlands (Figure 4.1). Ontario's family doctors fare better than Australia and Sweden; however, in two other countries (the Netherlands and New Zealand), more family doctors are notified of their patient's discharge from hospital than those in Ontario.

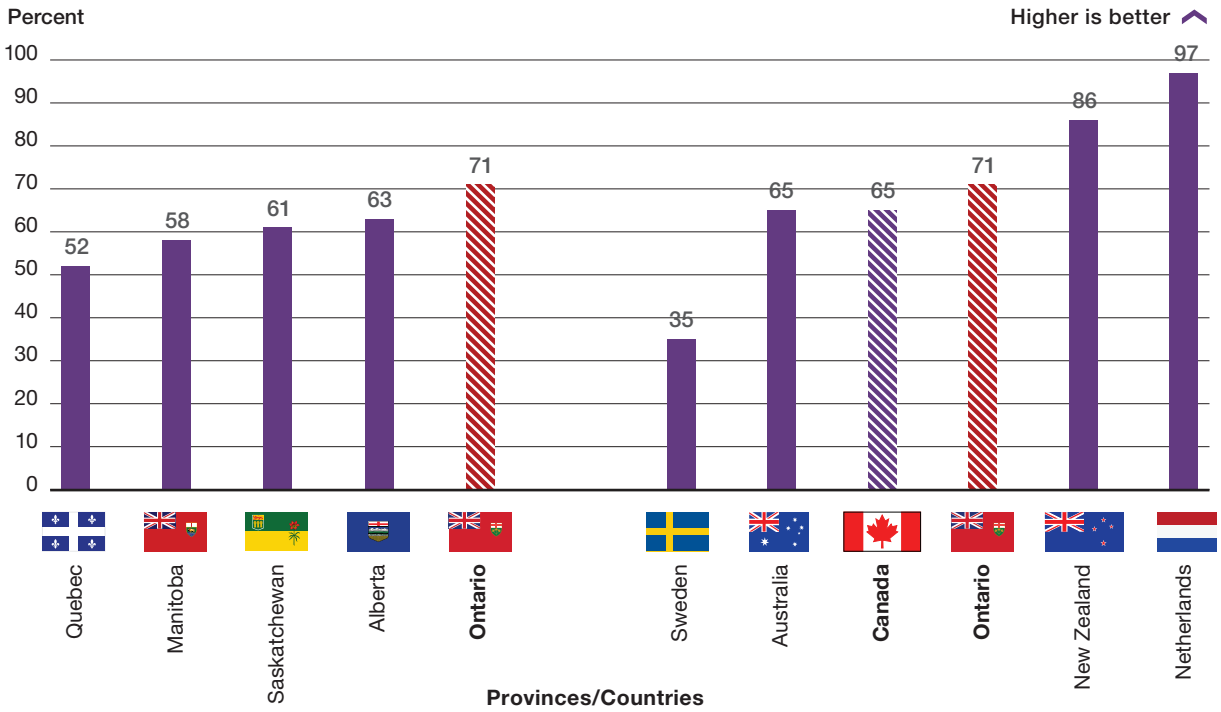
Family doctors who say they always, or often, receive notification when their patient is discharged from hospital

**71%**

in Ontario
(Higher is better)

FIGURE 4.1

**Percentage of family doctors who say they always, or often, receive notification when their patient is discharged from the hospital, 2015**




**Notes:** Only statistically significantly different results from Ontario are shown. Within Canada, there is a statistically significant difference between Ontario, Quebec, Newfoundland and Labrador, New Brunswick, Manitoba and Canada as a whole. Internationally, there is a statistically significant difference between Ontario, France, Sweden, Switzerland, the Netherlands, the United States, Germany and New Zealand. See Methods Notes for a description of statistical significance.

# Timeliness in receiving patient information after hospital discharge

It is generally considered best practice for a patient to have a follow-up visit with a provider in the community within seven days after being discharged from the hospital.[17] And the provider should receive patient information about the hospital stay in time for that follow-up visit.

Survey responses vary when family doctors are asked about how quickly they receive information from the hospital about a patient's discharge. Just over half of family doctors in Ontario (54%) say that, on average, it took up to four days after their patient was discharged to receive this information (Figure 4.2).

Internationally, a higher percentage of family doctors in several other countries, including Germany, the Netherlands, New Zealand, Switzerland, and the United States, say they receive patient information for follow-up within four days after their patients are discharged from hospital (Figure 4.2). In some countries, such as Germany, more than a quarter of family doctors (27%) say that, on average, they receive information for follow-up within 24 hours (data not shown).

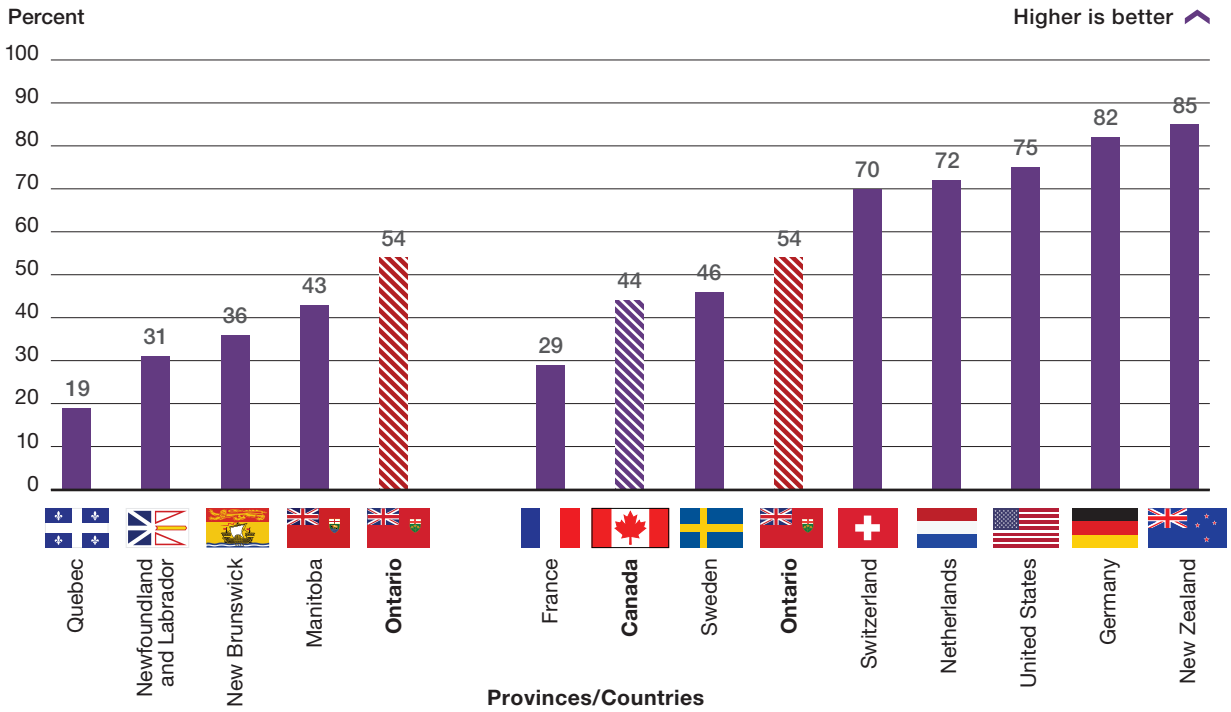
Family doctors say that it took up to four days after their patient was discharged

**54%**

in Ontario
(Higher is better)

FIGURE 4.2

**Percentage of family doctors who say that, on average, it takes up to four days to receive patient information for follow-up after hospital discharge, 2015**




**Notes:** Only statistically significantly different results from Ontario are shown. Within Canada, there is a statistically significant difference between Ontario, Quebec, Newfoundland and Labrador, New Brunswick, Manitoba and Canada as a whole. Internationally, there is a statistically significant difference between Ontario, France, Sweden, Switzerland, the Netherlands, the United States, Germany and New Zealand. See Methods Notes for a description of statistical significance.

## Coordinating patient follow-up care

How family doctor practices are organized, both within the actual practice and within the geographic region, can greatly impact the ability of care coordination. For example, some family doctors may work in the hospital as well as in a family practice or primary care office. In these situations, family doctors may care for their patients when they are in the hospital. Scenarios such as this are not captured in the data, but offer a unique way care is coordinated for some patients in Ontario.

## Dr. O'Halloran: Local 'culture of integration'

The medical community in the small town of Collingwood, Ontario has made it a priority to stay engaged in care coordination, says Dr. Harry O'Halloran. He and the 46 other family doctors in Collingwood, all using a single Electronic Medical Records system containing 55,000 patients, "have a local culture of integration." This culture, and the size of the community – 18 sites no more than 40 kilometres apart- have enabled the medical community to achieve "big strides in care coordination," says Dr. O'Halloran.

Collingwood family doctors are using the system, which allows for direct transmission of electronic reports with same-day communication. The system is automated, so doctors do not have to request patient data.

The doctor can see the patient's chart, including their full history. "Many hospitals do send reports – a big improvement over just last year," says Dr. O'Halloran.

When an Emergency Department doctor in a Collingwood hospital accesses the local Electronic Medical Records system, the family doctor will receive an automatically generated message. The hospital also sends a paper copy of the Emergency Department visit to that patient's primary care provider after the visit. If the patient is admitted to the hospital, the primary care provider is notified by phone. However, "if the patient is outside the local system, there is likely no notification," says Dr. O'Halloran. "The family doctor will find out only when the patient visits."

Among family doctors in Ontario, 50% say they, or someone in their practice, frequently coordinates follow-up care with hospitals when their patients are being discharged. Responses across Canada range from 37% in Quebec to 65% in New Brunswick. Among provinces, Ontario is positioned in the middle, higher than Alberta (38%) and Quebec (37%) but lower than New Brunswick (65%) and Saskatchewan (64%).

Internationally, there is a large variation in responses, from 25% of family doctors in Norway to 66% in Germany. The responses of Ontario's family doctors are higher than many other countries, including Australia, New Zealand, Norway, Sweden and Switzerland. However, the top four countries—France, Germany, the United Kingdom and the United States—have higher frequency of coordination than Ontario.

# In summary

Compared to receiving patient information from specialists (as reported in Chapter 3), fewer family doctors in Ontario report that they reliably receive notification from hospitals after the patient's visit and/or stay there. About seven in 10 family doctors in Ontario report that they always/often receive notification when a patient leaves the hospital after a stay, and just over half of family doctors report it taking, on average, up to four days to receive this information.

The frequency with which family doctors, or someone in their practice, help coordinate care with hospitals when their patients are discharged varies by province and by country. Fifty percent of family doctors in Ontario report being involved in this type of care coordination, though there is at least a two-fold variation between countries. This tells us that family doctors in Ontario, and elsewhere, may not always be informed when their patients have a stay in the hospital, nor receive hospital discharge information when needed.

# 5. The Road Ahead

Photo of Dr. Pham taken by Roger Yip, please see her story on page 11.

Family doctors and other primary care providers in Ontario play an important role in coordinating care for their patients. However, they often face structural limitations when they interact with other parts of the health system, in particular where they need to work with home care, community and social services.

In discussions with primary care providers, Health Quality Ontario has heard that there is often insufficient capacity – resources, time and infrastructure – to optimally coordinate care for patients. Although there are some initiatives, such as hospital discharge protocols or electronic medical records, which can improve information flow, these initiatives are not standardized across Ontario or well utilized across health care providers in the system.

Ontario's family doctors report experiences similar to those in other provinces and countries when it comes to coordinating care with specialists. However, Ontario's family doctors report less communication with home care and social services, when compared to the rest of Canada and internationally. Variations in the structure of health systems across provinces and countries, which are included in the survey, could impact any interpretation of the survey results.

## A shared vision

There is clear consensus among partners in Ontario's health system that we need to work together to ensure patients can transition more easily between providers and across care settings. A host of organizations, including the Ontario College of Family Physicians, the Ontario Hospital Association, the Association of Ontario Health Centres, the Registered Nurses Association of Ontario, the Nurse Practitioners Association of Ontario, the Association of Family Health Teams, the Ontario Medical Association, and Health Quality Ontario, have all committed to advancing this shared vision.

The Ministry of Health and Long-Term Care released *Patients First: A proposal to strengthen patient-centred care in Ontario* in December 2015. It includes recommendations to make care more integrated and responsive to local needs, including links to population health, public health, and home and community care. Partners are working together to help realize this vision, building on important assets like a common primary care performance measurement framework, routine system and practice-level reporting, and shared priorities for practice and quality improvement.

An integrated, strategic effort by all stakeholders across the health system in Ontario is underway with the goal of advancing primary care quality. To this end, a Primary Care Quality Advisory Committee has been initiated at Health Quality Ontario to provide advice on strategy and opportunities for a coordinated, effective approach to leveraging resources available through system partners.

Health Quality Ontario will continue to work closely with partners to advance primary care quality in the areas of quality standards, quality improvement/ practice improvement, performance monitoring, public reporting, and system-level advice.

# Methods Notes

## Data source

The 2015 *Commonwealth Fund International Health Policy Survey of Primary Care Doctors* was conducted among a random sample of primary care doctors in 11 countries: Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom and the United States. The Commonwealth Fund is a private U.S.-based foundation that provides core funding and leads the development of the surveys. Social Science Research Solutions was contracted to conduct the survey and carry out data collection in Canada.

## Sampling methodology

The sampling methodology varied in each country. However, a common questionnaire, translated and adjusted for country-specific wording, was used. For the Canadian portion of the survey, Social Science Research Solutions invited respondents (via postal mail) to participate in a paper-copy or online version of the survey. Data collection took place between March 5th and June 5th, 2015, in English and French. There were 2,284 respondents in Canada, including 558 in Ontario. The overall response percentage in Ontario was 32.5%.

Health Quality Ontario provided additional funding to increase the sample size in Ontario to increase the ability to detect statistically significant differences in performance. Due to the small sample sizes, results from Prince Edward Island and the Territories are only included in the overall Canada totals.

# Weighting of results

The survey data for Canada were weighted to represent the primary care doctor population and account for sample design and probability of selection. Population parameters used for weighting were age, gender and province. Benchmarks were derived from the Canadian Medical Association masterfile, January 2015. In the final weighting step, the weights were adjusted so that the share of each province would reflect the share of that province among Canadian primary care providers. For example, the Ontario sample (24.4% of respondents) was weighted to reflect the province's share of the national population of family doctors (33.3%).

*Weighted and unweighted distributions and number of responses in each province*

| Province | Distribution, unweighted | Distribution, weighted | Number of responses |
|---|---|---|---|
| British Columbia | 8.6% | 14.4% | 196 |
| Alberta | 7.8% | 11.9% | 179 |
| Saskatchewan | 8.3% | 3.6% | 189 |
| Manitoba | 8.0% | 3.7% | 183 |
| Ontario | 24.4% | 33.3% | 558 |
| Quebec | 19.9% | 23.9% | 455 |
| New Brunswick and Prince Edward Island | 8.1% | 3.4% | 180 |
| Nova Scotia | 7.6% | 3.5% | 173 |
| Newfoundland and Labrador | 7.3% | 2.4% | 166 |

# Significance testing

Social Sciences Research Solutions conducted statistical analyses to compare responses across countries and provinces within Canada. For provincial comparisons, statistical tests were conducted to compare each province's response to every other province and to Canada as a whole. Ontario's results were also compared to other countries. Significance was assessed based on a P-value of less than 0.05, meaning that there was less than a 5% probability that the difference was due to chance rather than real differences in respondents' experiences.

# Survey questions

We report on the following set of questions from the 2015 *Commonwealth Fund International Health Policy Survey of Primary Care Doctors:*

**Do you and/or other personnel that work with you in your practice provide care in the following ways?**

- Coordinate follow-up care with hospitals for patients being discharged (% family doctors who answered 'frequently')
- Coordinate care with social services or other community providers (% family doctors who answered 'frequently')

**When your patient has been seen by a specialist, how often do you receive the following?**

- A report back from the specialist with all relevant health information (% of family doctors who answered 'always/often')
- Information that is timely and available when needed (% of family doctors who answered 'always/often')

**When your patients are admitted to the hospital, how often do you receive...**

- Notification your patient is being discharged from the hospital (% of family doctors who answered 'always/often')
- After your patient has been discharged from the hospital, on average, how long does it take before you receive the information you need to continue managing the patient, including follow-up care? (% of family doctors reporting up to 4 days)

**During the past month, did the following occur with any of your patients?**

- Tests or procedures had to be repeated because results were unavailable (% of family doctors who answered 'yes')

**If any of your patients receive home care services (e.g., nursing or personal care), how often...**

- Do you or other personnel in your practice communicate with your patient's case manager or home care provider about your patient's needs and services to be provided (% of family doctors who answered 'routinely')
- How easy or difficult is it to coordinate your patient's care with social services or other community providers when needed (e.g., housing, meals on wheels and transportation)? (% of family doctors who answered 'very easy/easy')

# Limitations of the survey

Because the survey is cross-sectional, causal relationships between survey items cannot be determined.

The survey provides self-reported data, which relies on respondents to recall aspects of their day-to-day practice, as well as past events concerning care coordination for their patients. There may be some gaps or errors in their memory of events.
The survey is not able to verify information.

Caution is advised in comparing results of previous year's surveys of primary care doctors from The Commonwealth Fund with this survey as there is some variation in questions between surveys that may not be directly comparable.

Observed variation between provinces and countries may reflect differences in how care is organized and delivered, or the role of the family doctor in coordinating specific types of care for their patients, within the health system.

This report addresses the results of a set of care coordination questions from the survey, and are not specific indicators of performance measurement.

# Acknowledgements

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This report was developed by a multi-disciplinary team from Health Quality Ontario, including: Sneha Abraham, Heather Angus-Lee, Susan Brien, Shirley Chen, Naushaba Degani, Gail Dobell, Ryan Emond, Louise Grenier, Sharon Gushue, Sandra Kerr, Isra Khalil, Reena Kudhail, Timothy Maguire, Jennifer Riley, and Amira Salama.

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## About The Commonwealth Fund:

The Commonwealth Fund is a foundation that aims to promote high performing health care systems. One way it does this is through an international program in health policy. Each year, The Commonwealth Fund conducts a health policy survey of high income countries: Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom and the United States.

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