ONTARIO MEDICAL ASSOCIATION & MINISTRY OF HEALTH WORKING GROUP ON WALK-IN CLINICS.

FINAL REPORT

March 28th, 2024

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Overview of Working Group

The need for improvement in communication between walk-in clinics and patients' primary care physicians is a priority for both the Ontario Medical Association ('OMA') and the Ministry of Health ('MOH'). The 2021 Physician Services Agreement ('PSA') established the bilateral Working Group on Walk in Clinics to provide recommendations within the scope of the PSA by March 31, 2024.

The Working Group's mandate, as prescribed in the 2021 PSA, is:

a. The Ontario Medical Association (hereafter "OMA") and the Ministry of Health (hereafter "MOH") will work together to develop a framework that will enable and ultimately require walk-in clinics to communicate back to the patient's primary physician concerning the reason for the visit, as well as the diagnosis and treatment, if any. This applies to both in-person and virtual services.
b. The OMA and Ministry will develop a process for communication with patients who regularly use walk-in clinics to understand why they do so, and how they could be best encouraged to engage in a continuity of care environment, through enrolment with a comprehensive primary care provider, or where they are already enrolled with their own rostered practice. This applies to both in-person and virtual services.

The Working Group had the following composition of members:

Ministry of Health:	**OMA:**
Dr. David Price (Co-chair)	Dr. Joshua Stern (Co-Chair)
Dr. Danielle Brown-Shreves	Dr. Rosemarie Lall
Claire Munhall	Steve Nastos
Greg Powers	Kate Damberger
Kate Jackson	Schavana Sims
Bahram Rahman	Seyi Dada
Martin Ochman	Aileen Thomas
	Benu Sethi

The Working Group met for a total of 8 bilateral meetings, with its inaugural meeting on May 16, 2023. We also met with stakeholders to discuss leveraging existing EMRs. More specifically, we discussed the idea of exploring solutions designed to connect patients, providers, and healthcare systems through the secure exchange of healthcare data and automating communications from the walk-in clinic doctor back to primary care doctor.

This report outlines the Working Group's discussions and final recommendations for each of our mandates above.

Introduction

Continuity of care is of the utmost importance to patient health. Accessing health care by different providers, although may be necessary, if not understood by all parties involved could be detrimental to patient health outcomes. As such, the Working Group was tasked with understanding patient behaviour and how to address patient services and communication between walk-in clinics and their primary care providers.

As a first step, the working group determined that it would be important to agree on the definition for 'Walk -In Services'. As such, based on stakeholder input and research, the Working Group agreed on the following definition:

> "*Services provided by a General Practitioner who is not the patient's primary care physician (formally enrolled or virtually rostered), nor part of the primary care physician's group or is a service that has been designated under the Bilateral GP Focused Practice Designation Committee or through the GP Psychotherapy Premium Schedule of Benefits designation*."

See Appendix A for a fulsome description and commentary on the definition.

It's important to note the rational behind the Working Group's reasoning to explore walk-in services as opposed to walk-in clinics. There is a limitation to the OHIP provider database in that it's unable to identify walk-in clinics. As such, the Working Group felt that the above definition of walk-in services was more viable and measurable - however, there are limitations. The above definition would not address patients who do not have a primary care physician. Therefore, it may be the case that a certain number of visits to one particular primary care physician would establish a patient home in the absence of enrollment. However, determining when the patient-physician relationship is met can be challenging. The CPSO notes that '*Patients have a role to play in managing their care. In particular, it's important for patients to understand the value of seeing physicians with whom they have a sustained relationship and how this contributes to continuity of care.*'[1]

The Working Group felt that it was important to recognize that the CPSO has regulations around walk-in clinics and coordination with primary care providers [2] namely:

> *Physicians practising in a walk-in clinic **must** provide the patient's primary care provider (if there is one) with a record of the encounter when:*
>
> *a. The patient makes a request to do so; or*
> *b. In their opinion, one is warranted from a patient safety perspective and the patient has provided consent to do so.*

Lastly the Working Group wanted to recognize the CPSO has also recently developed guidelines on who is responsible for ordering tests and tracking results for patients. The CPSO noted the following[3]

[1] CPSO - Advice to the Profession: Continuity of Care

[2] https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Walk-in-Clinics

[3] CPSO - Advice to the Profession: Continuity of Care

Generally, any physician who determines that a test is needed is responsible for ordering that test, tracking the results, and managing any follow-up stemming from that test. By ordering tests that they themselves have deemed necessary, physicians ensure that patient care is not unnecessarily delayed, and that their colleagues are not required to receive results or manage care that falls outside their scope of practice.

The following sections outline the experts that were invited to present to our Working Group along with our recommendations, where possible, on each of the two mandates.

Stakeholders and Experts

As noted above, the Working Group met with experts in the field to gain a better understanding of the unique challenges faced by patients, physicians and the system when it comes to the integration of walk-in clinics within the patient's health care team and journey. We also asked them for their input on our proposed definition of walk-in services and how they would approach our specific mandates. The working group met with the following people:

1. Dr. Tara Kiran
2. Dr. Lauren Lapointe-Shaw
3. Rob Fox, Ontario MD
4. Ocean MD
5. OMA Legal Department

Please see Appendix C for each of the presentations by each respective expert above.

Mandate A:

Communication between Walk-In Clinics and Primary Care Providers.

As noted above, the first mandate of the Working Group was the following:

The Ontario Medical Association (hereafter "OMA") and the Ministry of Health (hereafter "Ministry") will work together to develop a framework that will enable and ultimately require walk-in clinics to communicate back to the patient's primary physician concerning the reason for the visit, as well as the diagnosis and treatment, if any. This applies to both in-person and virtual services.

The Working Group discussed at great length the implementation and consequences of this particular mandate. These considerations included minimizing any administrative burden (for both the walk-in physician and the patient's primary care physician) and addressing the technological challenges of sharing information digitally. Appendix B outlines an example of the current workflow from the walk-in physician's perspective and the primary care physician's perspective, in terms of patient-related communication to the respective party. The Working Group felt that adding to these two challenges was something that required a great deal of consideration, time and in-depth review of how both administrative burden and technological challenges impact physician practices. It is important to recognize while the current workflow includes fax, with technological advances there may be opportunities to improve the workflow over time.

The Working Group would like to acknowledge that the above issues, in particular administrative burden, have been tabled at the current on-going bilateral negotiations for the 2024 Physician Service Agreement with the Ministry and OMA. In light of these bilateral discussions the Walk-In Working Group has made the additional decision to refrain from making formal recommendations to this mandate so as to not impede on the negotiation discussions.

Mandate B:

Communication to patients who regularly use Walk-In Clinics

The Working Group was tasked with the following second mandate:

> *The OMA and Ministry will develop a process for communication with patients who regularly use walk-in clinics to understand why they do so, and how they could be best encouraged to engage in a continuity of care environment, through enrolment with a comprehensive primary care provider, or where they are already enrolled with their own rostered practice. This applies to both in-person and virtual services.*

The Working Group had extensive discussions around this mandate and the need to better understand why patients go to walk-in clinics. To do so, the Working Group discussed the potential idea of a patient survey that could be used to better understand patients' reasons for use of walk-in clinics using a QR code that would be completed when a patient went to a walk-in clinic. The survey would be quite short in length and would be optional. The purpose would be to gather data to understand patient decisions regarding their decision to using a walk-in clinic. This method may not result in a representative sample as older populations or marginalized communities may be less likely to be able to access the survey through QR code. An existing survey such as the Primary Care Experience Survey (the replacement for the Health Care Experience Survey), which has a number of questions on walk-in clinics could be used to achieve this goal.

The ministry and OMA can work on a process to provide the OMA with data on walk-in clinics collected under the PCES regularly.

The survey could be designed by experts in the policy/survey world however, we envisioned a multiple-choice question, reflective of the following:

> Q: Why did you go to a walk-in clinic today?
>
> A: My primary care physician was not available; the walk-in was closer in location; I did not want to go to my primary care physician, etc.

The Working Group understands the limitations associated with this recommendation and considerations attached such as:

a) who would administer the data?
b) Who would develop the survey?
c) Who would fund the initiative?
d) Who would process and interpret the data?

The parties would need to explore this recommendation further and discuss implementation considerations and feasibility. Further discussion around implementation would need to be had in order to identify who would implement the survey.

It is also highlighted that a solution is required to determine the physical location (address) of walk-in clinics in order to accurately determine walk-in clinics use in the future. There are currently no clinic identifiers that designate a walk-in clinic.

Lastly, the working group discussed the Health Care Experience Survey (HCES) which is retiring this year and its replacement survey, Primary Care Experience Survey (PCES), which recently launched. The PCES - has a number of questions on walk-in clinics, including reasons for use. The Ministry has agreed to share the results of this survey pertaining to walk-in clinics in the hopes that it may help to understand patient choices with regards to utilization of walk-in clinics

Summary: Mandate B Working Group Recommendations

1. Conduct a point-of-care Patient Survey that can be accessed using a QR code while the patient is in the walk-in clinic waiting room to better understand the reason(s) for use of the walk-in clinics.
    a. Possibility of empowering OH to manage the data and engage a researcher to compose questions and analyze the data.
2. Once the new PCES has been launched, the MOH will regularly share results with the OMA, which will assist in monitoring and understanding patient walk-in use.

Conclusion

In conclusion, the Walk-In Working Group recognized more information and work is needed to understand why patients use walk-in clinics, how to identify these clinics and how to integrate them into the patient's primary care home and care continuum. The working group recognizes that we were not able to come to a bilateral conclusion in terms of our first Mandate due to the ongoing bilateral negotiations between the Ministry and OMA for the 2024 Physician Services Agreement, although a great deal of discussion was held on this particular mandate.

We would also like to express our sincere thank you to the stakeholders and subject matter experts who presented and provided materials (Appendix C) to our Working Group. And lastly, a thank you to the physicians and staff who sat on this Working Group for their work, time and commitment.

Appendix A: Walk-In Service Definition

A Walk-In Service is any episodic care provided by a General Practitioner who is not the patient's primary care physician (formally enrolled or virtually rostered), nor part of the primary care physician's group or is a service that has been designated under the Bilateral GP Focused Practice Designation Committee or through the GP Psychotherapy Premium Schedule of Benefits designation.

Inclusion and Exclusion Criteria:

- Any visits by formally enrolled physician or physician group, identified by the enrolment form.

- Any visits provided by a physician that the patient is virtually rostered as identified below:
  a) Patients are rostered to group in group-based models and solo physician in solo FFS models with the highest fee approved [with 10% extra paid to FHG and CCM physicians removed] for in-basket codes (FHO in-basket codes).
  b) The patient must have had two or more in-person visits with any physician (B28, B29 or B27) within that group or solo physician in the last two years.
  c) If there is a tie for groups with the highest fee approved, then the patient is virtually rostered to the group with the most recent visit.
  d) Visits to a Community Health Centre (CHC) that is patient's regular location of receiving primary care.

- Exclude services that have been designated under the Bilateral GP Focused Practice Designation Committee or through the GP Psychotherapy Premium Schedule of Benefits designation.

Limitations and comments:

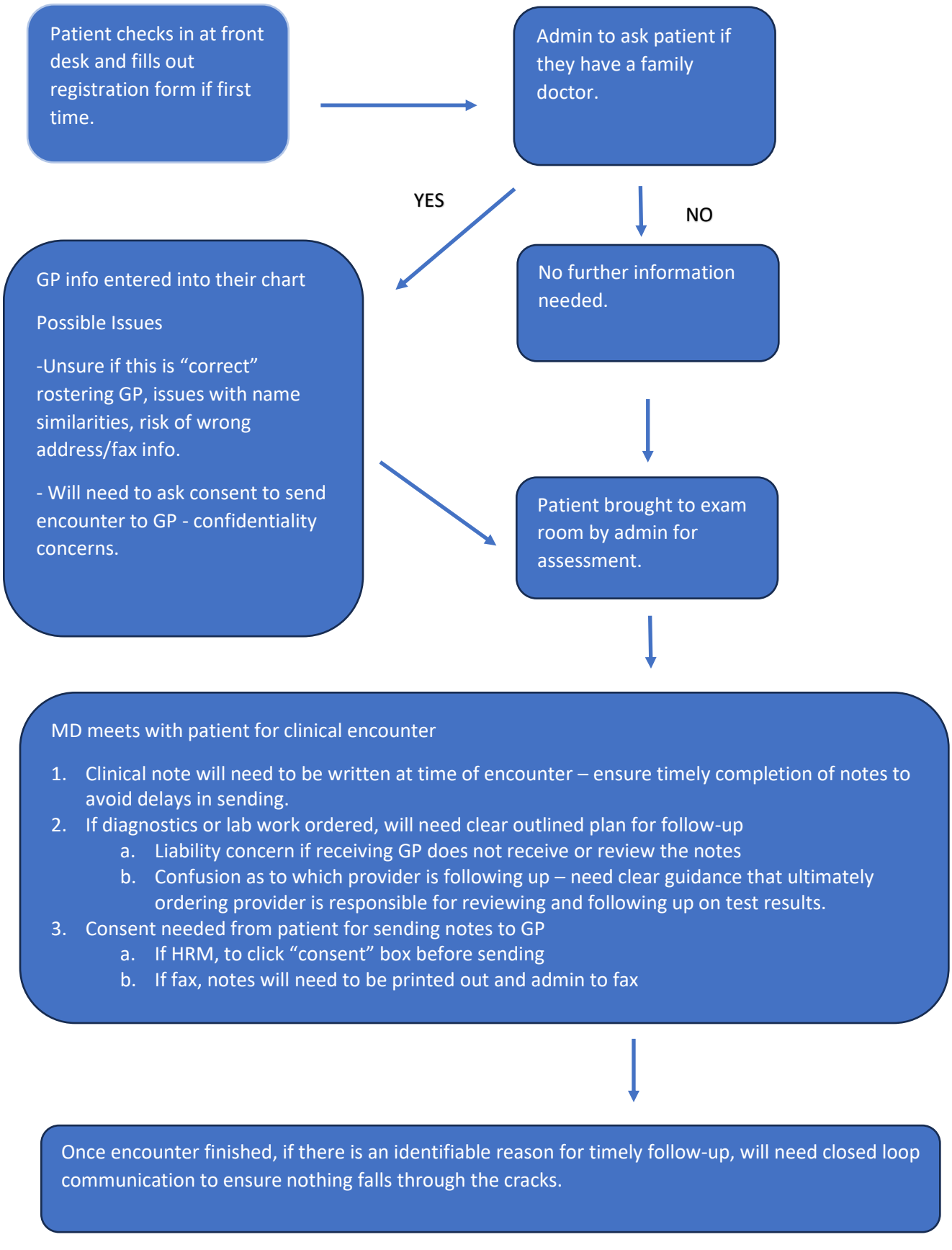
- The exact location of the service (whether it was provided a walk-in clinic or somewhere else) is unable to be identified within the provider data.

- The virtual rostering will not capture everyone, and services provided by nurse practitioners or primary care models that don't submit OHIP billing will be excluded.

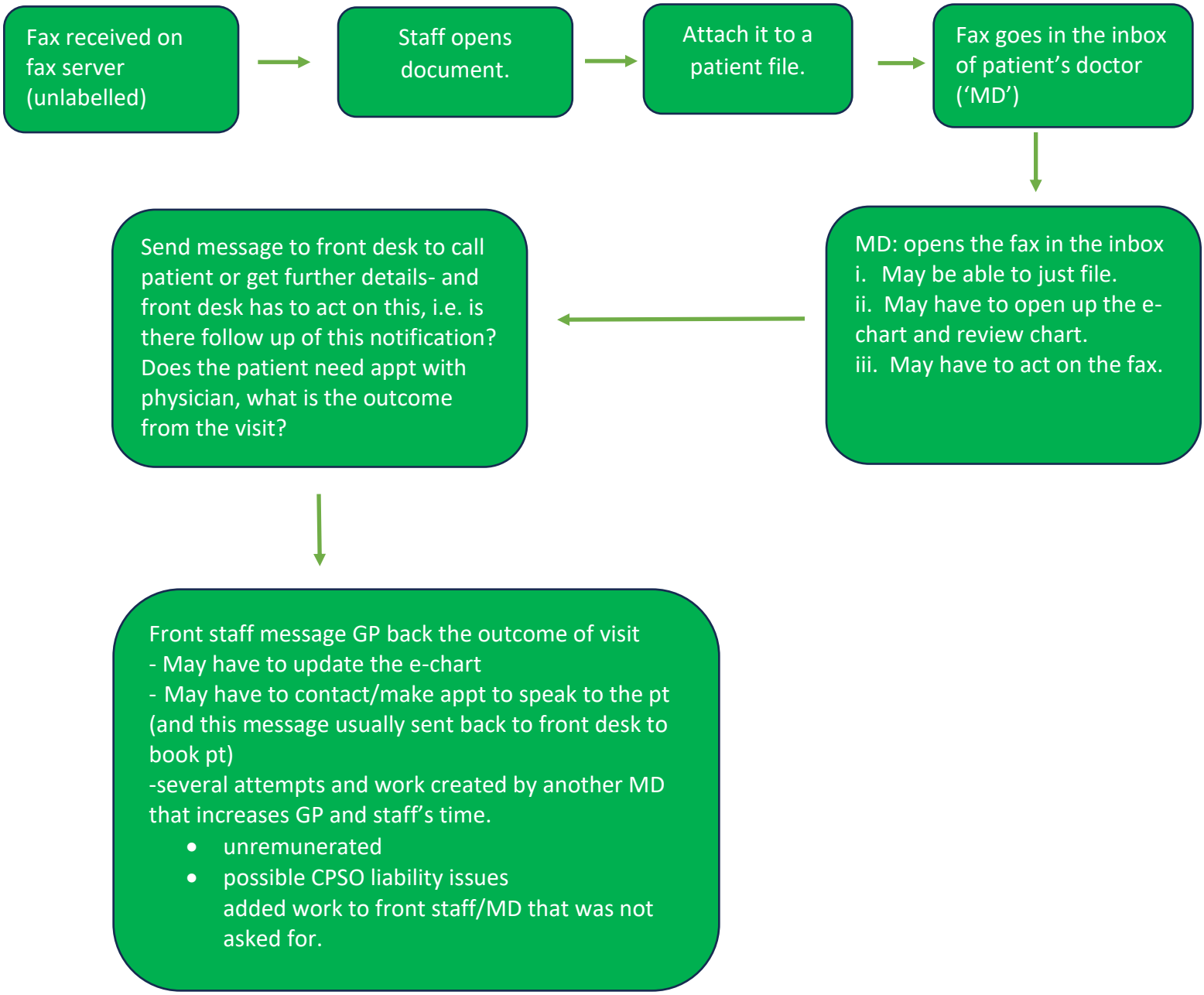
- The method could be validated by Institute of Clinical Evaluative Sciences (ICES) or INSPIRE PHC through an Applied Health Research Question (AHRQ) process.

Appendix B: Workflow

***Walk-In Physician → Primary Care Physician (*Workflow for Patient Encounter at Walk-In Clinic if need to relay encounter to GP.)**



Primary Care Physician Walk-in Physician (FAX)



Note: receiving a document via HRM eliminates the first three steps of this work flow.

Challenges:

- Faxes and HRM sent to wrong clinic, former patient of the clinic;
- What are the obligations of the physician if this happens?
- Physician calls the patient – sometimes several attempts before connecting.
- HRM- there is no way to send back or to notify sending facility of the error.
- There are outstanding, clinically relevant or important outcomes that have to be followed up- how is this to managed.
- If patient is not from this clinic
- Fax- can be faxed back to sender with a front cover stating not pt here- faxes cost $ per page time of MD or staff
- Fax- sent to former patient of clinic – MD has to redirect this information creating additional administrative burden.

Appendix C: Presentations by Stakeholders and Experts

1. Dr. Tara Kiran
2. Dr. Lauren Lapointe-Shaw
3. Rob Fox, Ontario MD
4. Ocean MD

Temerty Medicine

OMA-MOH Working Group on Walk-in Clinics

Dr. Tara Kiran, MD, MSc, CCFP, FCFP @tara_kiran

Fidani Chair in Improvement and Innovation and Vice Chair Quality & Innovation, University of Toronto
Family Physician, St. Michael's Hospital Academic Family Health Team
Scientist, MAP Centre for Urban Health Solutions

June 19, 2023

Family & Community Medicine UNIVERSITY OF TORONTO

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MAP Centre for Urban Health Solutions

Walk-in Clinics (WICs) are meeting a need for patients

- Care for those who are unattached
- Timely (and convenient) access
- Access point for those new to Canada

They seem to meet a need for physicians

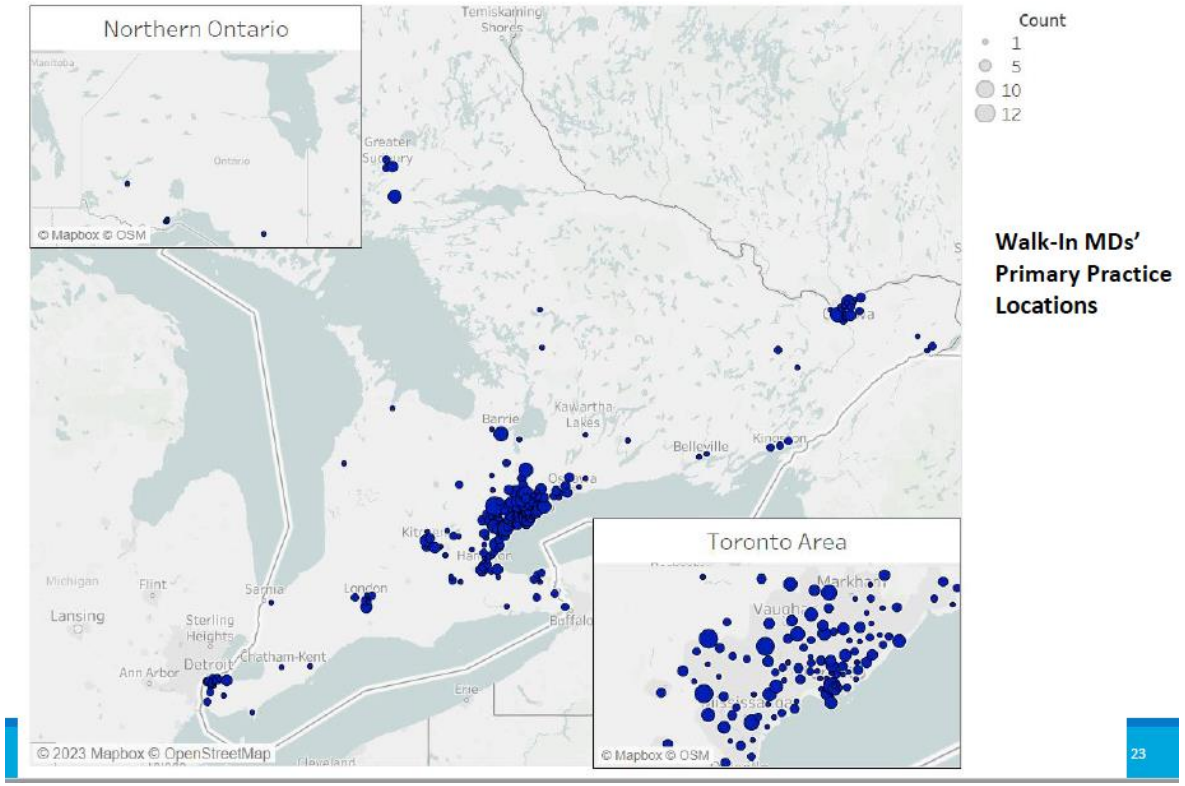
- Good remuneration
- Turnkey set up
- Offer MDs work they can “walk away from”

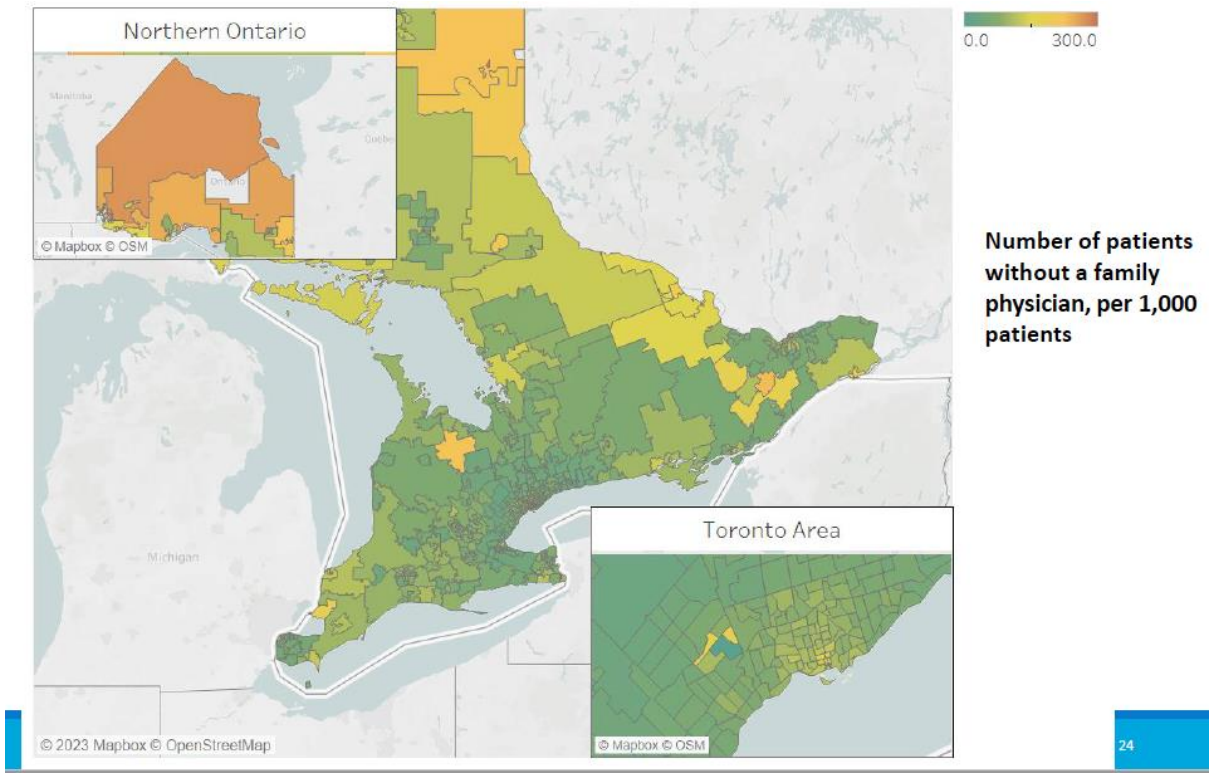
They are also profitable businesses

But WIC can come at a patient and system cost

- Association with higher healthcare use
- Disruption in care continuity
- Diversion of workforce from comprehensive care

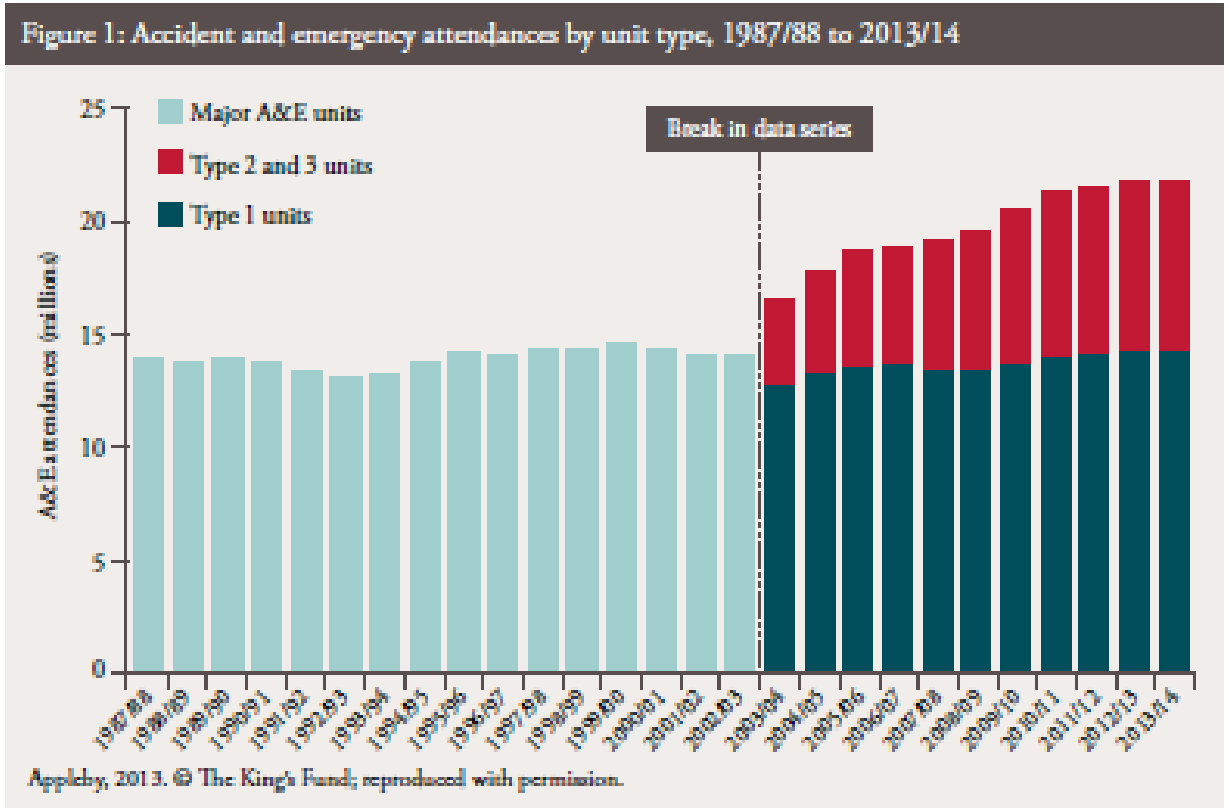
They are not located in many of the areas with highest unattachment





Confidential unpublished data from Dr. Lauren Lapointe-Shaw from 2019

And they can lead to supply-induced demand



"Data from The King's Fund (Appleby, 2013) illustrate this point well, in an analysis of the impact of type 3 services (that is, walk-in centres, minor injury units and urgent care centres) on A&E attendances. The data show that, despite their aim of substituting for A&E attendances, the services are largely additive, with little change in overall A&E attendance since the time the new services were introduced."

https://www.nuffieldtrust.org.uk/research/meeting-need-or-fuelling-unnecessary-demand-understanding-the-impact-of-improved-access-to-primary-care

How can we address?

- Attachment: every person needs a primary care home
- Primary care practice support and accountability for timely access
- Outreach to newcomer neighborhoods

How can we mitigate?

- Judicious, planned distribution
- Integration with primary care within an OHT
- Network that can support regional after-hours care
- Possibly off-set timely access during the day
- Support unattached patients with a view to permanent attachment
- Informational continuity
- Make relationship-based family practice more attractive

How should we define?

I think gold standard is self-identification by physicians. Could do this through:

- existing CPSO question
- Billing location code
- Requirement for registration of walk-in clinics

Can use a definition e.g.

- Do you provide episodic care to patients who do not have an ongoing relationship with you or another physician in your group? In this circumstance, episodic care means you are not taking responsibility for ongoing management of a patient or a care episode. The focus is on management of acute problems and you are generally not seeking to provide preventive or chronic condition management.

The trouble with ICES data definitions

A Walk-In Service is any episodic care provided by a General Practitioner who is not the patient's primary care physician (formally enrolled or virtually rostered), nor part of the primary care physician's group or is a service that has been designated under the Bilateral GP Focused Practice Designation Committee or through the GP Psychotherapy Premium Schedule of Benefits designation.

- Virtual rostering does not tell us whether a patient or doctor think they have an ongoing relationship with each other. Many would be virtually rostered to a walk-in clinic physician
- Generally very difficult to unmask providers or patients for follow-up/intervention/understanding work

What is the goal with this definition?

If you want to use ICES data, choices include i) linking to CPSO (e.g. per Dr. Lapointe-Shaw) ii) using low-continuity def'n (per Dr. Glazier) iii) billing location code (future state) iv) other data linkage (future state)

Committee's mandate 1

The Ontario Medical Association (hereafter "OMA") and the Ministry of Health (hereafter "MOH") will work together to develop a framework that will enable and ultimately require walk-in clinics to communicate back to the patient's primary physician concerning the reason for the visit, as well as the diagnosis and treatment, if any. This applies to both in-person and virtual services.

- This is a first great step and should be readily doable (e.g. pharmacies, specialists)
- Can we go further to get to integrated digital systems—small steps within an OHT

Committee's mandate 2

The OMA and Ministry will develop a process for communication with patients who regularly use walk-in clinics to understand why they do so, and how they could be best encouraged to engage in a continuity of care environment, through enrolment with a comprehensive primary care provider, or where they are already enrolled with their own rostered practice. This applies to both in-person and virtual services.

- What is the goal? Understanding the problem? Changing patient behaviour? Changing physician behaviour?
- I think we understand the key root issues (eg. Attachment, timely availability, convenience, patient perception of need). Some of these issues are hard to address (attachment), others are easier (patient education). Could consider gathering more data for deeper understanding (e.g. survey, qualitative interviews and point of care) but should inform concrete next steps (e.g. patient education – public campaign, posters, handouts, community outreach)

Suggestions for system-level changes related to walk-in clinics that you would do if you had unlimited resources?

- Long-term goal: Redesign primary care so that ultimately WICs are not needed
- Automatic rostering to local teams that are appropriately resourced
  - Make comprehensive practice more attractive than WIC or focused practice (e.g. remuneration, support)
- Accountability & support of primary care practices for timeliness
  - Routine patient experience survey administered by region/province that measures timeliness & continuity, reports data back to teams and reports team data publicly
- Network of teams provide shared after hours (and some day-time coverage eg for those who are travelling/commuting)
- A single health record that can be accessed by patients (legislation of digital inter-operability)

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OurCare is inviting thousands of people living in Canada to share their ideas, aspirations and priorities for creating a more equitable and sustainable primary care system that delivers better care for all.

1 national survey, 9000+ people

The OurCare National Research Survey explored people's experiences, priorities and preferences for primary care. Explore the results at data.ourcare.ca.

5 Provincial Priorities Panels, 175+ people

Each panel includes 36 randomly selected residents from the province who will spend 30 to 40 hours learning and deliberating about primary care before issuing consensus recommendations for a better system.

10 community roundtables, 200+ people

Each roundtable gathers 24 people from a marginalized community for a one-day session to identify specific needs and priorities for their group. Two roundtables will be held in each of 5 provinces.

Recommendations from patients and the public will inform a Blueprint for the future of primary care in Canada.

Join the movement and learn more at OurCare.ca.

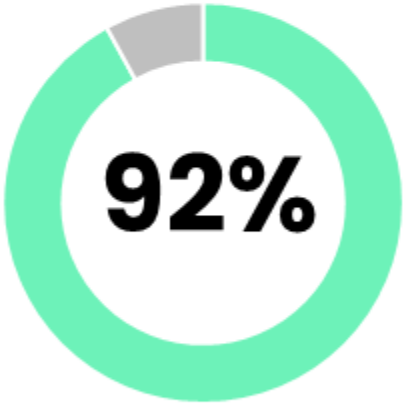
OurCare

The OurCare study surveyed a diverse group of more than 9,000 people across Canada (Sept-Oct 2022) about their care experiences and what's important to them when it comes to family doctor care. Learn more at **OurCare.ca**.

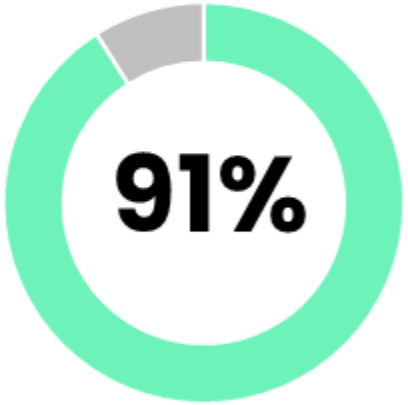
WHAT'S MOST IMPORTANT TO PATIENTS?

98% of Canadians feel it is important that everyone have access to a family doctor, NP or team of health professionals that they can see regularly.

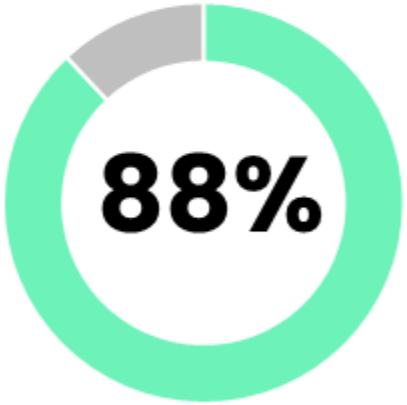
What patients value most about their family doctor or nurse practitioner *:



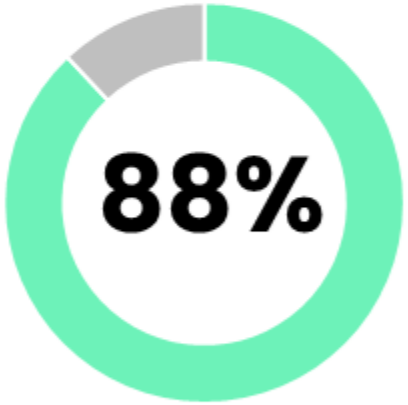
They know me as a person and consider all the factors that affect my health



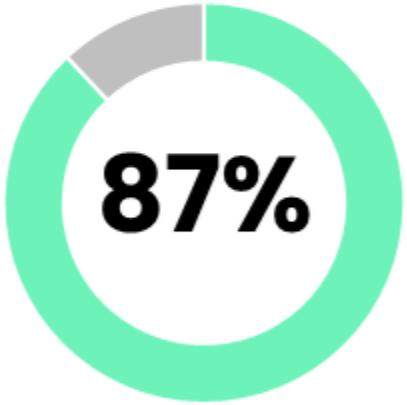
They make it easy for me to get care during the day



They are able to provide most of my care



They coordinate the care I get from multiple places



They stand up for me

**Percentage reporting the attribute was fairly or very important*

Explore the data yourself: **data.ourcare.ca**

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Welcome
Bienvenue
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"We urgently need to reduce harm to patients by legislating the interoperability of Electronic Medical Records (EMR) systems. We recommend establishing a body (e.g. Health Records Ontario) that oversees and ensures patients' access to their own records."

Read the Ontario Panel Report at OurCare.ca

Models of Care

- Invest a greater proportion of total healthcare funding in primary care
- Expand team-based care to every resident of Ontario
- Connect stand alone walk-in clinics to team-based care organizations
- Implement province-wide automatic rostering system for patients that maintains an element of patient choice
- Develop a centralised digital referral platform for specialist care

Thank you!

Email: tara.kiran@utoronto.ca

Explore the OurCare data yourself: **data.ourcare.ca**

Read about WICs in Healthy Debate:

- **"More than 6.5 million adults in Canada lack access to primary care"**
- **"Virtual care must be integrated into public system, not driven by profit"**

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The panel believes that primary care in Ontario should be guided by these 11 values:

Equity • Continuity • Accountability • Data-Enabled
Transparency • Public and Universal •Evidence-based
Sustainability • Accessibility • Patient-Centred
Holistic, Intersectional, and Culturally Responsive

Read the Ontario Panel Report at OurCare.ca

Recommendation highlights:

Expand team-based care to every resident of Ontario

Expand access to mobile care and comprehensive virtual care models.

Connect stand alone walk-in clinics to team-based care organizations.

Implement province-wide automatic rostering system for patients that maintains an element of patient choice.

Develop a centralised digital referral platform for specialist care.

Ensure patient access to personal health data

Legislate and enforce Interoperability data standards

Expand OHIP coverage to mental health, vision, dental, and pharmacare.

Expand our understanding of primary care to include Indigenous modes of thinking and knowing.

Increase the number of seats for primary care residencies.

Invest a greater proportion of total healthcare funding in primary care.

Develop accountability measures for each of the values identified by the Panel. Monitor and assess compliance.

Hold Ontario accountable to the principles of the Canada Health Act.

Review, consolidate, and revitalize existing health care bills of rights.

Strengthen links between primary care practitioners and community agencies.

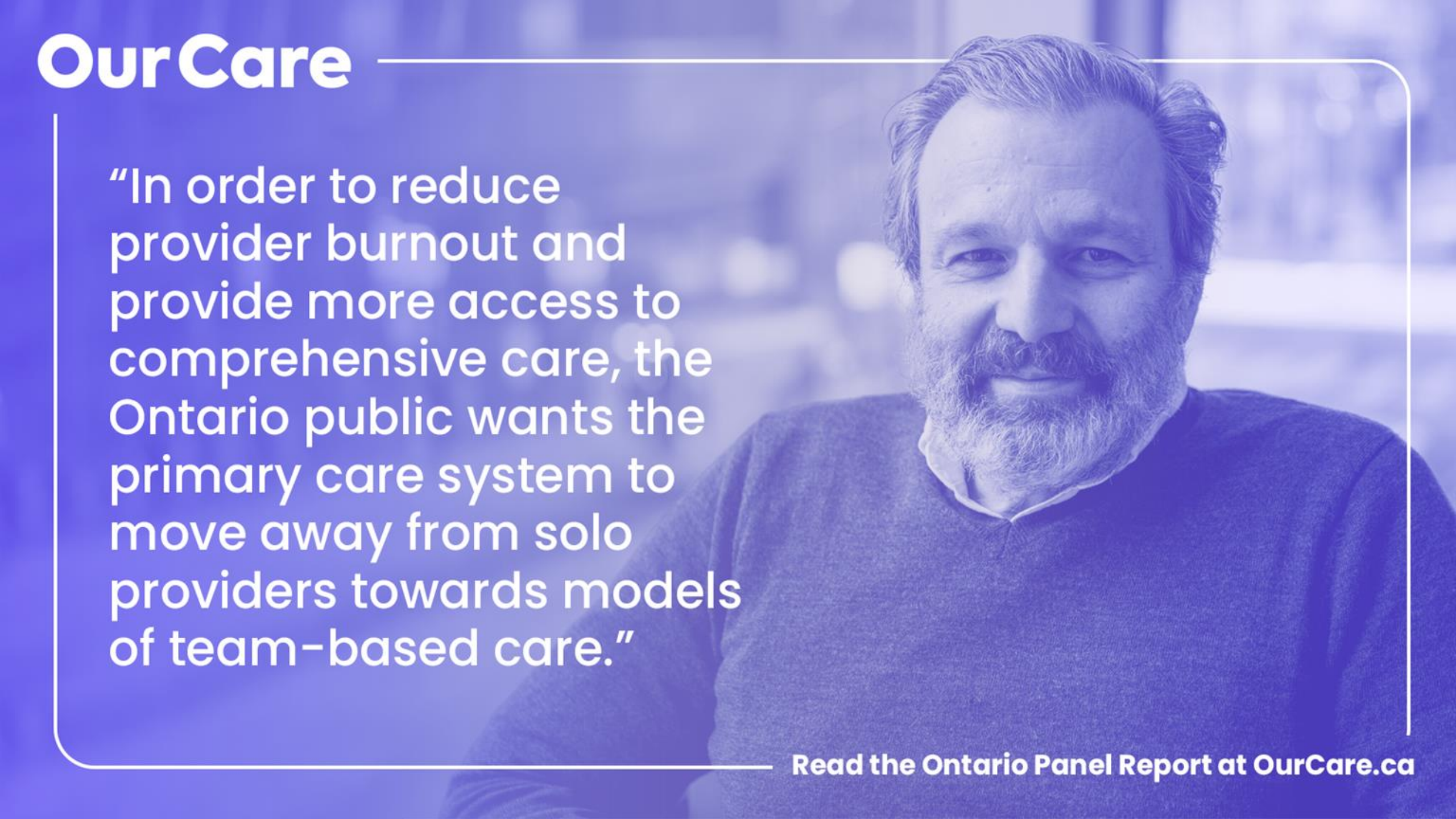
Ensure community members are included in the governance of primary care organizations.

Integrate newcomer practitioners and improve accreditation processes for immigrant primary care providers.

Examine and address the reasons fewer medical students are choosing to practice comprehensive family medicine.

Foster a culture of lifelong learning, culturally safety and collaboration at medical education sites.

OurCare



"In order to reduce provider burnout and provide more access to comprehensive care, the Ontario public wants the primary care system to move away from solo providers towards models of team-based care."

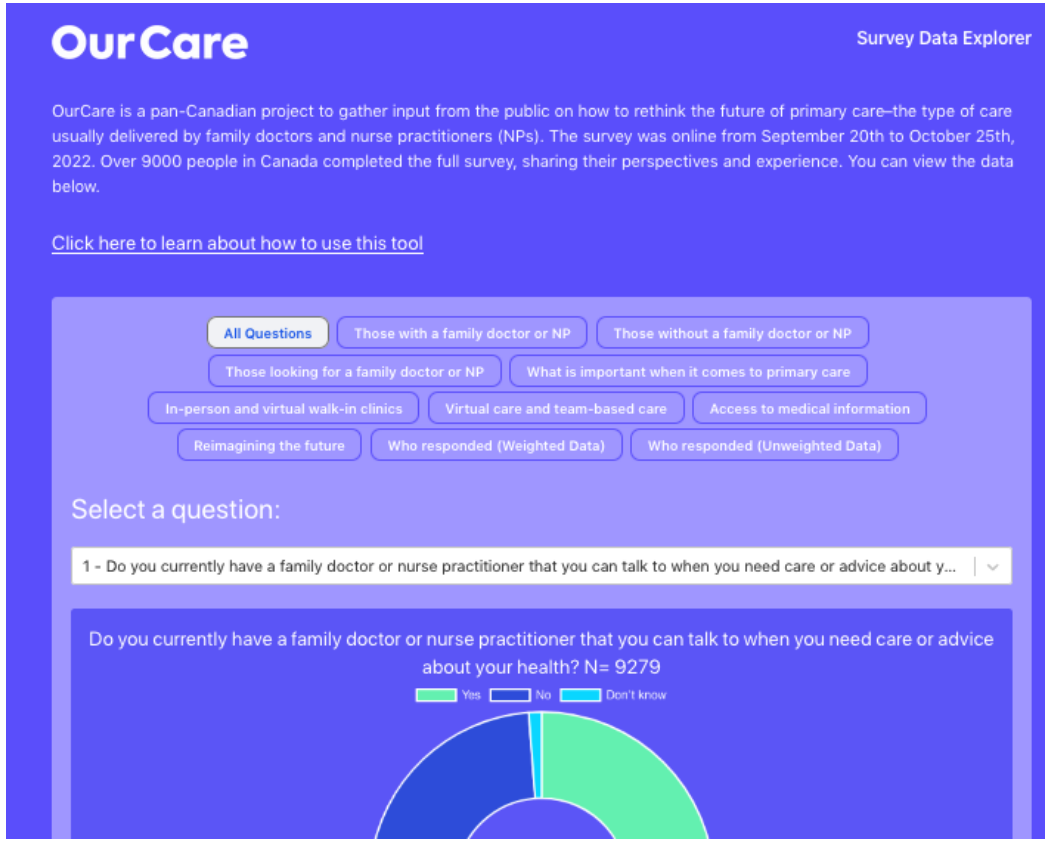
Read the Ontario Panel Report at OurCare.ca

OurCare

"To ensure that every Ontarian has a primary care home, the government should move towards automatic rostering similar to the public school system. While health teams should be mandated to accept any patient from their catchment area, it is important to maintain an element of patient choice."

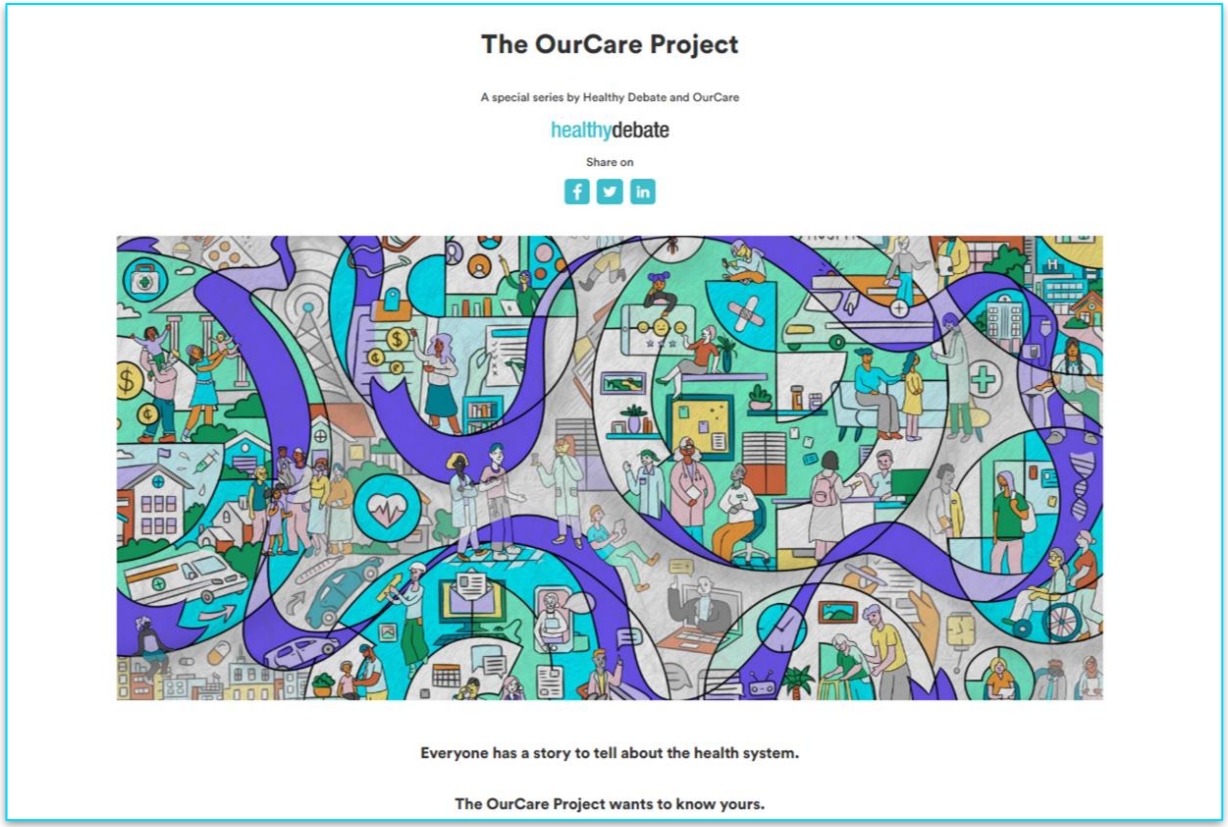
Read the Ontario Panel Report at OurCare.ca

Explore the data yourself



data.ourcare.ca

Read about the findings



ourcare.ca/media

healthydebate.ca/special-series/the-ourcare-project/

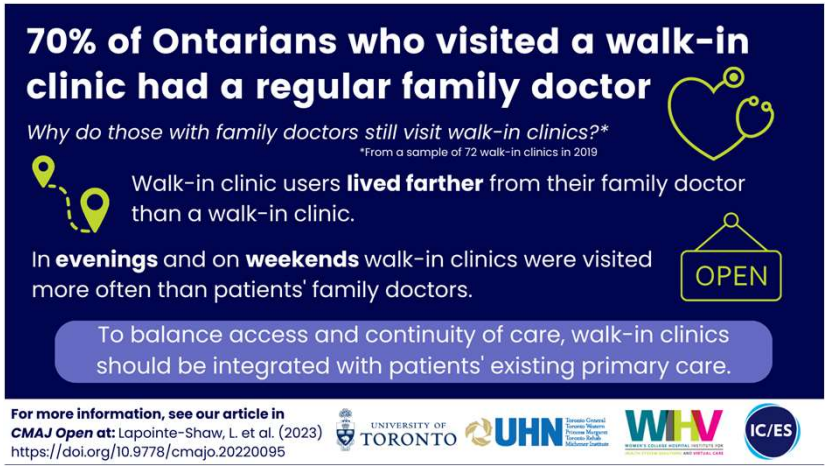
Walk-in Clinics

OMA-MOH Working Group on Walk-in Clinics

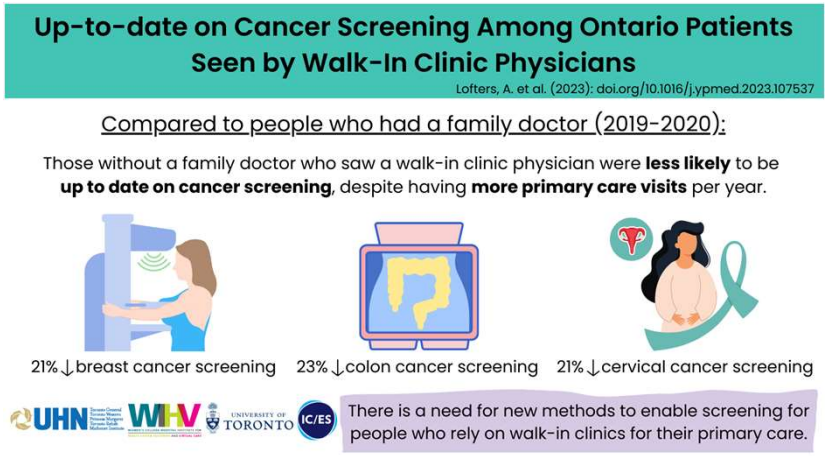
June 19, 2023

Lauren Lapointe-Shaw MD PhD
Assistant Professor, Medicine
Institute for Health Policy, Management & Evaluation
University of Toronto
Staff Internist Physician, University Health Network
Adjunct Scientist, ICES

Recent Relevant Work



CMAJ Open. 2023 Apr 25;11(2):E345-E356.



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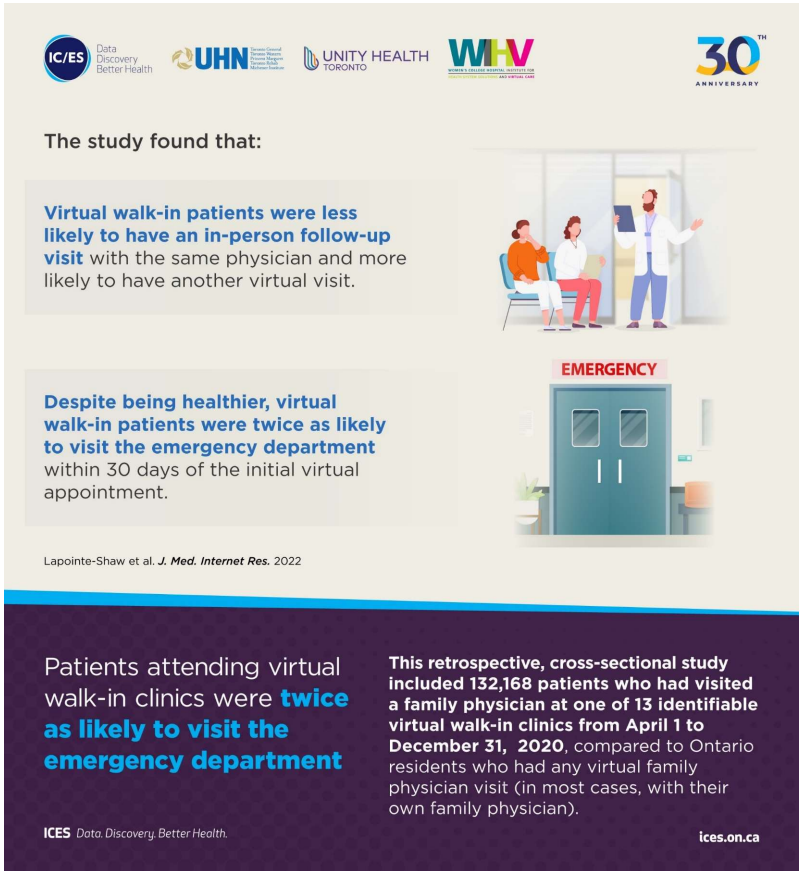


J Med Internet Res. 2023 Jan 12;25:e40267.

Ongoing Work

- Characteristics of Physicians who Mostly Practice in Walk-in Clinics (CPSO data, 2019)
- Understanding the Experiences of Physicians Practicing in Walk-in Clinics (Qualitative Study)
- Healthcare Utilization After a Visit with a Walk-in Clinic Physician, Compared to a Within-Group Physician: a Propensity Score-Matched Cohort Study
- Healthcare Utilization After Virtual Visits with Own Family Physician vs an Outside Physician: a Propensity Score-Matched Cohort Study

Questions I was asked to address

1. What are your thoughts on our proposed definition? Is it measurable or achievable?
2. Any recommendations to support the working group's mandate?
3. Suggestions for system-level changes related to walk-in clinics that you would do if you had unlimited resources?

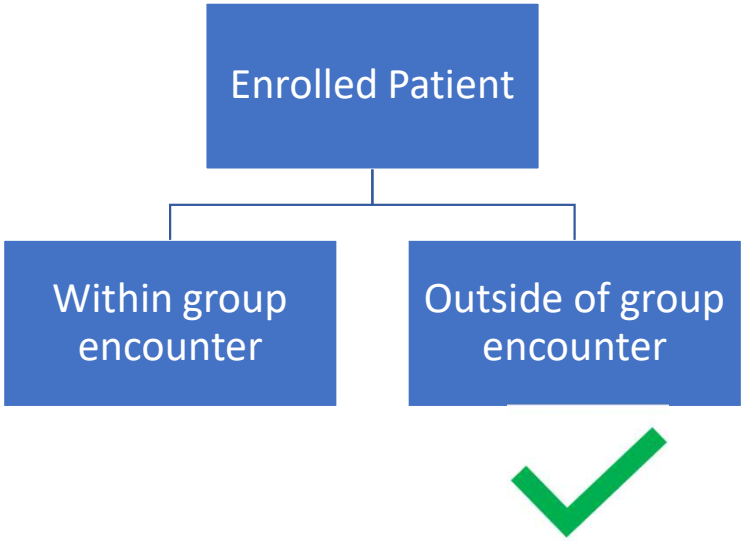
Walk-in Definition

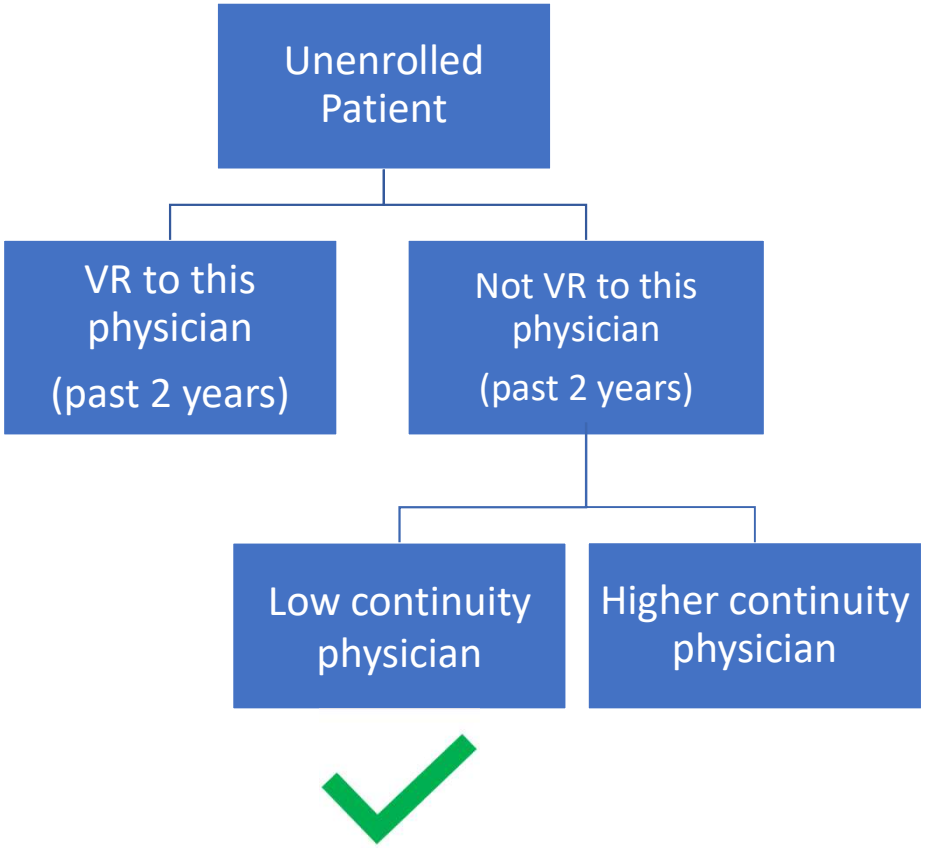
A Walk-In Service is any **episodic care** provided by a General Practitioner **who is not the patient's primary care physician (formally enrolled or virtually rostered),** nor part of the primary care physician's group or is a service that has been designated under the Bilateral GP Focused Practice Designation Committee or through the GP Psychotherapy Premium Schedule of Benefits designation.

Identifying the primary care physician & group

- Formal enrolment definition is ok
  - Outside-of-group MD encounter = walk-in service
- Virtual rostering considerations:
  - ***To be virtually rostered to that group, the patient must have had two or more in-person visits with any physician within that group.***
  - What about patients whose encounters are only with FFS physicians (no 'group')?
  - We found that **30% of the MDs who practice mostly in walk-in clinics** (CPSO survey data from 2019) belong to **FHG**s
  - **Walk-in clinic encounters themselves will contribute to 'virtual rostering'**

Proposed Alternative Approach





<u>Excluded encounters</u>

- Those not provided in a virtual or office setting
  - Exclude if location codes for home visit, hospital, emergency department or LTC settings
- Those not provided by an FP/GP
- Focused practice

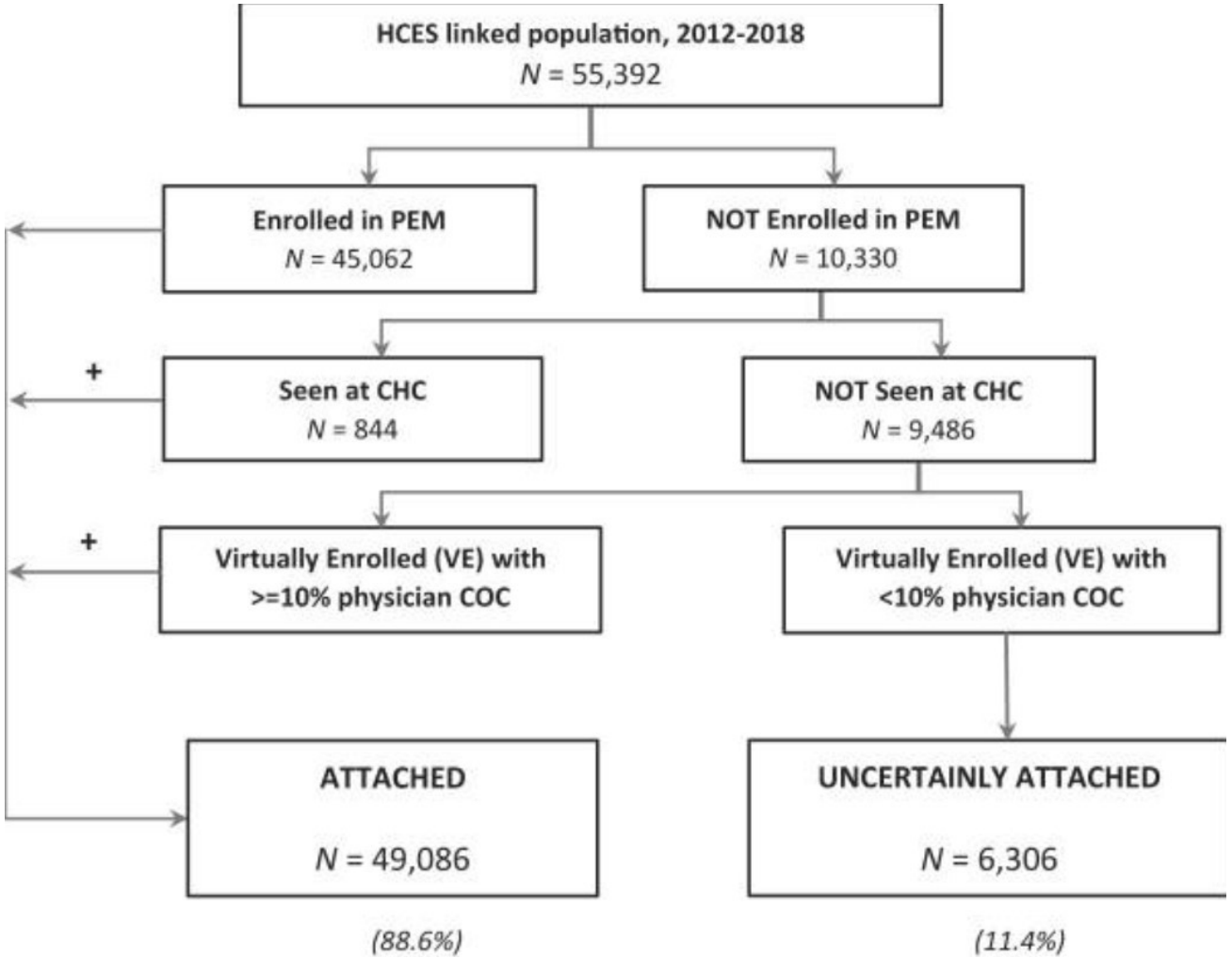
Low-Continuity Physician Definition

"We did not want to virtually enroll (…) to a PCP whom themselves may have low continuity of care (CoC) with their patients, such as walk-in clinic PCPs."

PCP CoC index:
- numerator of patients virtually rostered to a PCP
- denominator of all unique patients the same PCP had seen over two years.

"If the **PCP CoC was less than or equal to 10%,** then this PCP had a low PCP CoC and HCES respondents virtually enrolled to these PCPs were then deemed to be uncertainly attached."

Jaakkimainen L et al. Development and validation of an algorithm using health administrative data to define patient attachment to primary care providers. *J Health Organ Manag*. 2021:733-743.

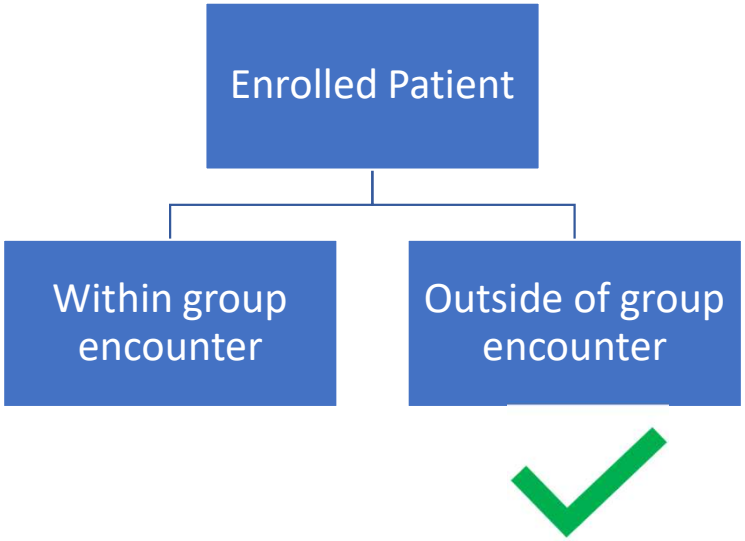


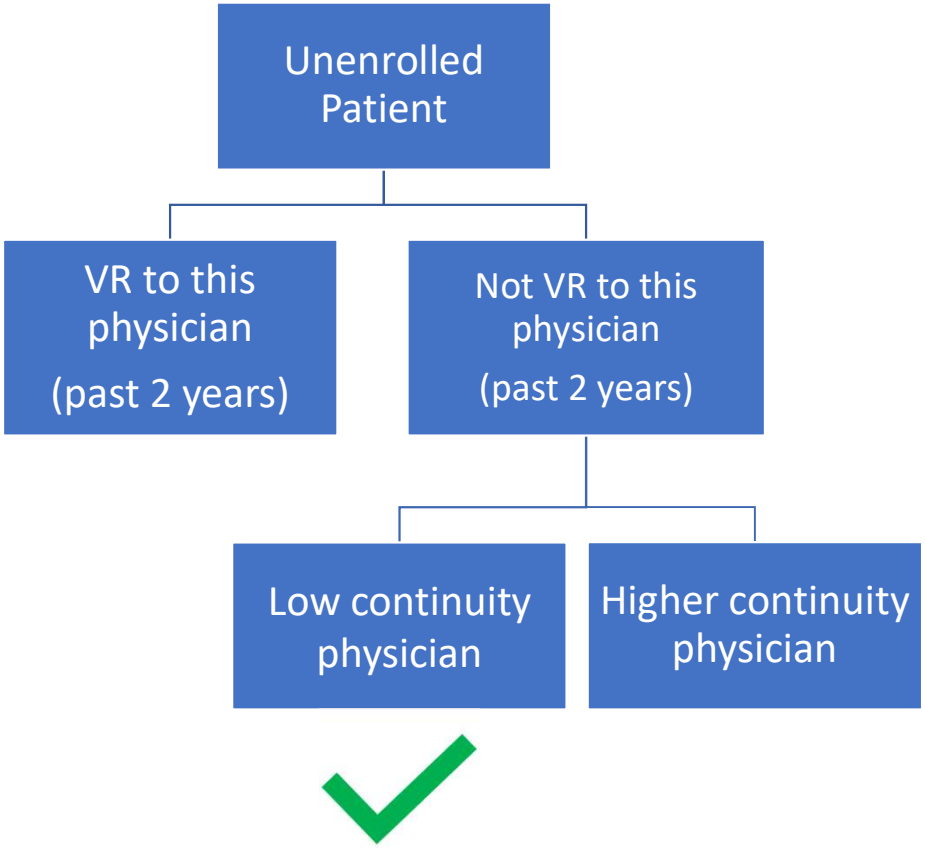
Jaakkimainen L et al.
J Health Organ Manag. 2021:733-743.

Low-Continuity Physician Definition

- Sensitivity 91% for attachment, so 91% of those saying they are attached are captured as attached
- Specificity 46% is low- misclassified some who said they were unattached as attached (but for purpose of walk-in clinic definition, probably want to be sure they are unattached, so this set-up is better than the reverse).
  - Rather undercount walk-in encounters than overcount

Jaakkimainen L et al. Development and validation of an algorithm using health administrative data to define patient attachment to primary care providers. *J Health Organ Manag*. 2021:733-743.





<u>Excluded encounters</u>

- Those not provided in a **virtual or office setting**
  - Exclude if location codes for home visit, hospital, emergency department or LTC settings
- Those not provided by an FP/GP
- Focused practice

Mandate of the Working Group

- ***a) The Ontario Medical Association (hereafter "OMA") and the Ministry of Health (hereafter "MOH") will work together to develop a framework that will enable and ultimately require walk-in clinics to communicate back to the patient's primary physician concerning the reason for the visit, as well as the diagnosis and treatment, if any. This applies to both in-person and virtual services.***

- ***b) The OMA and Ministry will develop a process for communication with patients who regularly use walk-in clinics to understand why they do so, and how they could be best encouraged to engage in a continuity of care environment, through enrolment with a comprehensive primary care provider, or where they are already enrolled with their own rostered practice. This applies to both in-person and virtual services.***

Feedback on Mandate (a)

- I support the goal: continuity of care
- CPSO Policy on Walk-in Clinics (2019)
  - “must provide the patient’s primary care provider with a record of the encounter when:
    - A) the patient makes a request to do so or
    - B) in their opinion, one is warranted from a patient safety perspective and the patient has provided consent to do so.”
- How to make communicating back to PCP a requirement
  - CPSO policy amendment
  - Walk-in MDs need access to a registry to know who the PCP is (CAPE?)
  - Billing restrictions

Feedback on Mandate (b)

Is underlying objective about knowing the reasons?

Or is it about assisting or even influencing the patients?

Or even about feedback to physicians?

Reasons for Using Walk-in Clinics

Why did you try to get care at a walk-in clinic (OurCare, Canada, 2023)?

- Walk-in clinic was the only place I thought I could get care from at the time – 32%
- I was unable to get an apt as soon as I wanted- 28%
- I don't have a regular health care provider- 28%
- I was unable to get an apt with my doctor or team- 26%
- I needed care for a small health issue- 24%
- The walk-in clinic was the most convenient option for me – 19%

https://data.ourcare.ca/all-questions

Reasons for Using a Walk-in Clinic (Ontario, 2013-2020)

Self-reported reasons for using walk-in clinics:	
Provider was not available or could not get an appointment	6,970 (50.8)
It was faster to go to the walk-in	3,196 (23.1)
The walk-in was closer	2,339 (18.3)
Provider advised or follow-up	357 (2.2)
Don't know or refused	125 (0.9)
Missing	711 (4.6)

Among **enrolled patients** who had used a walk-in clinic in the past 12 months, as reported in Ontario's Health Care Experience Survey (HCES).

Rahman B et al. The association between timely access to patient's usual primary care physician and use of walk-in clinics in Ontario, Canada. CMAJ Open 2023 (Accepted).

Feedback on Mandate (b)

Is underlying objective about knowing the reasons?

Or is it about assisting or even influencing the patients? Or providing feedback to physicians?

- Scalable approach- potential to be costly and labour intensive
- Unattached: Invitation to join an enrolling practice
- Attached: how would this information be used
  - Education to patients
  - Feedback to physicians- could do this even with just the admin data, but qualitative data more rich

Infinite Resource Suggestions- Physical Walk-in Clinics

Walk-in clinics with an EMR that is shared with local enrolling practices.

Affiliation of walk-in clinics with local enrolling practices, allowing for:
- better after-hours access for enrolled patients
- attachment of unattached patients attending the walk-in clinic
    - **incentives to walk-in docs/clinics to promote attachment?**

If no shared EMR, then at least a registry to look up who a patient's PCP is to facilitate communication back to PCP.

Infinite Resource Ideas Depend on Being Able to “Find” Walk-in Clinics

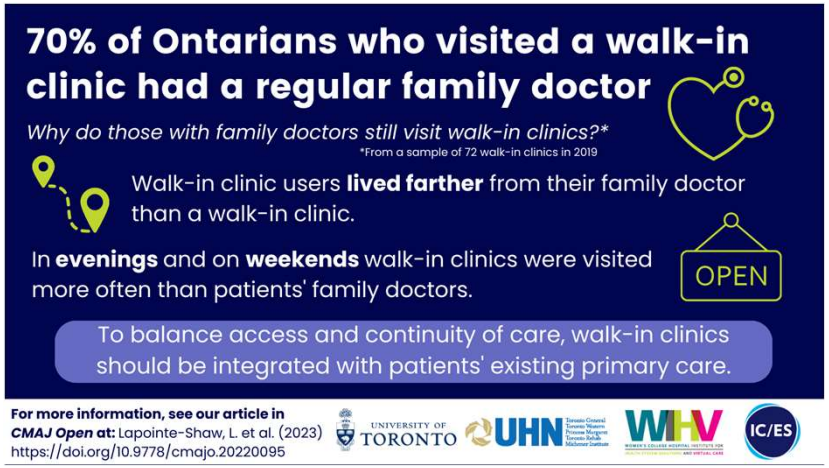
- Need a flag for walk-in clinic setting through a registration process
  - Billing (group numbers), accreditation, other
- “grouptype” variable captured walk-in clinics until late 90s
  - How was this done before?
  - Could this be started again?

Infinite Resource Suggestions- Virtual Walk-in Clinics

Tethering of virtual walk-in clinics to physical sites (walk-in/ED)

- Patients within a defined geographic area
- Allows for in-person assessment if needed
- Support attachment to local enrolling practices
- And similar to physical walk-ins…
  - Shared EMR
  - Or at least a registry to see who a patient's MD is
  - Communicate back to usual MD

Recent Relevant Work



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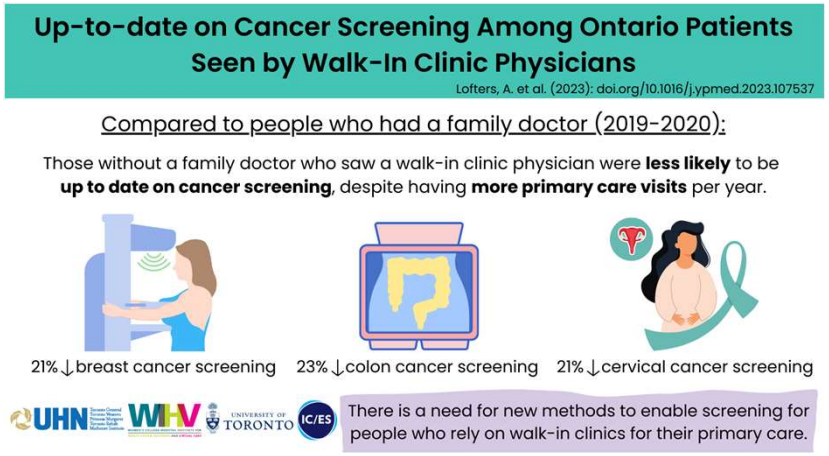

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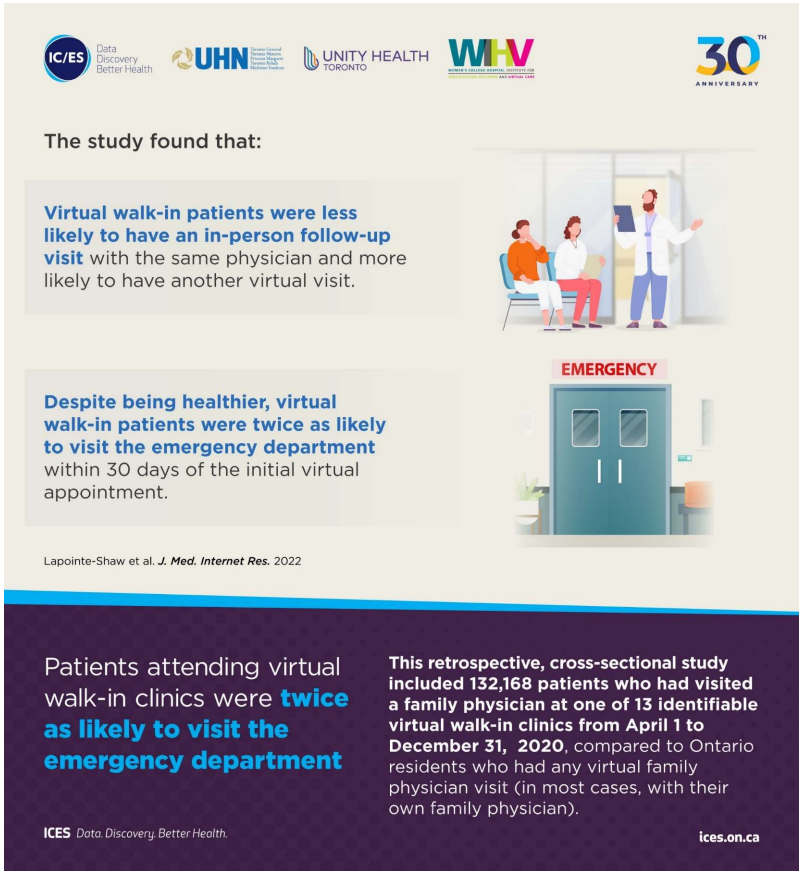


J Med Internet Res. 2023 Jan 12;25:e40267.

Advancing Walk-in Clinic Interoperability

- June 2023 -

Modernizing Care Delivery for Walk-in Clinics

Several key gaps in information exchange have been identified related to episodic patient encounters in Walk-in Clinics (WICs), where the patient has a regular Family Physician. (Most Responsible Physician, MRP)

Closing these gaps would improve care delivery within the circle of care and in turn patient outcomes.

Identifying the MRP at the WIC	For reasons of convenience, access to care, locale, urgency etc, patients seek provision of care in WICs, versus seeing their regular family physician, or MRP. Clinicians providing care in WICs, may not be aware of an MRP on file, or the patient may not be able to properly convey the specific MRPs identifiable information, including the location of the practice which they typically receive care.
Lack of patient history available to the WIC	Clinicians in WICs who provide care to a patient with a designated MRP, are missing important information about that patient typically available to primary care (e.g.: Past Procedures, Family History, Allergies, Medications etc)
Notification of episodic care	At the conclusion of an episodic care event, there is currently no digital health mechanism for ensuring the MRP (and more broadly the EHR) is notified of the encounter and the outcome as it informs ongoing care in the circle of care.
Patients' preferred choice of care provider	Why don't, won't or can't patients access their own Family Physician and thus go to a Walk-in Clinic

Long-Term Alignment

Identifying the MRP at the WIC	Under the vision for “Primary Care Information Exchange” (PCIE), the Province has prioritized the provision of Patient Summaries (PS) from primary care to the provincial EHR. The longer-term strategy is to provide access to Patient Summaries more broadly to all downstream providers, through either EHR viewers or purpose-built viewers. This Patient Summary will reveal the MRP.
Lack of patient history available to the WIC	Access to Patient Summaries from Primary Care, will also reveal key information relevant to the provision of care in the WIC, such as past procedures, family history, allergies, medications, immunizations, problem list.
Notification of episodic care	Providing encounter summaries has two paradigms: 1) long-term, persistent, centralized storage for adhoc access as required and 2) real-time notification of events as they occur. The PCIE/PS vision will enable MRPs to subscribe to all notifications for their rostered patients. The provision of Patient Summaries will also be extended beyond primary care encounters and could include WICs, such that at the end of an encounter, PS would be automatically sent to the EHR at the end of the encounter and the MRP notified.
Patients’ preferred care provider	Data analytics correlating billing information against MRP location may reveal what % of patients with MRPs visit WICs, with added perspectives on regional influence, urban/rural etc. The REASON for choice is a personal perspective, albeit opportunities to collect information through surveys etc for those who have received care through WIC

Near-Term Opportunities

Identifying the MRP at the WIC	Advocate MOH/OH for provision of PS to provincial EHR from WICs
Lack of patient history available to the WIC	Advocate MOH/OH to provide access to EHR Viewers for WICs
Notification of episodic care	Champion support from MOH/OH to prepare a pilot that: • Generates PS or Encounter Summaries at the WIC Point of Care • Send encounter/patient summaries through HRM to named MRP where identified • Preserves long-term investment • (for WICs who leverage an OMD Certified EMR for medical record keeping)
Patients' preferred care provider	Investigate opportunity for customized reports through MOH Claims Branch to reveal WIC visits, cross referenced where MRP is different than billing provider #. Potential for outreach to patients receiving care in WICs (privacy consideration)

Thank You!

Ocean Platform: Provider Messaging for Walk-in Clinics

July 21, 2023

OceanMD
A WELL Health Company

Understanding the Challenge

Walk-in Providers Need to Communicate with Primary Care

Providing a simple way for walk-in providers to share visit details will improve continuity of care.

Messaging Solutions Need to Be Fast & Easy to Use

Communication tools need to be easily built into existing workflows and not significantly add to walk-in provider .

Integration to Current Systems is Critical

Messaging needs to be available in the EMR – asking over-burdened clinicians to use additional systems is not a reasonable option.

The Ocean Platform: Connecting Patients, Providers & Systems

Patient Engagement Suite

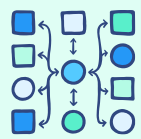
EMR-integrated tools that connect healthcare providers with patients through:

- Online Booking
- Patient Messages
- Patient Reminders
- Check-In Kiosks and Tablets
- Website Forms
- Ocean Studies

Ocean Provider Network

Provincial solutions that connect healthcare providers to securely share patient health information with:

- eReferrals
- eConsults
- eSubmissions
- eOrders
- The Ocean Healthmap Directory



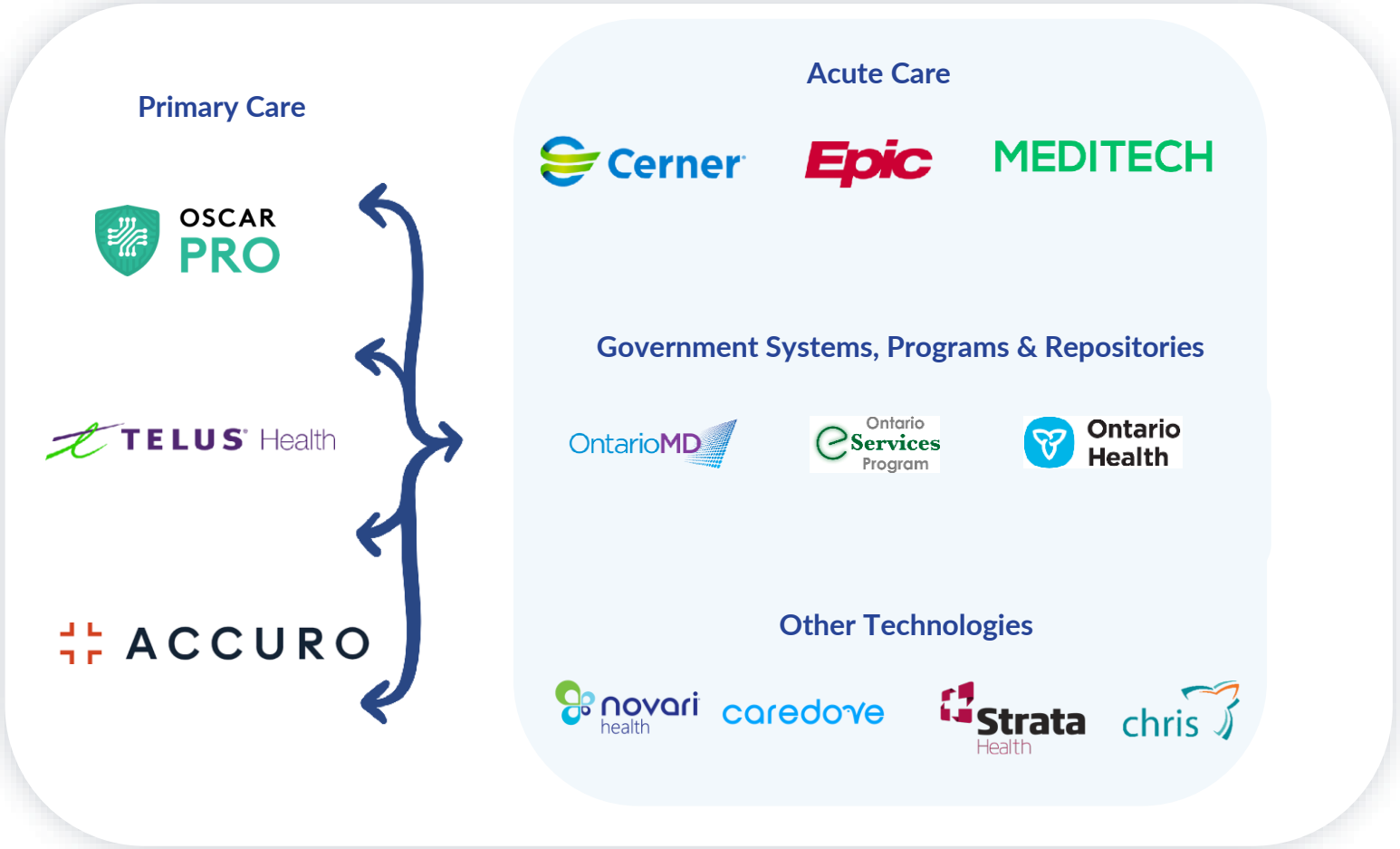
Ocean Platform & Integrations

Shared underlying infrastructure to support standards-based integrations and a shared, open forms library:

- Ocean FHIR® Integration Layer
- Ocean Forms Library
- Ocean Forms Editor

OceanMD
A WELL Health Company

Ocean: The Digital Gateway for Providers



Open, HL7 FHIR®-based APIs with no transactional fees

25+ Integrated Solutions & Provincial Assets

4,100+ Clinics with Over 8,000 Providers

10,000+ Shared, Customizable Forms in the Ocean Library

Deployed by OMD, Ontario Health, UHN Connected Care & Ontario eServices Program

OceanMD
A WELL Health Company

Ocean's Secure Communication Channels

Sender EMR

PATIENT MESSAGES

Over 8,700 healthcare providers securely send 400,000+ messages each month from the EMR on Ocean

PROVIDER NETWORK

Over 8,500 healthcare providers send 75,000+ eReferrals each month on the Ocean Network to over 5,000 specialists

PROVIDER MESSAGES

Allow providers to send messages to providers on the Ocean Network/HRM

Patient via Email

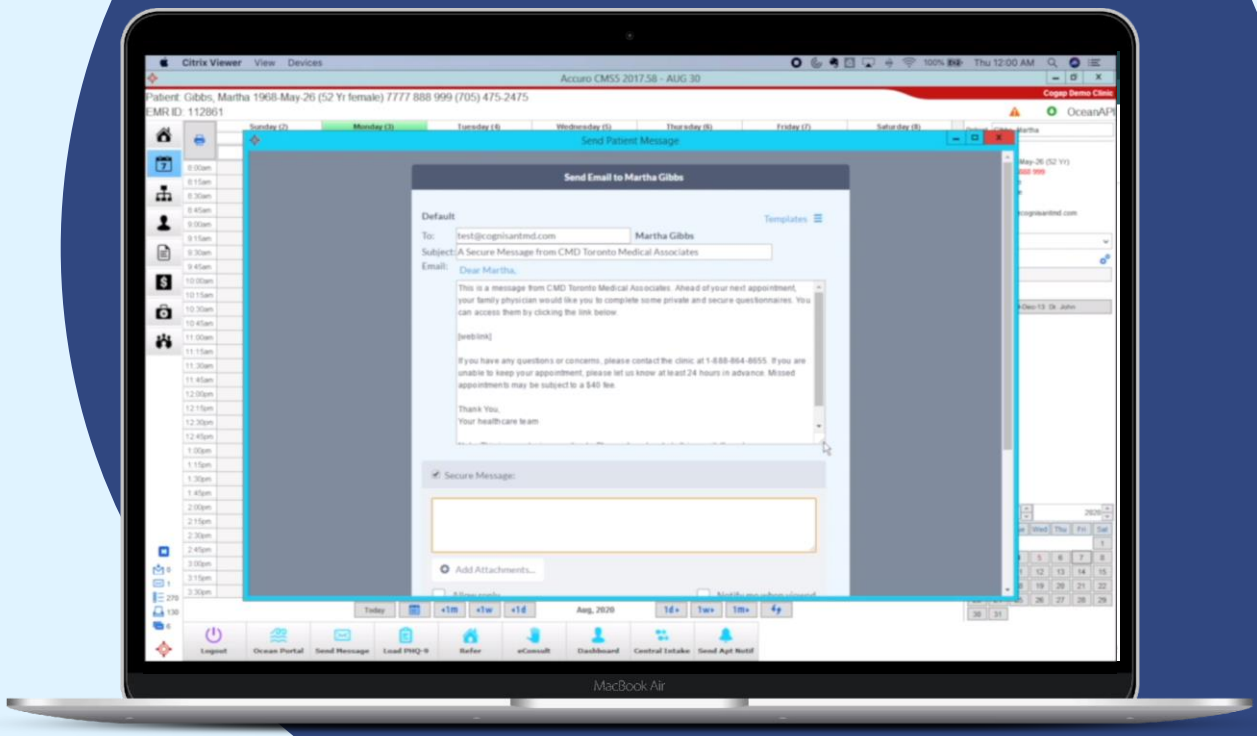
Receiver EMR

HRM File Delivery

OceanMD
A WELL Health Company

Ocean Patient Messaging

- Launch directly from the EMR to a simple messaging window
- Easily add notes and attachments from the chart
- Automatically track a record of the message in the patient chart
- Optionally allow responses if follow-up is required



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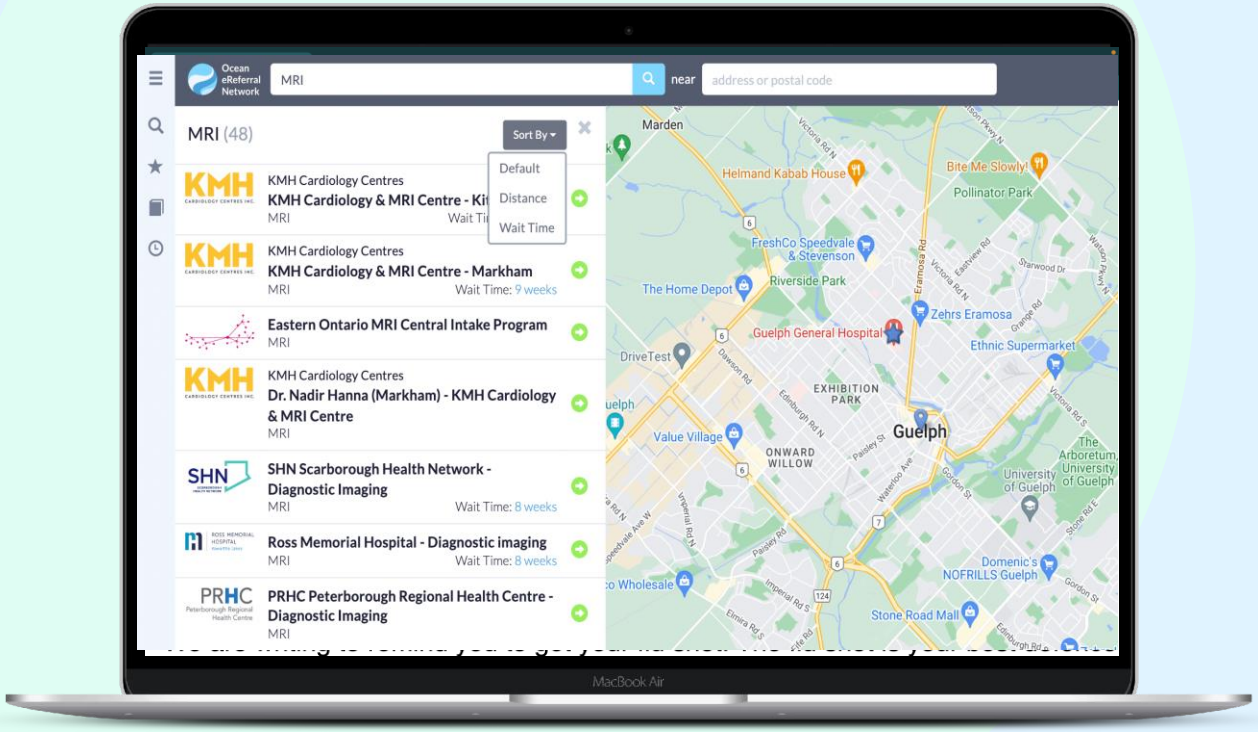

Ocean Provider Network

- Easily Locate Providers using the map-based directory (integrates with PPR)
- Send eReferrals to health services and specialists with auto-populated forms
- Add Attachments or files right from the patient's chart
- Receive Update Alerts to keep both providers in the loop
- Integrate with HRM to support additional delivery of reports when needed

OceanMD
A WELL Health Company