INTEGRATING PHYSIOTHERAPISTS INTO FAMILY HEALTH TEAMS IN ONTARIO

2009

Prepared by

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Executive Summary

Increasing prevalence of chronic diseases (such as arthritis, obesity, cardiovascular disease, cancer, stroke and musculoskeletal disorders) continue to burden the primary health care system. Some chronic diseases require extensive rehabilitation in order to optimize an individual’s function in the community. The importance of rehabilitation providers, such as physiotherapists, is increasing due to their role in chronic disease management. Family Health Teams (FHTs) and Community Health Centres (CHCs) are publicly funded settings that provide a multidisciplinary approach to primary patient care.

Our purpose was to examine the potential for integrating physiotherapy services into FHTs and CHCs. Key informant interviews were used to address the research objectives:

- To identify appropriateness and feasibility of various models that integrates physiotherapy services into FHTs.
- To identify opportunities and challenges regarding the implementation of each model in various settings.
- To identify policy issues that addresses the identified barriers and challenges.

In this report we identify various opportunities and barriers to enhance primary health care and chronic disease management by integrating physiotherapists (PTs) into FHTs. However, the major issue remains the limited access to physiotherapy services by many Ontarians due to the lack of public funding for physiotherapy outside of hospital settings.

Different models of embedding PTs into FHTs and CHCs were explored and found to have various opportunities, challenges and potential solutions. These can be summarized in the table below. Participants agreed that an embedded PT would provide the greatest health benefit for the community, however creating partnerships with existing physiotherapy clinics was a feasible option given budget constraints.

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<td>Embedded PT</td>
<td>• Communication enhanced</td>
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<td>• Streaming</td>
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<td>e.g. CHCs</td>
<td>• PT part of team &amp; able to take on roles in Chronic Disease Management</td>
<td>• Salary/benefits are much lower than in other sectors</td>
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<td>• High job satisfaction and good quality of working life</td>
<td>• Costs of space, equipment</td>
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<td>• Isolation of PT</td>
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<td>• Providing public service to clients with extended health care</td>
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<td>Refer to PT Clinic</td>
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Integrating Physiotherapists into Family Health Teams in Ontario

April 2009

Opportunities  Challenges  Potential Solutions

▪ FHT does not have to recruit and supervise PTs professionally  ▪ Communication between PT and MDs/ Access to electronic health record  ▪ Rounds, electronic health record
▪ FHT does not have to rent space, purchase PT equipment  ▪ Differences in salaries and benefits between public and private purse  ▪ Purchase services using salary model, not fee for service
▪ Using public money to purchase private services/ Preferred Provider Status  ▪ Already being done: PT and Nursing Homes Housekeeping

Funding physical therapy services outside of the hospital sector was the major challenge identified by both FHTs and PTs. Most of the successful integration of physiotherapy into primary health care in Ontario was found in the CHCs, where all services providers are paid by salary, and the decision to include allied health professionals in the practice does not negatively impact the physician's income. Currently FHTs cannot offer physiotherapy as part of their circle of collaborative care, which has resulted in the absence of an important team member for primary health care and chronic disease management. Although an embedded PT is considered ideal within the FHT model, creating partnerships with existing health organizations and private clinics can bridge the access gap. Although these partnerships have the potential to be created, strategies around reimbursing physiotherapists would remain an issue given the large discrepancy between salaries through the public versus the private sector. Cut backs and scarce resources have encouraged providers to compete with one another for resources, making it difficult to share expertise, decision-making or authority. Related to funding, there are challenges around acquiring space and equipment that are difficult to come by in environments that were not originally built for physical therapy.

The theme of access was another common concern among rural participants due to the lack of PT clinics outside of urban areas. These inequalities reinforce a multi–tiered health care system. It has been suggested that access to rehabilitation services through FHTs would overcome the regrettable inequity that has arisen in recent years.

Policy Recommendations

Each model for physiotherapist in primary care provides several opportunities and barriers in order to provide a greater scope in health care services. However, there is not one specific model or variation of a model that can be generalized for every FHT or CHC. This is primarily due to the geographical variation of rehabilitation services. For example, in urban communities there are several private rehabilitation communities in contrast to rural centres where some clinics can be spread apart by great distances. When using a model of rehabilitation, the surrounding environment of the community must be taken into full consideration to make efficient use of existing health resources.

Ontario has taken a well-informed decision to widen the primary care network in the province. However, despite the intent to provide a fully integrated primary care environment, FHT appear to have structural restrictions that limited the provision of services such as physiotherapy. This has created an important gap in timely and
effective service delivery for individuals with chronic disease. Given that the prevalence of chronic disease is rising in the province, and given that the application of physiotherapy services for these individuals allows them to manage their condition in the community, we identify a imbalance between the demand (i.e. chronic disease management) and supply (i.e. access to physiotherapy services) which will have an effect at the client and overall health system levels.

The limited provision of PT in FHT forces individuals to either access publicly-funded PT services elsewhere, or to purchase them privately (either out-of-pocket or through third party insurance). The profile of the majority of individuals with chronic disease generally precludes them from the latter, and forces them to the first approach which is to attempt to access services elsewhere. Unfortunately, as identified in this study, the availability of such publicly-funded services is diminishing. The effect of limited access for individuals with chronic care may be circular in that lack of access to PT at specific points along the disease trajectory aggregates the conditions to a point where high-cost institutional care (which is fully publicly-funded) is medically necessary.

The lack of access to physiotherapy services also alters best practice. As reported in this study, knowing that individuals cannot, or will not be, able to access public or privately funded physiotherapy services increases the utilization of prescription medication to manage the condition. Not only is this outcome less than ideal practice because it is a way in which to deal with the acute symptoms, it is extremely costly to the public system in the long term.

Our research has identified the opportunities and challenges of different models of providing physiotherapy services within the context of the innovative FHTs. However, each of these requires shifting scarce resources. Allocation of resources is driven by values and interests among the stakeholder who stand to gain (or lose) from the outcome. The stewardship of the MOH-LTC is significant the structural adjustment that is required to improve access to physiotherapists within the FHTs.
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1.0 Background

1.1 Rationale

Several factors, including an aging population, an increase in the prevalence of chronic diseases, and a shift in the delivery of health care from hospital to the community are placing increased demands on Ontario’s primary health care system. Primary care is the first level of contact in the health system (1) and has an important role in the ongoing management of persons with musculoskeletal disorders, which is the second most common reason for visits to primary care physicians (2). Family physicians play a major role in the coordination and provision of primary health care services and, more recently, nurse practitioners have started to play a significant role. Physiotherapists (PTs) and Occupational Therapists (OTs) are key members of the interdisciplinary health care team and can be an important resource for primary health care physicians and nurse practitioners. Indeed, Eldar (3) argues that primary health care physicians should work closely with rehabilitation professionals and integrate rehabilitation into their day-to-day work. In particular, it has been suggested that offering rehabilitation services at the primary health care level could result in several positive outcomes including lower costs than for services offered at hospitals or large health care clinics, shorter travel time for patients, and greater continuity of care for people with disabilities.

Chronic disease places a significant demand on the health care system with diseases such as cardiovascular disease, diabetes, cancer, obesity, and respiratory conditions accounting for 46% of the global burden of disease (4). Some chronic conditions are more likely than others to be associated with disability (e.g., arthritis, musculoskeletal disorders, and stroke) and therefore are more likely to require ongoing rehabilitation intervention to optimize a person’s ability to function in the community. Rehabilitation therapists are key to the successful and efficient management of chronic conditions (e.g. musculoskeletal conditions) through strategies such as supporting self-management and behaviour change. This role for rehabilitation therapists is likely to become increasingly important in the face of the increasing prevalence of arthritis and other chronic diseases associated with aging, putting pressure on the resources of primary care physicians.

Community rehabilitation services are currently available throughout the province of Ontario, in both the public and private health care sectors. There is an increasing shift of focus of care from the hospital to community – and currently, an increasing proportion of physiotherapy services are delivered through private for profit clinics, and use of private funding sources. On the other hand, the majority of publicly funded community rehabilitation services are provided in hospital outpatient departments. There are approximately 90 Designated Physiotherapy Clinics that still provide publicly funded services to seniors, youth and other categories of clients. Other publicly funded settings include a limited number of Community Health Centres (CHC) located throughout the province and the Arthritis Society Rehabilitation and Education Program. Finally, those who are physically unable to access care at outpatient facilities may qualify for publicly funded community home care services through Community Care Access Centres (CCACs).

In our previous work on rehabilitation and primary care in Ontario, we found that the structure of provincial health care itself may act as a barrier to access to physiotherapy...
services, especially among vulnerable populations such as those with chronic conditions; those lacking private health insurance, and those living in less urban regions of Ontario (5). Moreover, we found little evidence of teamwork and collaboration between primary care PTs and physicians. For example, PTs rarely work in the same setting as physicians. The majority of primary health care physiotherapy is delivered in private PT clinics; whereas the majority of primary health care physicians work in private practice and Ontario Family Health Network settings. One of the few primary health care settings in which rehabilitation professionals work together with physicians is in CHCs, however, the number of rehabilitation professionals employed by CHCs in Ontario is very small (5).

Since the above research was conducted, three initiatives have occurred in health care delivery in Ontario that signal major changes in delivery of physiotherapy services at the level of primary care: 1) the creation of Family Health Teams (FHT) whose mandates are to provide multidisciplinary, comprehensive, and frontline health care; 2) the partial delisting of publicly-funded community-based physiotherapy services within the network of Designated Physiotherapy Centres; and, 3) the advent of Advanced Practitioner training programs. Given these changes, the time is appropriate to examine the integration of physiotherapy into FHTs in Ontario. We have chosen to focus on physiotherapy and have not included occupational therapy because in our previous research we have identified that referral patterns and issues regarding accessing occupational therapy differ from physiotherapy, particularly with respect to musculoskeletal disorders. The time frame and therefore the scope for these projects are insufficient to adequately address both physiotherapy and occupational therapy. Thus, in this project we will examine the opportunities, barriers and challenges to integrating PTs into FHTs in Ontario.

1.2 Significance of the Research

Due to the aging population, an increased prevalence of chronic disease and the transfer of care from inpatient to community-based settings underscore the need to better understand how to integrate rehabilitation services into primary care. This research will significantly contribute to policy decisions and organization of service delivery within Family Health Teams so as to make best use of resources and ensure that clients are seen by the most appropriate clinician at the best place and at the best time.

1.3 Models for Rehabilitation Professionals

There are four models for rehabilitation professionals in primary care currently identified in the literature: 1) Rehabilitation services delivered in primary care settings such as family physician offices or health centers (versus rehabilitation in a secondary care site); 2) Rehabilitation services as a resource for primary care physicians; 3) Rehabilitation professionals as first-contact health care providers; and 4) Extended role or advanced practitioners. These models are not mutually exclusive and overlap in some cases.

1. Rehabilitation Services Delivered in Primary Care Settings:
In this model, rehabilitation professionals are practicing in primary care settings with family physicians. This model is more common in the United Kingdom (UK) where there is a trend towards shifting rehabilitation services from secondary care locations, such as
hospital outpatient departments, to primary care sites, such as family physician practices and health centers (6-14). In Ontario, a small number of rehabilitation professionals work together with physicians and nurse practitioners in CHCs, however, this model is the exception rather than the rule (5).

An ideal model of rehabilitation in primary care would include: rehabilitation professionals (e.g. PTs) as integrated members of the primary care team, working closely on a day-to-day basis with family physicians and other team members; rehabilitation services offered in primary care sites, such as health centers or family physician offices or in the home or workplace; and, rehabilitation services focused on helping people with chronic conditions manage their disabilities across the trajectory of the condition in order to ensure continuity of care and appropriate referral to specialized programs in secondary care sites if needed (3;15).

Establishing rehabilitation services in primary care settings can result in several positive outcomes including: high levels of satisfaction with service among patients and primary care physicians (6;10;14); decreased waiting times for services (8;9;12;14); cost-effectiveness when compared to hospital-based services (8;9); reduced referral rates to specialists (11); and, improvements in patient-related outcomes such as quality of life, exercise tolerance and health status (6;7;10;14). Most of the studies that examined rehabilitation in primary care settings focused on the provision of physiotherapy services (12). Shifting hospital-based physiotherapy to general practices can increase the use of physiotherapy services (11) which may represent a previously unmet need for physiotherapy in the community (13). However, there is currently no evidence that meeting this need will result in the reduced use of other health care services in the secondary sector (13).

Rehabilitation services in primary care settings are particularly important for the treatment of chronic conditions, such as arthritis, chronic low back pain, and pulmonary disease (6;7;10;16;17). Available evidence suggests that most of the patients seen through this model are elderly (14) and suffer from chronic musculoskeletal disorders such as osteoarthritis and rheumatoid arthritis (14;18).

2. Rehabilitation Services as a Resource for Primary Care Physicians:
In this model, rehabilitation professionals are not located in physician practices; rather physicians refer clients to outpatient clinics. Presently, this is the model most commonly in use in Ontario. In general, the literature suggests that primary care physicians underutilize rehabilitation services, particularly in the care of the elderly and those with chronic conditions (19-22).

For example, Glazier et al.’s (19) mail survey of a random sample of family physicians in Ontario suggests primary care physicians do not refer patients with arthritis to rehabilitation therapists often enough. Primary care physicians do not use rehabilitation services as often as optimal guidelines recommend because they feel it is too difficult for patients to access these services. According to a survey by Roberts et al., (23), 68% of the general practitioners surveyed felt waiting lists for physiotherapy were too long. Many respondents felt poor access to resources, such as physiotherapy, led to an inappropriate use of pain-killers for the treatment of musculoskeletal conditions. Similarly, our survey of family physicians in Ontario found that physicians felt that wait times for publicly funded physiotherapy were too long and private physiotherapy services too expensive.
Assuming that adequate rehabilitation services exist, one of the potential advantages of increasing referral rates from primary care physicians is a possible decrease in the number of inappropriate referrals to specialists, such as orthopedic surgeons and rheumatologists (11). Primary care physicians may rely on specialists such as rheumatologists for subsequent referrals to occupational therapy and physiotherapy (19). However, according to systematic literature reviews by Robert & Stevens (24) and Hensher (13), accessing physiotherapy through a specialist instead of a primary care physician leads to significant increases in waiting times, greater inconvenience and higher costs for the patient, and higher costs for the health care system in terms of cost per patient. In addition, patients appear to be significantly more satisfied with physiotherapy services if they access these services sooner rather than later, even if early access simply involves receiving advice over the telephone (25).

3. Rehabilitation Professionals as First-Contact Health Care Providers:
This model involves the rehabilitation professional acting independently from family physicians as the first contact health provider. The limited research that is available suggests very few patients requiring rehabilitation services do so without a physician’s referral. However, using rehabilitation professionals as first contact health care providers may be a cost-effective way of delivering services.

In North America, the term “direct access” refers to the ability to evaluate and/or treat patients without referral from another health care professional, such as a physician (26-28). When it exists, direct access legislation allows professionals to act as first-contact health care providers. Under Ontario’s 1991 Regulated Health Professions Act, physiotherapists, occupational therapists and speech-language pathologists are granted the privilege of direct access. However, there are barriers to their ability to act as first-contact providers. For example, in the private sector, most third-party payers do not reimburse patients for rehabilitation services without a physician’s referral (29). In the private sector, clients who are covered by WSIB and automobile or disability insurance are able to access rehabilitation professionals directly, but in many cases, they are not reimbursed for services unless they have a physician’s referral.

In our literature search, we did not find any Canadian studies examining the extent of direct access practice in this country. However, research in the United States suggests first-contact physiotherapy is an occasional service in states with direct access legislation, rather than a routine mode of practice (26;27).

Although few people currently see rehabilitation therapists without a referral, the limited research that is available suggests the lay public in North America may be willing to consult directly with a physiotherapist if given the option. In a survey of 361 patients being treated by physiotherapists in 25 privately-owned clinics in Indiana, 71.5% of those surveyed reported they would consult directly with a physiotherapist if they experienced the same symptoms again (30). Similarly, in a random telephone survey of Florida residents, almost three-quarters (73.4%) of the sample stated they would go directly to a physiotherapist if reimbursed by insurance (28).

Critics of direct access cite potential over utilization of services and higher costs. Mitchell & Lissovy (31) investigated these concerns by using paid claims data from a private insurer, Blue Cross-Blue Shield of Maryland. They compared resource use and costs for direct access physical medicine procedures (provided by physiotherapists, chiropractors or physicians) versus those that involve a physician referral. Their results
revealed direct access claims required fewer visits and were much (137%) less expensive than those that involved a physician referral. They concluded that concerns that direct access can lead to over utilization of services or higher health care costs are unwarranted.

4. Extended Role or Advanced Practitioners
Recently there has been a move towards developing extended role providers (ERPs) or advanced rehabilitation practitioners usually in a team setting with orthopaedic surgeons or rheumatologists. In Canada they are mainly referred to as advanced practitioners. There is not an accepted definition of ERP but, in general, these therapists have additional training and skills in assessment and management and may use medical directives to perform activities such as ordering of X-rays or bloodwork which are typically out of scope of practice for Canadian therapists. In the UK and Canada there has been a piecemeal development of ERP models of care. Triage models have been developed to streamline and expedite access to orthopedic care particularly in the UK, and more recently in Canada in response to wait time reduction strategies for total joint replacement (TJR) surgery (32-45), and models are on the horizon to screen for early rheumatoid arthritis. Other models such as telemedicine have used health professionals to carry out a joint examination to facilitate treatment in geographic areas with no local specialists (38). Team care models using ERPs also have evolved in conjunction with rheumatological care to facilitate comprehensive management including rehabilitation (46;47), and there is increasing use of ERPs to follow up patients after orthopedic surgery (32). The majority of models to date use PTs with appropriate advanced training. There is a potential role for ERPs at different points of the continuum of care, however, to this point most of the focus has been on acute and surgical care. Integration of ERPs into primary care may be an important development to support early access to assessment and management as well as facilitation of referrals to the appropriate health care provider or community services.

To date there has been little research on ERPs and most comes from the UK. Research has focused primarily on PTs working in triage roles in orthopaedic clinics and demonstrated reductions in wait times for orthopaedic surgery, improved conversion rates, and high patient satisfaction (33;39;42-45;48). In other research, specially trained PTs have been shown to manage a substantive proportion of orthopaedic caseloads independently and diagnose orthopaedic problems accurately (33-37;41;44;45;48-52). Canadian research on ERPs in paediatric rheumatological care has show that patient satisfaction is similar for patients and parents seeing a PT as those seeing a rheumatologist (47). Research on ERPs in primary care settings is extremely limited.

1.4 Purpose and Objectives
The Family Health Teams (FHTs) model represents an approach to primary health care that brings together various health care providers to coordinate the highest possible quality of care (54). These teams primarily consist of physicians, nurses, nurse practitioners, as well as other health professionals – which vary from location to location to meet the diverse needs of the population. These multidisciplinary teams were created to: 1) provide better access to care closer to home; 2) work as a team to keep patient’s health; 3) provide extended hours and after hours access to a registered nurse through the telephone health advisory services; 4) help patients navigate their way through the health care system; 5) provide primary health care, chronic disease management and
self-help tools to improve health; and 6) use ‘state of the art’ information technology giving providers access to patient information (54). There are currently 106 FHTs throughout Ontario.

Although meant to be multidisciplinary, FHTs are not funded to provide physiotherapy services. In recent years numerous FHTs have applied for funding for physiotherapy but have been unsuccessful in receiving budget approval from the MOH-LTC.

The purpose of this study is to examine potential models for integrating physiotherapy services into Family Health Teams (FHTs) and Community Health Centres (CHCs).

**Objectives**

1. Identify appropriateness and feasibility of various models for integrating physiotherapy services into FHTs (embedded practitioner, PTs as consultant).
2. Identify opportunities and challenges for implementing each model in various settings.
3. Identify policy recommendations to address these barriers and challenges.

Based on previous work in this area, we expect that different integrative models will be appropriate (and feasible) depending on the current availability of publicly-funded and privately-funded PT clinics in proximity to the FHTs. In previous work we have mapped the location of all PT clinics (Designated Physiotherapy Clinics, Hospitals Outpatient Department Clinics and Private Physiotherapy Clinics) by Local Health Integration Networks (LHIN). From this work we know that there is considerable jurisdictional variation in terms of access and availability of primary care physiotherapy services, and therefore models of integrating PT into FHTs could vary from hiring PTs such as Advanced Practitioners specifically for the FHT to partner with existing physiotherapy clinics or CCACs to networks of PT clinics and FHTs. Further, our senior MOH-LTC contacts inform us that, at this point, the integration of the PT into FHTs is still at the planning stages and that the structure and funding of FHTs differ both within and between LHINs.

**2.0 Methods**

We used a two phase approach to achieve our objectives; 1) mapping of current FHTs vis-à-vis physiotherapy community-based clinics; and 2) key informant interviews.

**2.1 Geographic distribution of current FHTs**

We identified the geographic location of all FHTs vis-à-vis community-based physiotherapy service by LHIN, and used Geographic Information System (GIS) software to analyze this information. GIS was initially developed by geographers and is being increasingly used in health research. GIS allows data to be linked to geographically referenced locations (such as streets, postal code, GIS coordinates) and to be processed through a software system that manages, analyses and displays the data in the form of maps, allowing for higher level analysis. Geocoding refers to a process whereby data are imported into geographic information system software in order to identify its geographic properties. Coordinate positions are assigned to the data in
order to display the location of pertinent variables. Specifically, it allows one to determine a number of spatially related phenomenon that includes: adjacency (what is next to what), containment (what is enclosed by what), and proximity (how close is something to something else). Postal codes and contact information were obtained from the MOH-LTC website and were used to determine the coordinates of each site. From these maps we were able to develop a typology of FHTs according to proximity to physiotherapy community-based clinics that we will use to describe the current situation in Ontario and as a sampling frame for the key informant interviews. Please see Appendix A for maps, which include FHTs, CHCs, designated physiotherapy clinic (DPC), hospitals, The Arthritis Society Rehab Clinics (TAS), and private clinics. The maps were examined and categorized by the proximity of FHTs to current PT clinics: 1) no PT clinics in close proximity (criteria for close proximity will differ in rural or urban setting); 2) only publicly-funded PT clinics in close proximity; 3) only privately-funded PT clinics in close proximity; and 4) both privately and publicly funded clinics in close proximity. Proximity was examined by using ‘as the crow flies’ distances.

2.2 Sampling for Key Informants

FHT key informants were identified through the mapping project and were selected to ensure representation from various FHT settings and geographic locations across Ontario. The names of primary contact individuals at each of the 150 FHTs are available on-line at the MOH-LTC website. Physiotherapy Key Informants were identified through our contacts at the Canadian Physiotherapy and Ontario Physiotherapy Associations. We sampled for three types of physiotherapy community private practices: designated physiotherapy clinics; private, fee for service practices; and health corporations that provide multidisciplinary services. We focused on physiotherapy clinics not home care services and MSK services. Key informants were also identified using a snowball technique, where they were asked to recommend any other individuals who may be able to participate in the study.

2.3 Procedure

The research associate contacted potential key informants by telephone or email. Participants were chosen based on their location (urban vs. rural areas) as well as public and private centres. Those potential participants who expressed an interest in the study were sent additional information about the study, describing the purpose and the nature of the request for their involvement (see Appendix B). The research associate was available to answer any questions from individuals about the study and their participation. Key informants were also sent letters of consent, which were faxed or emailed back to the research associate, or verbal consent was given at the beginning of the interview. All interviews were held at a time that was convenient for the participant. The interviews were carried out in person or by telephone by the primary investigator at Toronto Western Hospital, The University of Toronto or at the location of the participant. The confidential nature of the interviews was emphasized prior to each session.

Interview length ranged from 30 minutes to an hour and questions were guided by the research objectives. A semi-structured interview guide comprised of open-ended questions was used to guide the interviews:
1. What are the current linkages between your FHT/CHC with respect to rehabilitation?
2. Would you like to see rehabilitation services incorporated into your health team? How?
3. Does your FHT/CHC have any plans to integrate physiotherapy into the services you provide?
4. What challenges or barriers would need to be addressed in the service delivery model in which you work in order to incorporate rehab?
5. Can these challenges be overcome? How?
6. Recommendations re: Anyone else who can inform our study?

The interviews utilized probes to encourage participants to share information on the structure of their clinic and provide further discussion.

2.4 Analysis

Transcripts were read by the research associate twice and coded the second time, using a thematic approach. This approach allowed us to report the experiences and realities that different types of physiotherapy clinics are facing in different regions of Ontario. Themes that emerged revolved around the research objectives, with respect to the working relationships between primary care providers, as well as their perspectives on barriers and opportunities with regards to the integration of delivery of primary care rehabilitation to adults. Data was analyzed by the research associate and coded using NVivo 6.

3.0 Results

3.1 Distribution of Public and Private Physiotherapy Clinics

The maps (appendix A) indicated that twenty-five FHTs across Ontario were not close to any physiotherapy services. These FHTs were all found in rural regions of the province. Thirty-six FHTs were close to only publicly funded physiotherapy clinics, these include designated physiotherapy clinics, TAS, and hospitals. In contrast, seventeen FHTs were situated near privately funded physiotherapy clinics, found in both rural and urban regions. In addition to these findings, fifty-one FHTs were in close proximity to both public and privately funded physiotherapy clinics throughout the province.

3.2 Key Informant characteristics

Key informant interviews were completed with 16 consenting participants. Table 1 summarizes the professional backgrounds of the key informants. Table 2 summarizes the types of organizations represented by the participants.
Table 1: Characteristics of Key Informants

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<td>Nurse Practitioner</td>
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<tr>
<td>Physiotherapist</td>
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<tr>
<td>Other*</td>
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<td>*(program director, administrator)</td>
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Table 2: Types of Programs and Geographical Area

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<tr>
<td>Designated Physiotherapy Clinic</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Private Practice, fee for service</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Health Corporation</td>
<td></td>
<td>2</td>
</tr>
</tbody>
</table>

4.0 Findings

4.1 Primary health care and primary care

Participants were careful to differentiate between primary care and primary health care. Primary health care is an approach which emphasizes health promotion, illness prevention, includes diagnosis and treatment, and provides a link to more specialized care (e.g., secondary or tertiary) (59). Primary health care is focused on preventive health measures such as health and wellness programs. In contrast, primary care can be defined as first-level contact, continuous, comprehensive, and coordinated care provided to populations undifferentiated by gender, disease, or organ system (60). Primary care is usually seen as an approach to providing care rather than a set of specific services (60), it is the contact between a person with a specific health problem and the person representing the first level of health care system (61).

Participants saw primary care as mainly relating to medical services whereas primary health care incorporates the entire multidisciplinary team. Table 3 outlines the types of primary care and primary health care with respect to physical therapy in Ontario.

Table 3: Primary care and primary health care institutions under the public and private purse in Ontario

<table>
<thead>
<tr>
<th></th>
<th>Primary Care</th>
<th>Primary Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Funding</td>
<td>• Designated Physiotherapy Clinics</td>
<td>• CHCs</td>
</tr>
<tr>
<td></td>
<td>• Hospital Outpatient Department</td>
<td></td>
</tr>
<tr>
<td>Private Funding</td>
<td>• Private Physiotherapy Clinics</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Health Care Companies</td>
<td></td>
</tr>
</tbody>
</table>

The only examples we found of PTs currently involved in primary health care were in CHCs. Community Health Centres are non-for-profit primary health care environments that provide health promotion programs for individuals, families and communities (55). CHCs work to provide information on existing health resources, health education, and
empower individuals to take on greater responsibility for their health. Community Health Centres also create health promotion strategies and work together with schools, housing developments and in the workplace (56). Multidisciplinary teams at CHCs include physicians, nurses, nurse practitioners, counselors, community workers and dietitians (56). Target populations are those who are at higher risk for developing chronic diseases and those that have difficulty accessing primary health care due to barriers such as language, culture, physical disabilities, homelessness, poverty or geographic isolation (56). There are currently only 7 CHCs in the province with physiotherapy services.

**Designated Physiotherapy Clinics** provide rehabilitation which is covered under OHIP. Individuals qualify for these services if they are: 19 years of age or younger, 65 years of age or older, had an overnight stay in the hospital, and/ or receive benefits under the Ontario Disability Support Program or Family Works. There are 94 designated physiotherapy clinics across Ontario (57). **Private Physiotherapy Clinics** work on a fee for service basis. Individuals pay per for treatments needed, pay scales range depending on the clinic. There are a total of 969 private, fee-for-service clinics in Ontario (57). Since the partial de-listing of PT services most Designated Physiotherapy Clinics also have a private, fee for service component. **Multidisciplinary Health Corporations** are large multi-site corporations who provide multidisciplinary assessment and treatment services.

Although all participants recognized the value of incorporating PT into primary health care we found no current examples of PTs in Designated Physiotherapy Clinics or Private Physiotherapy Clinics involved in health promotion or prevention or chronic disease management programs such as falls prevention. The majority of PT clinics provide direct one to one treatment of patients with predominantly MSK disorders. Participants linked this to the current funding system.

> “Even in a Designated Physiotherapy Clinic the government doesn’t fund a physiotherapist to run a falls prevention program or a diabetes education program or to reactive groups that have obesity issues, mobility issues, things that are program-based or more public-based.”

### 4.2 Importance of PT in Primary Health Care and Chronic Disease Management

All participants agreed about the importance of incorporating PTs into FHTs to enhance primary health care and chronic disease management.

Physiotherapists have the potential to enhance chronic disease management programs through exercise prescription and health education. Participants saw the need and value of the addition of PTs to chronic disease management team.

> “You can prescribe all the medications in the world but that doesn’t address the root cause. It doesn’t address what’s really happening. It doesn’t really empower the patient to take control of their own health either. You can include physiotherapy in the health care team, and the whole area of physical therapy, it’s very easy to come in and treat the symptom but you don’t treat the root cause of
the symptom. What we’re thinking about is the whole prevention piece. Its how can you make them feel better now before five years from now when they come back with all these co-morbidities.”

Participants saw PTs as having an important prevention, treatment and education role in primary health care programs for conditions such as: diabetes, obesity, arthritis, osteoporosis, falls, chronic obstructive pulmonary disease (COPD), Parkinson’s disease and Multiple Sclerosis.

“I think there’s a real role for physiotherapy to be a part of that team especially with the high numbers of COPD that we have and there is no, other than private pay out-patients for the COPD patients. I think that would be invaluable… Having a physiotherapy assessment… we have what we call ‘drop-ins’ and they come in a variety of problems that need triage. And certainly, a physiotherapist, a highly industrial town, although the economy is kicking us right now but with forestry and mining so a lot of industrial accidents and we also have a lot of self-employed people too.”

“[With our obese patients] I’d like to be able to send them to physiotherapists so that they could have an exercise prescription that’s appropriate for them.”

“The prevention piece is why the FHTs were created in the first place. It’s to do the health promotion. It’s to do the chronic disease prevention and management. So in terms of actually having a practitioner that can actually come in at the beginning, there’s so much opportunity around that and that’s something that I think the whole team would get around”

The lack of physiotherapy currently in FHTs was identified as an issue by all participants that had an impact on the quality of care delivered to patients. For example, physicians reported relying on other means of treatment such a prescription of medications as alternative solutions to the lack of physiotherapy. They recognized the shortcomings of this approach but felt they had few options.

“I don’t end up giving a referral to physiotherapy because I know they [the patients] can’t afford it. And so what happens is, I end up giving them pain medication until the point where they can’t stand it and sometimes they end up going to surgery or end up in the Emerg department.”

“…when they hear rehab the first thing they think about is – that costs money; I’m not going to go that route; lets try medication first.”

“I’d like to be able to decrease the amount of drugs we’re giving to our patients, mobilize them through physiotherapy so they can achieve a more active level of movement and lifestyle.”

“NSAIDS are a fairly dangerous group of drugs and they’re way overused because we’re treating musculoskeletal problems that we don’t have any
better idea what to do for so we feel we’ve got to do something. So I think if we had alternatives we could significantly reduce the amount of NSAIDS and narcotics that are being prescribed…so not only the cost of the drugs is involved but the morbidity as a result of using those drugs is a huge issue both the effects on quality of life and the extra cost to the system.”

Participants reported that although physiotherapy is perceived as important, because access is so limited there is often a lack of understanding on the part of referring physicians and nurse practitioners as to what physiotherapy could accomplish.

“It’s something we don’t even have as much expertise as we should in terms of who can it help most, who are the most appropriate referrals. Who are the people who are missed referring because we don’t know enough about what they do to recognize the need or who are we referring that’s wasted referral because they don’t have much to offer them.”

4.3 Opportunities and Challenges for Models of Incorporating PT into FHTs

We examined the opportunities and challenges of three models for incorporating PTs into FHTs: embedded PT; PTs as a consultant; and, Advanced Practitioners. Currently the predominant model in Ontario is PT as Consultant where the FHT refers clients to existing physiotherapy clinics. The only current example of embedded PT is in CHCs. Most participants were unfamiliar with the Advanced Practitioner model except in the instances of orthopaedic surgery. Table 4 summarizes the opportunities and challenges of embedded PTs and PTs as consultants.

Table 4: Models of rehabilitation for PTs and their opportunities, challenges and potential solutions

<table>
<thead>
<tr>
<th>Model</th>
<th>Opportunities</th>
<th>Challenges</th>
<th>Potential Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Embedded PT</td>
<td>▪ Communication enhanced</td>
<td>▪ Difficult to Recruit</td>
<td>▪ Streaming</td>
</tr>
<tr>
<td>(Currently only in a small number of CHCs)</td>
<td>▪ PT part of team &amp; able to take on roles in Chronic Disease Management</td>
<td>▪ Salary/benefits are much lower than in other sectors</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ High job satisfaction and good quality of working life</td>
<td>▪ Costs of space, equipment</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>▪ Isolation of PT</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Providing public service to clients with extended health care</td>
<td></td>
</tr>
<tr>
<td>Refer to Physiotherapy Clinic</td>
<td>▪ Could already be initiated with patients with extended health care</td>
<td>▪ Access</td>
<td>▪ Rounds, electronic</td>
</tr>
<tr>
<td>(Most common model used)</td>
<td></td>
<td>▪ Healthcare</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>▪ Coverage</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>▪ Geography</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>▪ Communication between</td>
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</table>
4.4 Embedded PT model

Most participants agreed that the embedded PT was the ideal model but identified challenges to that model. Table 5 outlines the opportunities, challenges and some potential solutions that were discussed in the interviews.

<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Challenges</th>
<th>Potential Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• PT is full members of Interprofessional team – available for rounds, informal and formal consults, use in chronic disease management programs (e.g., Better Breathing, Falls Prevention)</td>
<td>• Providing public service to patients with Extended Health Care</td>
<td>• Streaming</td>
</tr>
<tr>
<td>• High job satisfaction and good quality of working life</td>
<td>• Difficult to recruit – salaries and benefits 25% lower than hospital/private sectors</td>
<td>• FHT may not need services of full time PT</td>
</tr>
</tbody>
</table>

**4.4.1 Opportunities**

One of the most important aspects of having an embedded PT is that PTs embedded in primary health care teams are full active members of the interdisciplinary team. There are several opportunities to communicate with other team members including: scheduling meetings and conferences; lead physicians and other members of the team often found themselves chatting with each other in the hall and relying on technological advancements such as skype, email, and telephone calls.

“We have clinical team meetings, too, where we get together once every couple of weeks. And we sit down and you have doctors at the table and dieticians and physios, and we can communicate and sometimes we have case studies or conferences and that.”

Having an embedded PT would help address issues of lack of knowledge about the role and contribution of physiotherapy in primary care.
“If you are dedicated to work with that team then you’re not only treating the patients but you’re increasing the knowledge and skills of the team.”

Most participants preferred an interactive, face-to-face process of communication, having case meetings, formal meetings at the start of the day, reviewing case loads or referrals, in addition to informal meetings as the day progresses in order to keep that link between team members. Being in the same facility as other team members helps bring everyone together for team meetings.

“I think the opportunity to collaborate and prioritize the waiting list and discuss the appropriate referrals and have input, two way input, into what’s happening with patients, that’s the main advantage to (the PT) being on site.”

4.4.2 Challenges

Salary and Reimbursement

Salary and Reimbursement differs dramatically between public and private sectors. CHCs with funding for a physiotherapist found it challenging to recruit new hires, since starting salaries are not competitive with the rest of health care sector. CHCs currently provide a salary 25% lower than the hospital and private sectors, somewhat balanced by quality of working life and professional job satisfaction. Starting salaries for physiotherapists in hospital settings are typically around $62K with benefits and pension plans. In the private sector, physiotherapists are either paid a competitive salary or make a percentage of their per hour billing. Fee for service can be up to $120 per hour in the private sector. Typically new grads start off on a salary and then after six months switch over to a percentage of billing or fee-for service basis. A new hire/recent graduate could earn up to 40% of their per hour billing whereas someone with more experience could earn up to 50%.

“It’s an issue for me, for everybody. Anybody that works in the community always makes less than what they make in the hospital and we have the added complication of having the hospital across the street from us. It’s always an issue.”

Physiotherapy Set Up Costs

Acquiring treatment space, equipment, and space to set up a PT clinic is a potential barrier to having an embedded PT. For example if a FHT implements a healthy lifestyles program; then physical activity space would have to be allocated for the program. Renting rooms and creating the physical space for programs that could be used by all health professionals; in addition to still being accessible to patients was an ongoing challenge for participants.

“Well, one of the big limitations for a lot of add-on services to family health teams is they don’t have the space for it, and when you don’t have the space the outreach often doesn’t connect or work as well. It’s a huge problem in other programs where they’re adding on mental health services or even nurse practitioners in some sites. There’s no place to
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“...accommodate them so the nurse practitioner is accommodated in an unused room at the hospital or the mental health team is squeezed in somewhere but it’s not in the same building as the primary care...”

In general, physiotherapy services require assessment/treatment/education spaces and treatment equipment such as tables and machines. Space and equipment costs vary depending on the case loads, geographic location and needs of the population served.

“Yeah, you can do a lot in that space [2,000-3,000 square feet] for sure. And it depends on the case load. It depends on who you’re seeing. Some of our clinics are small by nature because they don’t tend to see as much diversity. Our location at X for instance, it’s a primarily private based caseload so they have a really nice gym but not a lot space dedicated to that. They have lots of private rooms because that’s what suits the caseload, that’s what suits the patients best.”

Providing Public Service to Patients with Extended Health Care

Whereas lack of funding for PT is a major access issue for FHTs, CHCs with embedded PTs have the issue of providing in-house physiotherapy services to rostered clients who have extended health care coverage and could access a PT in the private sector. To address this, CHCs screen patients extended health coverage and stream them to the appropriate provider. If they do not have extended coverage then they are seen by the CHC physiotherapists; if they do have coverage then they are referred to private physiotherapy clinic. However even then there are challenges in that patients with extended healthcare benefits run the possibility of exceeding their benefits package. Many extended health care benefits programs have cut their reimbursements for rehabilitation costs dramatically in the past few years.

“It’s not that difficult to do, to roster, I mean to account for the number of patients you have coming in, the number with some version of extended healthcare and what the actual cost would be based upon the amount of physio time that’s there. And if there is extended health being paid for by the employer, it should be accessed. And once they reach the threshold where they no longer have coverage then it would slide over into being the responsibility of the FHT.”

4.5 Referring to Existing PT Services Model

Although most FHTs currently refer to existing physiotherapy services for their clients with extended health coverage, we found few examples of interdisciplinary collaboration in urban settings. However we did find many examples of existing partnerships in rural and remote settings.

“We provide space free of charge in our clinic for them (The Arthritis Society) to set up and to come in and see us. We also rent space to a private physio which makes it really great because of our central location and because of the other Allied Health Professionals that work with us, make it easier for the patients who have that kind of coverage or who can afford it to come in and to see us. In that respect we already have that contact.”

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Table 6: Partnering with existing physiotherapy resources: opportunities, barriers and potential solutions

<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Challenges</th>
<th>Potential Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• FHT does not have to recruit and supervise PTs professionally</td>
<td>• Differences in salaries and benefits between public and private purse</td>
<td>• Purchase services by salary, not fee for service</td>
</tr>
<tr>
<td>• FHT does not have to rent space, purchase PT equipment</td>
<td>• Using public money to purchase private services</td>
<td>• Already being done by Designated PT Clinics and Nursing homes, purchase services e.g. housekeeping</td>
</tr>
<tr>
<td>• Opportunity for PT clinics to raise profile in community</td>
<td>• Communication</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Access to electronic health record</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Most current PT clinics focused on one to one treatment, not primary health care</td>
<td></td>
</tr>
</tbody>
</table>

4.5.1 Opportunities

Although having an embedded PT is considered the ideal by many participants, referring to existing PT clinics was also seen to have benefits, particularly in urban centers where there are already numerous private PT clinics. Table 6 summarizes the opportunities, challenges and some potential solutions to FHTs partnering with existing PT services.

“I would rather partner with our physiotherapy department downstairs – they have the facility. We don’t have the physical equipment or the space and I’m not sure I need a full time physiotherapist.”

“But even with funding we really would like to be partnering with a provider who has the personnel and the knowledge and the skills and expertise at running a program, and would like to link it to other rehab services.”

Some FHT participants were not anxious to take on the responsibility of recruiting, hiring and supervising PTs. They would prefer to purchase services from existing physiotherapy clinics. Further, by partnering with existing services the FHT does not have to incur rental costs for physiotherapy treatment space or equipment costs.

Most of the existing physiotherapy providers that we interviewed were very interested in developing partnerships and collaborations with FHTs.

“I think there would be a lot of therapists and clinics that would be really open to that...I don’t think it would appeal to all the therapists but I know that in each clinic there would be some that would enthusiastically say, ‘Absolutely’. Because that would give them that bridge to keep contact with the public sector and the public system if working in the hospital doesn’t quite work for you. I like the atmosphere of a private clinic. To me it could create a very appealing balance.”
Some Private PT Clinics have already been in discussions with their local FHTs and begun developing business plans.

4.5.2 Challenges

**Differences in Reimbursement Between Public and Private Purse**

One of the main challenges to FHTs partnering with existing physiotherapy services is the difference in salaries and benefits between the public and private sectors and the amount the public purse is prepared to reimburse for physiotherapy treatment. For example, current OHIP rates for Designated Physiotherapy Clinics are only $13 per treatment. In contrast, WSIB reimburses at $25 per treatment and in the insurance industry the accepted hourly rate is $90 per hour. Rates vary within private PT clinics.

“The initial assessment which is typically a half hour, maybe 45 minutes, is anywhere from about $65 and the highest could be around $85. In certain areas of Toronto it could be higher. And then as far as a 15 minute visit for treatment I think $45 is the lowest and it goes up to $55.”

In addition to salary and benefits costs, physiotherapy clinics also have differing costs with respect to rent and access.

“My clinic is incredibly expensive to run because we’re in a medical building. The rent we pay here is exorbitant. I can open up in a strip mall for a quarter of the rent but that’s not where I choose to practice…the other problem we have is the parking. But the bottom line is those are all costs that are going to vary from clinic to clinic so finding out what is the absolute bare minimum is virtually impossible.”

“Generally speaking we’ve gone to clinics between the two and three thousand square foot range, because the cost of doing business is increasing each year.”

“…I don’t want to make this thing so expensive that we don’t go ahead and do, I’ll be honest with you. But at the same time I don’t want to short change ourselves and the time we are going to devote to the program.”

“We can’t be giving our services away for nothing. There’s some pro bono that we do but it can’t all be pro bono.”

Most agree that given the differences between the public and private purse that a salaried, rather than a fee for service model would work best.

“Our physios will see anywhere from two to three, sometimes four patients an hour…depending on the nature of the clinic. It’s complex and there’s a certain amount of time that’s built in for communication, team meetings, but I would say that a reasonable salaried model would probably work.”
Purchasing Private Services with Public Funds

One FHT raised concerns about purchasing services from private companies with public funds. However, most others felt there were already many examples in the system of where this was occurring already.

“The OMA and physicians have worked so hard for many, many years to maintain physicians as independent entrepreneurs within their own practice, so independent private practice with public funding. So there’s no real difference in what we are talking about here because physicians continue to maintain their own corporations and their own practices even within the family practice piece.”

“If you look at the model in Home Care you have public funds, public service and all of it is contracted to the private sector.”

“We’re seeing it even more so in hospitals now with contracting out of services to the private sector to come in and provide services within the public. The Canada Health Act only asks that it’s publicly administered, it doesn’t have to be publicly delivered. So public/private partnerships in the case of Family Health Teams, it’s a system that just lends itself to the concept of examining what services you need and purchasing those services for volume in a contract.”

“We’d purchase their services, just like I do with the cleaning service or my bookkeeping service.”

4.6 Lack of Access to Physical Therapy for many Ontarians

All participants believe that accessing physiotherapy services for patients is an ongoing challenge. Major issues are extended health care plans (or lack there of) and the geographic accessibility of physiotherapy services.

Lack of Funding for Community PT

The main unresolved issue continues to be funding for those Ontarians who do not qualify for Designated Physiotherapy Clinics (Patients requiring physiotherapy services over the age 65 and under the age of 19 are covered by OHIP in Designated Physiotherapy Clinics) or do not have extended health care coverage.

“There’s a cost to the patient if the patient wants to have physiotherapy. Some people don’t have very good plans. Some people do. So that does limit people’s access to physiotherapy. The people who are out of a job, there are moms who aren’t working that are at home, their husbands may not have a great benefit package, there are a lot of self-employed people, they don’t tend to have any benefit packages and their families don’t have any benefit packages. So their accessibility to physiotherapy is very limited. So that’s a huge barrier.”
“I’d say 50 percent of the population in our area have no funding at all and another 50 percent have some version of funding and they’re quite limited most often between two and five hundred dollars. That gets eaten up really quickly.”

“And they may only have $500 coverage and you know we need 12 weeks (of treatment), you try to spread it out but they can’t afford it and you end up trying to find creative ways of getting them to get better. But at the end of the day, 500 bucks is like 9 treatments.”

“The insurance companies used to have different funding envelopes so everybody had $1,000 so if you’re seeing a chiropractor, you’d see a physio, a massage therapist, $1,000 a piece. Now they meshed it all to one envelope and said you’ve got $1,000 for any of these disciplines but you only have $1,000 for any of them. Now they’ve got to pick so the physios are not going to refer to massage anymore because we’re competing for the same funding source.”

**Geographic Access to Physiotherapy Services**

Geographic access is also a barrier to accessing existing physiotherapy services, particularly in rural areas. Several community hospital outpatient clinics have closed, and those that remain have extensive waiting lists or restricted access.

“I don’t know what hospitals have outpatient physios anymore – none. And where they are they’re really restricted and only accepting people from their own surgeons.”

In rural communities, medical centers with physiotherapy services can be as far as 100 kilometers away from the FHT. Accessing the physiotherapist would require driving, requesting home service or taking a cab.

“…we do have access to physiotherapy. It’s not that close. The nearest large community is X, which is about 25 kilometres from our site. So really, at this point, patients generally have to either travel or try to make arrangements for in-home visits, which some of them do receive from the physiotherapist. We can’t, we’re not able to offer those services on our site, because we don’t have funding from the Ministry for physiotherapy and don’t really have the space to be able to have someone come in and provide it for us.”

“… transportation is often an issue for these patients because if they’re, obviously if they need physiotherapy service, they’re probably having difficulty with mobility and most likely would not be able to withstand the drive to and from a physiotherapy appointment…”

Furthermore, even if they do manage to see a PT, patients in rural areas often find it difficult to follow up on exercise prescription.

“…one of the barriers too is with these physiotherapy clinics, they often have specialized equipment within their clinics. And often what they do is
they instruct patients on how to use the equipment and then they advise them to go home to their nearest health club and carry though with the exercises. But in our area, we really don’t have anything like that...don’t have much in the way of recreational facilities in our area, especially in the winter time.”

4.7 Communication as a Barrier

One of the major perceived drawbacks to referring to existing physiotherapy services is the challenges for interdisciplinary communication. In contrast to the embedded PT, communication between providers in different locations working for different organizations is challenging. Most participants agreed that currently there is little direct communication between FHTs and local physiotherapy clinics.

“So, somehow you have to work the communication if you’re not physically in the same location some way of truly making it a multidisciplinary approach to patient care… it has to be feasible and you can’t uproot everybody and build a new building, so, yeah, you have to do something as to how you’re going to make that work, whether there’s some time set aside for communication. Maybe great email connections, reliable they’re going to read. Certain times for telephone conversations as needed…”

The Electronic Health Record was seen as an important tool to facilitating interdisciplinary communication within the FHT.

“They’re all documenting on the same chart. And you know what, we all have lunch together; we’re small, we’re collocated so we’re really lucky in that way.”

Some participants were unsure about the feasibility of access for PTs in a different organization whereas others saw no difficulties.

“So what the physio does is they could just dial into the hospital website, key code in their access number and get in through there. We could have that set up tomorrow. The whole thing is the patient confidentiality thing, remember the patient’s the one that owns their data, we’re the custodians of it. If they agree that our physiotherapist can have access to it, just like they agree that the social worker or dietician can, it’s all part of their circle of care.”

Preferred Provider Status

Many participants discussed the issue of preferred provider status should FHTs choose to purchase services from existing PT clinics. All felt that there are current models that could be used to help develop guidelines for Preferred PT Providers.

“But you want to have 150 clinics all doing this service for you and how do you actually control that? ...I actually worked on a team that created a
preferred provider network and that was one of the things we took on. You just can’t have everybody on the list, as much as you’d love to.”

“On the insurance company preferred provider programme, we were all audited. We had to go through an accreditation process…so anyone that was going to be working with this insurance company as a preferred provider had to be audited.”

“But by referring to them then we’re making the assumption that it’s a preferential vendor and we like their services and we like what they’re doing and as a patient you should go there because of that. And that’s a dangerous thing to be saying to anybody and that always worries me, just the whole vendor of choice. Just because by sheer geography you’re the only game in town doesn’t necessarily mean you’re the best game in town.”

“There’s plenty of examples of RFPs for physiotherapy in rehab services…the CCACs would be a good example of that although their RFP process is quite arduous…but what you’re really purchasing are the outcomes and services.”

5.0 Discussion and Recommendations

The objective of this work was to identify the appropriateness and feasibility of various models of integrating PTs into FHTs, identify opportunities and challenges for implementing each of those models in various settings, and to develop policy recommendations to address these barriers or challenges. Our findings indicate that there are many opportunities for integrating physiotherapy into FHTs using either the embedded PT or refer to existing physiotherapy services models. The major challenge remains the lack of access to physiotherapy services outside of hospitals due to the lack of public funding.

5.1 Integrating Physiotherapists

Many participants saw the value of adding a PT to their centre, but challenges around funding and reimbursement prevented FHTs moving forward in this area. McColl et al (2006) state that the team approach has a number of advantages, including offering different types and degrees of expertise to patients, and generally offering more services and more perspectives on the problems patients face. This was portrayed in our interviews; participants that partnered with or hired a PT reported better chronic disease management care and education to the community. Embedded PTs were seen as key to building strong rapport between the health care team and patients. Inter-professional trust is essential to the success of collaborative care relationships and this type of relationship takes time and patience, as well as faith in the notion that the potential payoff is real and worthwhile (53). However, participants identified issues which meant that hiring their own PT may not be feasible with barriers such as set up costs, including equipment and physical space and funding. As an alternative, FHTs are considering creating partnerships with nearby existing physiotherapy clinics. Such solutions are
feasible in urban environments where there are a growing number of rehabilitation clinics and many participants believed that creating partnerships would be a step in creating a more efficient health care system. Even under the current funding system there are many opportunities to improve interdisciplinary collaboration between existing PT clinics and FHTs. Main concerns around establishing these partnerships for patients without extended health care surrounded reimbursement and issues around how physiotherapy hours would be purchased from clinics. Advanced practitioners are not commonly used in FHTs and few participants had heard of this model.

5.2 Challenges and Opportunities for Implementing Models

Funding physical therapy services outside of the hospital sector was the major challenge identified by both FHTs and PTs. Most of the success integrating physiotherapy into primary health care in Ontario has been found in the CHCs, where all services providers are paid by salary, and the decision to include allied health professionals in the practice does not negatively impact the physician’s income (53). Currently FHTs cannot offer physiotherapy as part of their circle of collaborative care, which has resulted in the lack of an important team member for primary health care and chronic disease management. Although an embedded PT is considered ideal, creating partnerships with existing health organizations and private clinics have in order to bridge the access gap is also a possibility should FHTs receive approval for funding for physiotherapy services. Although these partnerships have the potential to be created, strategies around reimbursing physiotherapists are still an issue given the large discrepancy between salaries through the public versus the private sector. Cut backs and scarce resources have encouraged providers to compete with one another for resources, making it difficult to share expertise, decision-making or authority (53). Related to funding are challenges around acquiring space and equipment that are difficult to come by in environments that were not originally set up for physical therapy. Access was another common concern among rural participants due to the lack of physiotherapy clinics outside of urban areas. These inequalities reinforce a two-tiered health care system. It has been suggested that access to rehabilitation services through FHTs would overcome the regrettable inequity that has arisen in years, where the only people who can access community rehabilitation services are those who can pay, or those who have private insurance (53).

Table 7: Summary of Challenges and opportunities for rehabilitation in primary care models

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Embedded Physiotherapy teams</td>
<td>• Doesn’t always ensure the best quality of care, some prefer sending patients to a clinic • Physiotherapists work in isolation • Poor reimbursement structures results in difficulty in recruiting new hires</td>
</tr>
<tr>
<td>Physiotherapists as Consultants</td>
<td>• Difficulty communicating back to physicians • Fee-for-service creates great</td>
</tr>
<tr>
<td>Challenges</td>
<td>Opportunities</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------</td>
</tr>
<tr>
<td>accessibility barriers for those without extended health care coverage</td>
<td>• Provide comprehensive rehabilitation care</td>
</tr>
<tr>
<td>• Not easily accessible in rural areas</td>
<td>• Have the ability to educate and provide chronic disease management programs</td>
</tr>
<tr>
<td>Advanced Practitioner</td>
<td>• Can alleviate some of the workload off physicians</td>
</tr>
<tr>
<td>• Not well known in Ontario</td>
<td></td>
</tr>
<tr>
<td>• Sometimes unclear how advance practitioners would partner with FHTs</td>
<td></td>
</tr>
</tbody>
</table>

### 5.3 Policy Recommendations

Each model for physiotherapist in primary care provides several opportunities and barriers in order to provide a greater scope in health care services. However, there is not one specific model or variation of a model that can be generalized for every FHT or CHC. This is primarily due to the geographical variation of rehabilitation services. For example, in urban communities there are several private rehabilitation communities in contrast to rural centres where some clinics can be spread apart by great distances. When using a model of rehabilitation, the surrounding environment of the community must be taken into full consideration to make efficient use of existing health resources.

Ontario has taken a well-informed decision to widen the primary care network in the province. However, despite the intent to provide a fully integrated primary care environment, FHT appear to have structural restrictions that limited the provision of services such as physiotherapy. This has created an important gap in timely and effective service delivery for individuals with chronic disease. Given that the prevalence of chronic disease is rising in the province, and given that the application of physiotherapy services for these individuals allows them to manage their condition in the community, we identify a imbalance between the demand (i.e. chronic disease management) and supply (i.e. access to physiotherapy services) which will have an effect at the client and overall health system levels.

The limited provision of PT in FHT forces individuals to either access publicly-funded PT services elsewhere, or to purchase them privately (either out-of-pocket or through third party insurance). The profile of the majority of individuals with chronic disease generally precludes them from the latter, and forces them to the first approach which is to attempt to access services elsewhere. Unfortunately, as identified in this study, the availability of such publicly-funded services is diminishing. The effect of limited access for individuals with chronic care may be circular in that lack of access to physiotherapy at specific points along the disease trajectory aggregates the conditions to a point where high-cost institutional care (which is fully publicly-funded) is medically necessary.

The lack of access to physiotherapy services also alters best practice. As reported in this study, knowing that individuals cannot, or will not be, able to access public or privately funded physiotherapy services increases the utilization of prescription medication to manage the condition. Not only is this outcome less than ideal practice because it is a way in which to deal with the acute symptoms, it is extremely costly to the public system in the long term.
Our research has identified the opportunities and challenges of different models of providing physiotherapy services within the context of the innovative FHTs. However, each of these requires shifting scarce resources. Allocation of resources is driven by values and interests among the stakeholder who stand to gain (or lose) from the outcome. The stewardship of the MOH-LTC is significant the structural adjustment that is required to improve access to PT within the FHTs.
6.0 References


Appendix A: Mapping Study

LHIN 1: Erie St. Clair
Percentage of Total Population Age 65 and Over by Dissemination Area and Distribution of Public and Private Physiotherapy Clinics

Date: August 2, 2009
Projection: NAD 1983 Datum, UTM Zone 17 N

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Integrating Physiotherapists into Family Health Teams in Ontario 29
April 2009
Integrating Physiotherapists into Family Health Teams in Ontario
April 2009
Appendix B: Participant interview package

Integrating Physiotherapy Services Into Family Health Teams in Ontario: Opportunities and Barriers

Dear <Participant Name>,

The Arthritis Research and Evaluation Unit, University Health Network has been funded by the Ontario Ministry of Health and Long-Term Care through the Health System Linked Research Unit grant to work together with you to discuss the potential for integrating Physiotherapy (PT) services into Family Health Teams (FHTs) and Community Health Centres (CHCs).

Several factors including, an aging population, an increase in the prevalence of chronic diseases, and a shift in the delivery of health care from hospital to the community are placing increased demands on Ontario’s primary health care system. Primary care is the first level of contact in the health system and has an important role in the ongoing management of persons with musculoskeletal disorders, which is the second most common reason for visits to primary care physicians. In particular, it has been suggested that offering rehabilitation services at the primary health care level could result in several positive outcomes including lower costs than for services offered at hospitals or large health care clinics, shorter travel time for patients, and greater continuity of care for people with disabilities.

As an informed professional we will be inviting you to take part in a key informant interview to better understand how to integrate rehabilitation services into primary care. Topics of discussion are as follows:

- FHT/CHC current structures and processes;
- Utilization and access of services;
- Plans for integrating physiotherapy into current FHTs/CHCs;
- Barriers and opportunities for integrating models of physiotherapy into FHTs/CHCs.

The results of the key informant interviews will be used to help guide the development of the questionnaire for this study. You will be asked to review the questionnaire and make suggestions for revisions with respect to the clarity and scope of the questions. If you are interested in participating in this study, please contact Shilpa Mandoda to arrange an interview time.

Yours respectfully,

Dr. Cheryl Cott, Ph.D.
Deputy Director, Arthritis Research and Evaluation Unit, University Health Network
416.603.5800 ext 3176
chery.cott@utoronto.ca
INFORMED CONSENT TO PARTICIPATE IN A RESEARCH STUDY
Integrating Physiotherapy Services Into Family Health Teams in Ontario:
Opportunities and Barriers
Principal Investigator: Dr. Cheryl Cott Ph.D., Arthritis Community Research &
Evaluation Unit (ACREU), University Health Network
This study is funded by the Ministry of Health and Long-Term Care

INFORMED CONSENT
You are being asked to consider participating in a research study. This form explains the purpose of this research study, provides information about the initiative, the process involved, possible risks and benefits, and your rights as a participant.

Please read this form carefully and ask any questions you may have. You may take as much time as you wish to decide whether or not to participate. Please contact project team members whose names are above to clarify anything you do not understand or would like to know more about. Make sure all your questions are answered to your satisfaction before deciding whether to participate in this research study.

INTRODUCTION
Several factors including, an aging population, an increase in the prevalence of chronic diseases, and a shift in the delivery of health care from hospital to the community are placing increased demands on Ontario’s primary health care system. Primary care is the first level of contact in the health system and has an important role in the ongoing management of persons with musculoskeletal disorders, which is the second most common reason for visits to primary care physicians. Family physicians play a major role in the coordination and provision of primary health care services and, more recently, nurse practitioners have started to play a significant role. Physiotherapists (PTs) are key members of the interdisciplinary health care team and can be an important resource for primary health care physicians and nurse practitioners. In particular, it has been suggested that offering rehabilitation services at the primary health care level could result in several positive outcomes including lower costs than for services offered at hospitals or large health care clinics, shorter travel time for patients, and greater continuity of care for people with disabilities.

Rehabilitation therapists are the key to the successful and efficient management of chronic conditions such as musculoskeletal conditions through strategies such as supporting self-management and behaviour change. This role for rehabilitation therapists is likely to become of increasing importance in the face of an increasing prevalence of arthritis and other chronic diseases associated with aging, putting pressure on the resources of primary care physicians.
WHY IS THIS STUDY BEING DONE?
The aging population, increased prevalence of chronic disease, and the transfer of care from inpatient to community-based settings underscore the need to better understand how to integrate rehabilitation services into primary care. This research will significantly contribute to policy decisions and organization of service delivery within Family Health Teams (FHTs) and Community Health Centres (CHCs) so as to make best use of resources and ensure that clients are seen by the most appropriate clinician at the best place and at the best time.

WHAT WILL HAPPEN DURING THIS STUDY?
We will use a three phase approach to achieve our objectives including:
1) mapping of current FHTs/CHCs; 2) key informant interviews; and 3) survey FHTs/CHCs.

HOW MANY PEOPLE WILL TAKE PART IN THE STUDY?
It is anticipated that the project will include 15 key informants interviews (Phase 2) that will steer the development of the survey, and approximately 115 FHTs/CHCs will be recruited for Phase 3.

WHAT ARE THE RESPONSIBILITIES OF STUDY PARTICIPANTS?
If you decide to participate in this study you will be asked to do the following:

* Take part in a key informant interview (approximately 1 hour). Questions will be designed to gather information about current structures, processes and funding in FHTs/CHCs in Ontario, plans and policies with respect to integrating physiotherapy services into FHTs/CHCs, perceived opportunities and barriers to integrating physiotherapy services. The interviews will last approximately one hour. Each interview will be taped and transcribed verbatim by a professional transcription service.

* Review and provide feedback of the anticipated survey for Phase 3. The results of the key informant interviews will be used to help guide the development of the questionnaires for Phase 3 of the study. Key informants will be asked to review the questionnaire and make suggestions for revisions with respect to the clarity and scope of the questions and ease of completion of the questionnaire.
WHAT ARE THE RISKS OR HARMS OF PARTICIPATING IN THIS STUDY?
There are no known risks to participating in this study.

WHAT ARE THE BENEFITS OF PARTICIPATING IN THIS STUDY?
As a result of participation in this project you and your team will have:

CAN PARTICIPATION END EARLY?
You can choose to end your participation at any time.

WHAT ARE THE COSTS OF PARTICIPATING IN THIS STUDY?
Participating in this study will not result in added costs to you.

ARE STUDY PARTICIPANTS PAID TO PARTICIPATE IN THIS STUDY?
You will not be paid to participate in this study.

DO THE INVESTIGATOR(S) HAVE ANY CONFLICTS OF INTEREST?
The investigators do not have any conflicts of interest with regards to this study.

WHAT ARE YOUR RIGHTS AS A RESEARCH STUDY PARTICIPANT?
All participants in a research study have the following rights:

1. You have the right to have this form and all information concerning this study explained to you and if you wish translated into your preferred language.

   Participating in this study is your choice (voluntary). You have the right to refuse to participate, or to stop participating in this study at any time without having to provide a reason. If you choose to withdraw, it will not have any effect on your present or future status at your primary health care facility.

   You have the right to receive all significant information that could help you make a decision about participating in this study. You also have the right to ask questions about this study and your rights as a research participant, and to have them answered to your satisfaction, before you make any decision. You also have the right to ask questions and to receive answers throughout this study. If you have any questions about this study you may contact the person in charge of this study Dr. Cheryl Cott at (416) 603-5800 ext 3176.

2. If you have questions about your rights as a research participant or any ethical issues related to this study that you wish to discuss with someone not directly involved with the study, you may contact Ronald Heslegrave, Ph. D., Chair of the University Health Network Research Ethics Board (REB) or the Research Ethics office number at 416-946-4438. The REB is a group of people who oversee the ethical conduct of research studies. These people are not part of the study team. Everything that you discuss will be kept confidential.
3. By signing the project consent form, you do not give up any of your legal rights.

4. You have the right to receive a copy of this signed and dated informed consent package before participating in this study.

5. You have the right to be told about any new information that might reasonably affect your willingness to continue to participate in this study as soon as the information becomes available to the study staff. This may include new information about the risks and benefits of being a participant in this study.

6. Any of your personal information collected or obtained will be kept confidential and protected to the fullest extent of the law. All personal information collected will be kept in a secure location. Providers will be identified with a study identification number only. While we will do our best to protect your information there is no guarantee that we will be able to do so. No identifying information will be used in any publication or presentations. The study staff and The University Health Network Ethics Board will have access to your information for purposes associated with the study, but will only be allowed to access under the supervision of the Principal Investigator and will be obligated to protect your privacy and not disclose your personal information.

7. The paper surveys will be stored in a secure office within a locked cabinet. All electronic data arising from the study will be stored on a secure server and be accessible only to project staff. In addition, all hard copies of data (i.e., field notes) and audiotapes will be kept in a locked filing cabinet at the ACREU offices and will be accessed only by the research staff involved with the study. The data file for analyses will not include any identifiers that could be linked to a participant. All identifying information will be destroyed after five years. Audiotapes and field note data will be destroyed five years following the completion of the study.

8. The researchers intend to publish the findings from this study in peer reviewed journals and present the findings at conferences, your identity will not be disclosed. The researchers may plan to conduct secondary analyses of the data, however a separate ethics submission will be made at a later date with respect to this.

9. You have the right to be informed of the results of this study once the entire study is complete.
DOCUMENTATION OF INFORMED CONSENT

Full Study Title: Integrating Physiotherapy Services Into Family Health Teams in Ontario: Opportunities and Barriers

Participant/Nominated Facilitator
By signing this form, I confirm that:
• This research study has been fully explained to me and all of my questions answered to my satisfaction
• I understand the requirements of participating in this research study
• I have been informed of the risks and benefits, if any, of participating in this research study
• I have been informed of any alternatives to participating in this research study
• I have been informed of the rights of research participants
• I have read each page of this form
• I authorize access to my research study data as explained in this form
• I have agreed to participate in this study
• I will receive a signed copy of this form

__________________________________________  ____________________________  ______________
Name of participant/ Nominated facilitator (print)  Signature  Date

__________________________________________  ____________________________  ______________
Name of Investigator/ Delegate (print)  Signature of Investigator/ Delegate  Date