Models of Integrating Physical Therapists into Family Health Teams in Ontario, Canada: Challenges and Opportunities

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ABSTRACT

Purpose: To explore the potential for different models of incorporating physical therapy (PT) services within the emerging network of family health teams (FHTs) in Ontario and to identify challenges and opportunities of each model.

Methods: A two-phase mixed-methods qualitative descriptive approach was used. First, FHTs were mapped in relation to existing community-based PT practices. Second, semi-structured key-informant interviews were conducted with representatives from urban and rural FHTs and from a variety of community-based PT practices. Interviews were digitally recorded, transcribed verbatim, and analyzed using a categorizing/editing approach.

Results: Most participants agreed that the ideal model involves embedding physical therapists directly into FHTs; in some situations, however, partnering with an existing external PT provider may be more feasible and sustainable. Access and funding remain the key issues, regardless of the model adopted.

Conclusion: Although there are differences across the urban/rural divide, there exist opportunities to enhance and optimize existing delivery models so as to improve client access and address emerging demand for community-based PT services.

Key Words: chronic disease, physical therapy, primary care

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RÉSUMÉ

Objectif : Explorer les effets potentiels des divers modèles d'inclusion des services de physiothérapie (PT) dans le réseau émergent des équipes de santé familiale (ESF) de l'Ontario et identifier les défis et les possibilités offertes pour chaque modèle.

Méthode : Une démarche qualitative descriptive à méthodes mixtes en deux étapes a été utilisée. Tout d'abord, on a identifié les ESF déjà dotées de pratiques en physiothérapie dans la communauté. Ensuite, des entrevues semi-structurées avec des intervenants principaux ont été menées auprès de représentants d'ESF en milieu rural et urbain, et de représentants de diverses pratiques de physiothérapie en mode communautaire. Les entrevues réalisées ont été enregistrées en mode numérique, transcrites, puis analysées par catégorisation et édition.

Résultats : La plupart des participants ont convenu que dans un modèle idéal, le physiothérapeute fait directement partie des ESF. Dans certaines circonstances, toutefois, le fait de pouvoir compter sur un physiothérapeute partenaire pour ces équipes est plus envisageable et davantage viable. L'accès à un financement pour ce faire demeure l'un des grands problèmes, sans égard au modèle.

Conclusion : Même s'il y a des différences entre la pratique en milieu rural et celle en milieu urbain, il est possible d'améliorer et d'optimiser les modèles de prestation de soins en vue de faciliter l'accès pour les clients et de faire face à la demande émergente pour des services de physiothérapie en santé communautaire.

Mots clés : maladie chronique, physiothérapie, soins primaires

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INTRODUCTION

Several factors, including an ageing population, increasing prevalence of chronic diseases, and a shift in the locus of health care delivery from the hospital to the community, are placing increased demands on Canada's primary-care systems.¹⁻³ Primary care is the first level of contact in the health system,⁴ and it plays an important role in the ongoing management of persons with musculoskeletal disorders, which are the second most common reason for visits to primary-care physicians.⁵ Family physicians and, more recently, nurse practitioners play a major role in the coordination and provision of primary-care services in the province of Ontario.⁶⁻⁹

Physical therapists are an important resource for primary-care physicians and nurse practitioners, especially in managing chronic and episodic disease.¹⁰ Moreover, establishing physical therapy (PT) services in primary-care settings has been reported to yield several positive system outcomes, including high levels of client satisfaction;^{5,10,11} decreased wait times;¹¹⁻¹⁴ increased cost-effectiveness relative to hospital-based services;^{5,12,13,15} reduced rates of referral to specialists;¹⁶ and improved patient-related outcomes such as quality of life, exercise tolerance, and health status.^{5,10,11,17} PT services in primary-care settings are particularly important in treating chronic conditions such as arthritis, chronic low back pain, and pulmonary disease.^{5,10,17-19} Available evidence suggests that most patients seen by physical therapists in primary-care settings are elderly¹¹ and suffer from chronic musculoskeletal disorders such as osteoarthritis and rheumatoid arthritis.^{11,20}

Community-based PT services are available throughout Ontario in both public and private health care sectors. However, since the partial de-listing of community-based publicly funded PT services in 2005, an increasing proportion of community-based PT services is delivered through the approximately 1,500 private for-profit clinics that exist in Ontario.^{21,22} Despite the growth in the private for-profit sector, publicly funded community-based PT services continue to be available in four settings across Ontario: (1) hospital outpatient (OP) departments that have maintained ambulatory rehabilitation services; (2) the network of approximately 90 designated physical therapy centres that provide publicly funded services to seniors, youth, and other categories of eligible clients; (3) a small number of community health centres (CHCs); and (4) publicly funded home care PT services through community care access centres (CCACs). Each of these delivery settings has experienced important changes as a result of the waves of provincial health reforms within the last decade, which have diminished, or to some degree eroded, overall access to publicly funded community-based PT services.^{3,23}

As part of ongoing provincial health restructuring geared toward improving access, Ontario has recently

introduced a new model of primary care delivery through the establishment of family health teams (FHTs). According to Ontario's Ministry of Health and Long-Term Care (MOHLTC), FHTs will focus "on ensuring that people have access to health care in their community virtually around the clock, which should also help to relieve the reliance on emergency departments for non-emergency care."²⁴ Moreover, the provider team practising in FHTs will be composed of

a team of family physicians, nurse practitioners, registered nurses, social workers, dietitians, and other professionals who will work together to provide health care for their community. Family Health Teams provide more service and a wide range of health options, especially for people who don't have a doctor. Family Health Teams ensure that people receive the care they need in their communities, as each team is set-up based on local health and community needs. They focus on chronic disease management, disease prevention and health promotion, and work with other health care organizations, such as public health units.²⁴

Notwithstanding the MOHLTC's statement, the clinical staff of FHTs currently consists primarily of physicians, nurses, nurse practitioners, pharmacists, social workers, and dietitians.²⁵ At the time of this study, no rehabilitation professionals were employed by FHTs. Numerous FHTs have applied for funding for PT, but none have been successful in receiving budget approval from the MOHLTC (see McColl et al.²⁶ for specific information). At the time of our study, 30 physiotherapists were employed by CHCs²⁷ that deliver preventive health measures such as health and wellness programs. According to the MOHLTC, CHCs were created to

work with individuals, families and communities to strengthen their capacity to take more responsibility for their health and well-being. They provide education and advice on helping families access the resources they need from other community agencies. CHCs work together with others on health promotion initiatives within schools, in housing developments, and in the workplace. They link families with support and self-help groups that offer peer education, support in coping, or are working to address conditions that affect health. As such, the Community Health Centre Program contributes to the development of healthy communities.²⁸

Because physical therapists can have an important impact on people living with chronic disease in the community, and because the recently implemented FHTs focus on chronic disease management, the successful integration of physical therapists into these community settings would seem to be critical to the future of primary health services in Ontario.

The purpose of this study is to explore potential models of incorporating PT within the emerging network of FHTs in Ontario. Our specific objectives are (1) to

identify the appropriateness and feasibility of various models of integrating PT services into FHTs, (2) to identify opportunities and challenges related to the implementation of each model in various settings, and (3) to identify policy issues that arise from the identified barriers and challenges.

REVIEW OF THE LITERATURE

Two main models for incorporating rehabilitation professionals into primary health care are currently identified in the literature: (1) rehabilitation services embedded in primary-care settings and (2) rehabilitation services as an off-site resource.

1. Rehabilitation Services Embedded in Primary-Care Settings

In this model, rehabilitation professionals are practising in primary-care settings with family physicians. This model is more common in the United Kingdom, where there is a trend toward shifting rehabilitation services from secondary-care locations, such as hospital outpatient departments, to primary-care sites, such as family physician practices and health centres.^{5,10–14,16,17,29} In Ontario, a small number of rehabilitation professionals work together with physicians and nurse practitioners in CHCs, but this model is the exception rather than the rule.¹⁵

An ideal model of rehabilitation in primary care would include rehabilitation professionals (e.g., physical therapists) 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 would be located in primary-care sites such as health centres or family physicians' offices, or in the home or workplace, and would provide services focused on helping people with chronic conditions to manage their disabilities across the trajectory of the condition. This would ensure continuity of care and appropriate referral to specialized programs located in secondary-care sites if needed.^{4,30}

2. Rehabilitation Services as a Resource for Primary-Care Physicians

In this model, rehabilitation professionals are not located in physician practices; instead, physicians refer clients to existing private practices or outpatient clinics. At present, this is the model most commonly in use in Ontario. In general, the literature suggests that primary-care physicians under-use rehabilitation services, particularly in the care of the elderly and those with chronic conditions.^{31–34} For example, a mail survey of a random sample of family physicians in Ontario indicated that primary-care physicians do not refer patients with arthritis to rehabilitation therapists as often as optimal guidelines recommend because they feel it is too difficult for

patients to access these services.³¹ In another survey, 68% of general practitioners surveyed reported feeling that waiting lists for PT are too long.³⁵ Many respondents believed that poor access to resources such as physical therapists lead to inappropriate use of painkillers in treating musculoskeletal conditions.³⁵ Similarly, a more recent survey of family physicians in Ontario found that physicians consider wait times for publicly funded PT too long and private PT services too expensive.¹⁵

Based on the literature and on our previous work in this area, we expect that different integrative models will be appropriate (and feasible) depending on the current availability of publicly and privately funded PT clinics in proximity to particular FHTs. In a previous study, we mapped the locations of all PT clinics (designated PT clinics, hospital OP department clinics, and private PT clinics) by Local Health Integration Network (LHIN).³⁶ From this research, we know that there is considerable jurisdictional variation in terms of access to and availability of primary-care PT services and that, therefore, models of integrating PT into FHTs may vary, particularly between rural and urban regions.

METHODS

We used a two-phase, multi-methods qualitative descriptive approach to achieve our objectives, beginning with mapping of current FHTs in relation to community-based PT clinics, followed by in-depth, qualitative interviews of key informants from FHTs and existing community-based PT services. There is a long tradition of description in qualitative research; according to Sandelowski, the goal of qualitative descriptive studies is not to develop theory but to summarize everyday events by “staying close to the data and to the surface of words and events.”^{37(p.336)}

Phase 1: Mapping of Current FHTs in Relation to Community-Based PT Clinics

The purpose of Phase 1 was to identify the geographic locations of all FHTs in relation to community-based PT services by LHIN, in order to (1) describe the current situation in Ontario and (2) create a sampling frame for the FHT key-informant interviews. Geographic information systems (GIS) software (ArcMap v. 9.1, ESRI Inc., Redlands, CA) was used for this phase of the analysis. GIS software, initially developed by geographers and increasingly used in health research,^{38–40} allows geographically referenced locations (e.g., streets, postal codes, geographic coordinates) to be linked through a system that manages, analyzes, and displays the data in the form of maps, allowing for higher-level analysis. *Geocoding* is a process whereby data are imported into GIS in order to identify their geographic properties and coordinate positions are assigned to the data in order to display

the locations of pertinent variables.⁴¹ Specifically, geocoding allows the researcher to determine a number of spatially related phenomena, including adjacency (what is next to what), containment (what is enclosed by what), and proximity (how close something is to something else).

For the present study, postal codes and contact information obtained from the Ontario MOHLTC Web site⁴² were used to determine the coordinates of each site. The maps were examined and categorized according to the proximity of FHTs to current PT clinics: (1) no PT clinics in close proximity (criteria for close proximity will differ between rural and urban settings); (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.

Phase 2: Qualitative Key-Informant Interviews

Phase 2 consisted of qualitative in-depth interviews with key informants from FHTs and community-based PT clinics. Key informants were either individuals who oversaw the overall operations of the FHT or PT clinic (e.g., programme managers, owners, or directors) or those directly involved in delivery of health care (e.g., nurses, physical therapists, physicians). FHT key informants were identified through the mapping project and through our contacts with senior policy analysts at MOHLTC and were selected so as to ensure representation from various FHT settings and geographic locations across Ontario. The names of primary contact individuals at 129 FHTs are available on the MOHLTC Web site.⁴²

PT key informants were identified through our contacts at the Canadian Physiotherapy Association. We sampled for PT key informants from four types of community-based PT services (not OP departments or home care services), two publicly funded (CHCs, designated PT clinics) and two privately funded (private, fee-for-service practices and private for-profit health corporations that provide multidisciplinary community-based services).

Both FHT and PT key informants were also identified using a snowball technique whereby informants recommended any other individuals who would be appropriate to participate in the study.

Potential key informants were contacted by telephone or e-mail by the research associate (RA), following a protocol approved by the University Health Network's Research Ethics Board. Participants who expressed an interest in the study were sent additional information, describing the purpose and the nature of the request for their involvement in key-informant interviews (one 30- to 60-minute interview). Key informants were also sent letters of consent; either these were faxed or e-mailed back to the RA, or verbal consent was given at the begin-

Table 1 Overview of Semi-structured Interview Guide Questions

1	What are the current linkages between your FHT/CHC/PT services with respect to rehabilitation?
2	Are there currently any plans to integrate physiotherapy into your local FHT?
3	How might PT services be incorporated into your local family health team? <i>Probe re: embedded PT model, referral to existing PT services model.</i>
4	What challenges or barriers would need to be addressed in order to incorporate PT into your local FHT using either of these models?
5	How might these challenges be overcome?

FHT = family health team; CHC = community health centre; PT = physical therapy

ning of the interview. All interviews were conducted by the principal investigator (PI), either in person or by telephone, and held at a time and location convenient for the participant. The PI (CC) has an extensive background in qualitative research and community-based rehabilitation service delivery. All interviews were digitally recorded and were transcribed verbatim by a professional transcriptionist. A semi-structured interview guide composed of open-ended questions was used to guide the interviews (see Table 1).

Data analysis occurred concurrently with data collection. Following each interview, the interviewer wrote detailed field notes and began to develop a typology of barriers and opportunities for service-delivery models according to setting. Ongoing data analysis consisted of categorizing and coding responses according to the concerns raised by participants with respect to the importance of PTs in primary health care. These categories were organized by exploring the facilitators and barriers to two models of PT integration in FHTs: (1) the embedded PT model and (2) the external referral model. The RA coded the transcripts, in frequent consultation with the PI to review the emerging codes. Data were managed using NVivo 6 (QSR International, Cambridge, MA).

RESULTS

We mapped the locations of 129 FHTs, along with existing PT clinics, by LHIN. It is not feasible to include all 14 maps in this article, but readers can access them online as part of the working project report.²⁵ Examination of these maps indicates that almost 20% of FHTs ($n = 25$) across Ontario, mainly in rural regions, are not located in close proximity to any community PT services; approximately 28% of FHTs ($n = 36$) are close to publicly funded PT clinics only; and 13% ($n = 17$) are close to privately funded PT clinics only. Finally, almost 40% of FHTs ($n = 51$) throughout the province are located in close proximity to both public and privately funded PT clinics. Not surprisingly, these FHTs are found mainly in highly populated urban areas.

Sixteen key-informant interviews were conducted with 18 participants (two sites requested that two people be interviewed together). Five FHTs (2 urban, 3 rural) were contacted and agreed to participate. FHT key informants were executive directors or administrators ($n = 3$), lead physicians ($n = 2$), and nurse practitioners ($n = 2$). PT key informants from one CHC ($n = 3$), one privately funded PT clinic ($n = 2$), two designated PT clinics ($n = 2$), and two private for-profit health corporations ($n = 4$) were contacted and agreed to participate. PT key informants were practice owners or programme directors ($n = 7$) and PT direct service providers ($n = 3$). At the time of this study, there were no physical therapists practising within the network of approximately 129 FHTs.

After review of the data, the key issues that emerged from the key informant interviews were summarized into the following categories: (1) the importance of PT in primary health care and chronic disease management; and (2) opportunities and challenges to existing and potential models for incorporating physical therapists into FHTs, particularly around access and funding, salaries and reimbursements, and space and equipment.

The Importance of PT in Primary Health Care and Chronic Disease Management

Many participants emphasized the difference between primary care and primary health care and the implications of this difference for PT. *Primary health care* is an approach that emphasizes health promotion and illness prevention through health and wellness programs; includes diagnosis and treatment; and provides a link to more specialized (e.g., secondary or tertiary) care.⁴³ In contrast, *primary care* is usually defined as first-level contact with the health care system and is generally seen as an approach to providing care rather than a set of specific services.⁴⁴

All participants noted the importance of incorporating PT services within FHTs in order to enhance the delivery of primary health care, specifically with respect to managing chronic and episodic disease. For instance, one FHT participant remarked that

you can prescribe all the medications in the world but that doesn't address the root cause ... What we're thinking about is the whole prevention piece. It's how can you make them feel better now before 5 years from now when they come back with all these comorbidities.

Participants perceived physical therapists as having an important role in prevention. As another FHT participant stated,

The prevention piece is why the FHTs were created in the first place. 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.

FHT participants identified the lack of physical therapists currently practising in FHTs as one of their top three issues, particularly as it relates to access to services. Access to PT services is a long-standing issue in Ontario, and all of the participants in this study reiterated concerns about the erosion of publicly funded options for access to PT services. They also noted that the clients who most need PT services are those least likely to have access to private insurance to pay for services. Physicians reported reliance on other means of treatment, such as prescription of pharmaceuticals, as alternative short-term solutions to limited access to PT at the primary-care level. According to one FHT physician,

I don't end up giving a referral to physiotherapy because I know they [the clients] 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.

He went on to state,

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.

FHT participants also reported that although PT 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 PT can accomplish:

We don't even have as much expertise as we should in terms of who can [PT] 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.

Existing and Potential Models of Incorporating PT into FHTs

Participants were familiar with both the embedded model and the external referral model as potential models for delivering PT services in FHTs. Table 2 summarizes the major opportunities of and challenges to each model.

Model 1: Embedded Model

We found existing examples of the embedded PT model in the publicly funded sector (the CHCs) and in the privately funded sector (some private for-profit clinics and health corporations) in Ontario, although, as we describe below, the most common model in Ontario is the referral to existing PT services model.

Participants reported that the major strength of the embedded model is that physical therapists are full and active members of the primary-care team. Enhanced

Table 2 Models of Incorporating Physical Therapists into FHTs: Opportunities and Challenges

	<i>Embedded PT</i>	<i>Partner with Existing PT Clinic</i>
Opportunities	(1) Communication is enhanced. (2) The PT professional is part of team and is able to take on roles in managing chronic disease. (3) Job satisfaction is high, and quality of working life is good.	(1) Such partnerships may already be initiated for patients with extended health care coverage. (2) The FHT does not have to recruit and supervise physical therapists. (3) The FHT does not have to rent space or purchase PT equipment.
Challenges	(1) Salary and benefits are much lower than in other sectors. (2) The physical therapist may experience professional isolation. (3) The FHT must cover the costs of space and equipment.	(1) Access is reduced. (2) Communication between the physical therapists and physicians or other FHT team members is more difficult. (3) There are differences in salaries and benefits between public and private sectors.

communication and direct involvement with client care are key arguments in favour of this model. Having physical therapists on site provides many formal and informal opportunities to communicate with other team members and to participate more fully in goal setting and decision making. As one FHT participant said,

Potentially, there's a huge benefit of having [PT] on site where you're truly collaborating because you discuss those things and you have feedback and you say, is this an appropriate referral or, what can you do for this type of problem? So that's one of the greatest advantages, whether you're urban or rural it doesn't make a difference.

In CHCs where physical therapists are part of the primary health care team, they are integral to chronic disease management programmes, in addition to providing direct one-on-one client care.

Although most participants considered the embedded model ideal, there were three main barriers to or concerns about implementing and sustaining this model: salaries and reimbursement; professional supervision of physical therapists; and space and equipment allocation.

Important differences in physical therapists' salaries and reimbursement exist between the public and private sectors in Ontario. Participants from CHCs with embedded physical therapists reported that it is challenging to recruit new staff because CHC baseline salaries for health professionals are not competitive with those in the rest of the public sector, let alone the private sector. Participants noted that CHCs currently offer a salary approximately 25% lower than that offered in the hospital sector and considerably less than can be earned in the private sector, where physical therapists either are paid a higher salary or earn a percentage of their individual or group billings. The Ontario Physiotherapy Association gives a suggested rate of \$37.50 per 15-minute unit of service,⁴⁵ and although not all private settings charge this amount, some private fee-for-service practices have reported billing up to \$120.00 per hour. As one physical therapist participant told us, "It's an issue for me, for everybody.

Anybody that works in the community always makes less than what they make in the hospital ... It's always an issue."

Some of the senior FHT participants acknowledged the importance of embedded PT for primary health care but expressed apprehension about assuming responsibility for recruiting and hiring physical therapists and managing PT services. One FHT administrator said that "as a nurse, I don't feel that I know enough about how to evaluate and monitor PT standards and practice to supervise PT staff." Other FHT participants expressed concern about the potential for embedded PT providers to feel isolated from their professional peers, which could lead to job dissatisfaction and lower standards of care.

The third barrier to the embedded model mentioned by participants is related to acquiring space for PT services, purchasing related equipment, and managing the overall costs (e.g., space and set-up costs). In general, PT services require space for assessment, treatment, and education, along with equipment for effective implementation of specific and effective programmes. For instance, a healthy lifestyles programme that includes physical activity would require reasonable space and some targeted exercise and training equipment. One participant expressed her concern about the success of PT services embedded in FHTs because of the lack of physical space available:

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.

Space and equipment costs vary depending on patient caseload, geographic location, and the demands of the population served; however, allocating space within the existing square footage of FHTs was consistently reported as an important barrier. Incurring additional costs by renting additional space was not considered to be a feasible solution.

Model 2: External Referral Model: Partner with Existing PT Services

Within the external referral model, FHTs would develop partnerships with and refer clients to existing community-based PT services. Participants signalled that this model might be more feasible to initiate—particularly in urban settings, where there are already numerous PT clinics—primarily because the FHT would not have to recruit clinicians and would avoid set-up and equipment costs. Given the financial and operational barriers to implementing the embedded model, participants reported, effective referral to existing PT clinics may be an untapped opportunity. As one FHT participant said,

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.

Most of the physical therapist participants in existing PT clinics were correspondingly interested in developing such partnerships and collaborations with FHTs. At the time of the interviews, some private PT clinics and health corporations had already entered into discussions with their local FHTs to explore potential contractual agreements.

One FHT administrator expressed concerns about purchasing private PT services with public funds. However, most others felt that there were already many such examples in the provincial health system; as another FHT administrator said,

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 [system]. 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.

Once again, one of the main challenges for FHTs considering partnering with existing PT 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 PT services. For example, current Ontario Health Insurance Plan (OHIP) rates for designated PT clinics are only \$13 per treatment; by contrast, the Workplace Safety and Insurance Board reimburses at \$25 per treatment, and in the insurance industry the accepted hourly rate is \$90 per hour. Rates vary within private PT clinics. As one PT practice owner said,

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.

Most agree that, given the differences between the public and private purses, 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.

Aside from reimbursement issues, one of the major perceived drawbacks of referring to existing PT services is maintaining effective inter-professional communication. In contrast to the embedded PT model, 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 PT clinics, even for those clients with extended health care benefits:

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 e-mail connections, reliable, they're going to read. Certain times for telephone conversations as needed ...

The Major Issue for Both Models: Lack of Public Funding for Community-Based PT

All participants agreed that the main unresolved issue for both models continues to be the lack of public funding for those Ontarians who do not qualify for designated PT clinics (only patients over age 65 or under age 19 who require PT services are covered by OHIP in designated PT clinics) and do not have adequate extended health care coverage. As one PT participant said,

I'd say 50% of the population in our area have no funding at all and another 50% have some version of funding and they're quite limited, most often between two and five hundred dollars. That gets eaten up really quickly.

Geographic access is also a barrier to accessing existing PT services, particularly in rural areas. Several community hospitals' OP 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 centres with PT services can be as much as 100 km from the FHT, meaning that

accessing PT services requires 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 km 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.

Ironically, despite the scarcity of PT providers, FHT participants in rural settings reported many examples of provider groups in rural areas that have already, by necessity, begun partnering in the delivery of services. For example, one rural participant reported that

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.

One might assume that the opportunities to partner would be even more robust in urban settings, thanks to the higher density of providers. In fact, however, we found few examples of this occurring, even for those patients with extended health care coverage. In fact, some urban PT and FHT participants reported either not knowing the proximity of PT providers or FHTs in their general catchment areas or not having given much consideration to developing partnerships.

DISCUSSION

The purpose of this study was to examine the potential of various models that could be used to incorporate PT services into FHTs in Ontario. Our findings indicate that there are many opportunities for integrating PT into FHTs using either the embedded PT model or the partner with existing PT services model. The major challenge in both cases remains the difficulty of accessing PT services outside of hospitals as a result of the lack of public funding for community-based PT services.

Most participants in this study believed that there is value in adding PT services to the FHT's list of offered services, particularly given the current and future challenge of meeting the primary-care needs of the growing number of Ontarians with chronic and episodic diseases. The embedded PT model was considered optimal, although barriers around salaries and reimbursement, supervision of PTs, and access to space and equipment were identified. Most successes in embedding physical

therapists into primary health care in Ontario to date have been achieved within CHCs, where service providers are salaried and the decision to include allied health professionals in the practice has no negative impact on the physician's income.⁴⁶ The CHC is an example of how embedding physical therapists within FHTs would allow for health professionals to work closely together and communicate frequently and for the physical therapist to be directly involved in patient care. However, given the existing barriers, such as salaries and reimbursement, professional supervision of physical therapists, and space and equipment allocation, participants considered creating partnerships with existing providers to bridge the access gap a feasible option. Strategies around reimbursing physical therapists are still an issue, however, because of the large discrepancy in salaries between the public and private sectors.

The adoption of the partner with existing PT services model is subject to different barriers in rural and urban settings. We found that although approximately 40% of Ontario FHTs (particularly those in urban settings) are located in close proximity to existing publicly and privately funded PT clinics, almost one-fifth of FHTs (mainly those in rural settings) are not in close proximity to any PT clinic. This finding supports our argument that one size does not fit all and that different models of incorporating PT into FHTs may be appropriate depending on geographic location.

Despite these arguments, the main underlying issue remains the lack of funding for PT services in FHTs. Recently the Ontario government announced that OT services would be funded in FHTs,⁴⁷ but PT services remain excluded. Funding will continue to be a key health-policy issue for the profession until this major disparity is addressed.

The strategic decision to deliver services within the FHT or to partner with external providers represents a policy predicament that has been colloquially termed the "make or buy" dilemma. The question is whether it is better to produce the services within the organization (i.e., to "make" services) or to forgo internal production and seek to contract with an external provider (i.e., to "buy" services). This is a choice that Osborne and Gaebler referred to as "steering rather than rowing," and the concept is related to the appropriate role of the state or government in health care.⁴⁸ Essentially, Osborne and Gaebler's metaphor suggests that the government and its representative institutions should be engaged in "steering," or health leadership, rather than in "rowing," or producing the services themselves. The argument in favour of the steering role is based on the premise that governments are inherently inefficient and that services delivered in the private sector are inherently efficient. It was this tendency to separate funder from provider that led the government of Ontario to implement massive restructuring to the home care sector in

the late 1990s.¹ A key element of Ontario's home care reform strategy was to replace the delivery of services by home care employees with a process of "managed competition" wherein a mix of private for-profit and not-for-profit community providers would bid on service contracts tendered by the newly formed CCACs. The evidence that contracting out community health services yields positive clinical or economic outcomes is debatable. However, it has been suggested that this process has resulted in more assessments but fewer units of services and that it ultimately represents a market failure, in that the objective of better service at a lower cost has not necessarily been met.⁴⁹ The example of home care in Ontario highlights the challenges that exist around the notion of contracting out services to external providers and can be used as a point of discussion in determining the course of action for FHTs.

Each of the two models for involving physical therapists in primary care offers several opportunities and is subject to several barriers in expanding the scope of primary health care services. However, no one specific model, or variation of a model, can be generalized to every FHT, given the differences across the rural/urban divide. Ontario has taken a policy decision to widen the primary-care network in the province; however, despite the intent to provide a fully integrated primary-care environment, FHTs appear to have structural restrictions that limit the provision of services, and particularly of PT services for the management of chronic and episodic disease. Given that the prevalence of chronic disease is rising in Ontario, and that providing PT services for affected individuals allows them to manage their condition in the community,³³ there is a potential imbalance between the demand for primary-care services such as chronic disease management and the supply of programming for PT services within FHTs. This may have an effect at both the client and the overall health system levels. The limited provision of PT in FHTs may direct individuals either to access publicly funded PT services elsewhere or to purchase them privately (either by paying out of pocket or through third-party insurance).

LIMITATIONS

This study was designed to identify the macro- or system-level opportunities for and barriers to integrating physical therapists into FHT in the province of Ontario. While we examine the issues at the macro level, there may be other specific nuances at the individual community level that were not raised during our key-informant interviews. Moreover, given the speed at which this particular area of practice is developing, new models may emerge over time that will alter the context of our analysis. While we acknowledge these limitations, we also underscore the critical nature of policy analysis of the models described in this study.

CONCLUSION

As identified in this study, the availability of publicly funded community-based PT services is diminishing in Ontario. The effect of limited access for individuals with chronic disease may be circular, in that lack of access to PT at specific points along the disease trajectory may worsen the underlying pathology to the point where high-cost institutional care (which is fully publicly funded) is medically necessary.²¹ Moreover, as reported above, physicians' awareness that individuals cannot access public or privately funded PT services may increase the use of prescription medications to manage chronic conditions. Not only is this outcome less than ideal clinical practice, it is likely to be a greater burden to the public system in terms of pharmaceutical products and institutional care, all of which are more costly than providing appropriate and timely services at the community level.

Our research has reported the opportunities and challenges of different models for providing PT services within the context of the emerging network of FHTs. However, implementing each of these models requires shifting scarce resources. Allocation of resources is driven by values and interests among the stakeholders who stand to gain (or lose) from the outcome. The stewardship of the MOHLTC is critical to the structural adjustments that appear to be necessary to improve access to PT services for Ontarians who are expected to use FHTs as their first point of contact with the health care system.

KEY MESSAGES

What Is Already Known on This Topic

Like many provincial jurisdictions across Canada, Ontario continues to implement health care reform strategies aimed at improving health outcomes while maintaining lower costs. As part of its ongoing reform strategy, Ontario has implemented family health teams (FHTs) to provide services closer to where individuals and their families live and to reduce the number of non-emergency cases entering the acute-care system. Although FHTs are designed to be multidisciplinary, the extent to which physical therapists are included or involved is limited.

What This Study Adds

At the time of this study there were no physical therapists practising within the provincial network of FHTs. There is a desire for physical therapists to be included in FHTs, and most study participants suggested that the ideal model is to embed the physical therapist directly within the FHT. In some situations, however, a more feasible model would be to create partnerships between the FHT and existing PT services. Some 40% of FHTs are

located close to both publicly funded and privately funded PT settings, which indicates that such partnerships could indeed be feasible.

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