



THE CHANGE FOUNDATION

HEALTH CARE DESERVES
OUR FINEST THOUGHT

WINNING CONDITIONS

to improve patient experiences:
integrated healthcare in Ontario

November 2011



About The Change Foundation

The Change Foundation is an independent policy think tank, intent on changing the healthcare debate, healthcare practice and the healthcare experience in Ontario.

A charitable foundation established in 1996 and funded through an endowment, The Change Foundation leads and leverages research, policy analysis, quality improvement and strategic engagement to enable a more integrated healthcare system in Ontario designed with individuals and caregivers top of mind.

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Introduction

The Change Foundation is committed to two inextricably linked goals: an integrated healthcare system and a better experience for the people who use it. Ontario possesses important resources to achieve both of these goals—a highly trained healthcare workforce and a well-resourced funding base—but that’s not enough. The full potential of these strengths can’t be realized within a system that is struggling with inefficient processes and where people experience gaps, gridlock and disconnects. That’s why Ontario’s healthcare system needs to be transformed by putting patients in a new position: squarely in the centre, keeping the quality of their experience top of mind.

The Change Foundation’s strategic priority is to *improve the experience of individuals and their caregivers as they move in, out of, and across Ontario’s healthcare system*. This focus, explained fully in *Hearing the stories, changing the story*, flows from the research, analysis and engagement we’ve undertaken over the past three years and from all we’ve heard and learned from patients, caregivers¹ and the healthcare community. We refined that focus further in *The Storyboard: Implementing The Change Foundation’s Strategic Plan*.

In those documents, we’ve stated that a good patient experience encompasses:

- **clear, consistent, reliable communication**—about all aspects of the healthcare process, including what will happen next at a transition point;
- **access to information and exchange of information**—continuity of information amongst providers and across organizations and sectors, and patient access to tools for self-management;
- **coordinated and connected care**—to appropriate providers, services and supports, with collaboration and with caring “hand-offs” between family physicians, specialists and other providers;
- **comprehensive care**—opportunities for patients to discuss their multiple needs and have their concerns addressed, with their living conditions and social supports considered and incorporated into care plans;
- **engagement in decisions about care**—a sense of shared responsibility while recognizing varying capacity, with patients welcomed as active participants in decision-making, and informal caregivers treated as partners and their involvement supported;
- **respectful, empathetic and considerate interactions**—patients treated with fairness and dignity and as equals and partners, and given the time they need to ask questions and express their concerns, fears and hopes;
- **timely and convenient care**—without long waits that prolong pain or emotional turmoil, or contribute to unnecessary deterioration of a patient’s health, and with minimization, whenever possible, of the need to go to different locations for services.

1. Throughout this paper the terms *caregivers* and *informal caregivers* refer to family, friends and neighbours who provide assistance, support and care.

This sounds good, but can we afford it? And will it make a difference in how our healthcare system functions, or in our health?

Our response to the first question is yes. Patient-focused healthcare is cost-effective healthcare. Consider the time and money wasted when results are lost, patient information isn't heard or shared, expensive tests are needlessly repeated, or inadequate home care leads to hospital re-admissions. To the second question: yes again. Improving the patient experience is no mere nicety. It means building better connections between the right services and the right people at the right time and in the right place. It means better access to integrated care. In the long term all of this, taken together, advances the health of the population and the sustainability of the system.

In this report, The Change Foundation offers its best advice on how Ontario can move closer to an integrated health system and improve the

experience of individuals and caregivers. It is based on work conducted and commissioned by the Foundation and on published research. It draws on what we have learned from other jurisdictions, and is informed by discussions with government officials, policy experts, regional planners and, most importantly, individuals and caregivers.

We begin with an overview of key contextual factors. We then discuss how an integrated healthcare system would look and offer concrete actions Ontario can take to get there. We describe challenges for the sustainability of high-quality healthcare—from both the system and individual perspective—and present recommendations for the next phase in the development of a more integrated system.





1. Context:

A Look At Three Key Factors

There are myriad contextual factors that shape our healthcare system. We will focus on three which we believe are particularly influential: the current fiscal environment, the recent passage of the *Excellent Care for All Act*, 2010, and the current mandate of our Local Health Integration Networks (LHINs).

Let's consider the **fiscal environment** first. Public spending on healthcare has increased annually by an average of 6.5% since 2003—more than double the rate of inflation.² Health expenditures—including hospitals, community care, long-term care and physicians—account for more than 46% of the provincial budget, with projections that this could increase to 70% by 2022.³ To look further back, Ontario's health expenditure has more than doubled from \$21.6 billion in 1999 to a forecasted \$47.1 billion for 2011-2012.⁴ The provincial government's 2011 budget projected a \$16.7 billion deficit for 2010-2011, and cautioned that “rising healthcare costs present a challenge to managing growth in healthcare spending without crowding out other priority investments.”

The provincial government's pre-election report on finances projected an average annual increase of 3.6% in health spending over the next three years.⁵ The Auditor General of Ontario has criticized the government's expense estimates—on health in particular—as being based on optimistic assumptions.⁶

“Unless there are changes in the kinds of healthcare services the government funds or there are significant cost inefficiencies in the healthcare system that the government can address, the past trend of annual increases in healthcare costs of about 7% may well continue.”

—Auditor General of Ontario

2. Ontario Hospital Association (OHA) and Ontario Association of Community Care Access Centres (OACCAC) (2011). *Four Pillars: Recommendations for Achieving a High Performing Health System*.

3. Ontario Ministry of Health and Long-Term Care (2011).

4. Ontario Ministry of Finance (2011). Ontario budget.

5. Ontario Ministry of Finance (April 26, 2011). 2011 *Pre-Election Report on Ontario's Finances*.

6. Office of the Auditor General of Ontario (June 28, 2011). *The Auditor General's Review of the 2011 Pre-Election Report on Ontario's Finances*.

“The magnitude and trajectory of healthcare spending means that the success of any plan to eliminate Ontario’s deficit, manage its debt, and fund other priorities, depends on successfully bending the healthcare cost curve.”

—OHA and OACCAC, 2011

We’ve been here before. In the mid 1990s, reduced budgets in the hospital sector were achieved largely through losses in nursing positions via attrition, lay-offs and restructuring.⁷ Patients were discharged to a community sector that was not prepared to provide the care they needed and to a primary care sector that was in crisis due to a shortage of family physicians. This time around, Ontario’s fiscal environment calls for smarter, more logical and strategic decision-making about how to get better value for our healthcare dollars—and, as the evidence suggests, more integrated services for people. We need to ask basic questions about how, where and by whom services should be delivered, and to pursue new and innovative approaches to high quality, patient-centred healthcare. The fiscal reality and the certainty of demographic change and growing healthcare needs provide the perfect opportunity for a long-overdue re-think and rework of how our healthcare services are organized and delivered.

The Excellent Care for All Act (ECFAA) is potentially a powerful tool to torque that change. This legislation came into effect in June 2010 with a goal of putting “Ontario patients first by strengthening the healthcare sector’s organizational focus and accountability to deliver high quality patient care.” ECFAA sets out requirements for provider organizations to establish Quality Committees and release annual quality improvement plans, links executive compensation to the achievement of quality targets, establishes processes for conducting patient/client/caregiver and staff satisfaction surveys, and includes requirements

for patient relations processes to address patient experience issues. All of this is being implemented in the hospital sector first and will spread to all healthcare organizations.

ECFAA has also expanded the mandate of Health Quality Ontario (HQP). This independent Ministry-funded agency is now tasked with making recommendations on evidence-based delivery of healthcare, based on clinical practice guidelines and protocols, and on possible changes to the way healthcare is funded. Given that 18 months have passed since HQO was given the expanded mandate, it needs to deliver some concrete results on priority initiatives as soon as possible.

ECFAA presents a legislative platform that is potentially transformative—and one which The Change Foundation applauds. The legislation seeks to improve the quality and value of the patient and caregiver experience through the application of evidence-based care and more robust accountability.

The third key contextual factor is the introduction and evolution of the **Local Health Integration Networks (LHINs)**—the role they’ve been given, and play, in integrating healthcare, and the resources and authority they’ve had with which to carry out their responsibilities.

The LHINs were established under the *Local Health System Integration Act* (LHSIA), 2006, with a mandate to “engage their communities, proactively plan an effective service system, facilitate integration and system transformation, and manage the overall funding of the health system within their devolved authority.”⁸

7 See Duncan S, Rochon M, and Leatt P (2005) *Riding the Third Rail: The Story of Ontario’s Health Services Restructuring Commission, 1996-2000* for a richer appreciation of the contextual factors contributing to hospital restructuring.

8 KPMG (2008). *MOHLTC—LHIN Effectiveness Review Final Report*.

However, their “authority” has been a debatable point, and it can be argued that the conditions under which they’ve had to operate have hardly been winning.

From the outset, the LHINs’ capacity and administrative apparatus have been restricted, compared with those of their counterparts in other provinces which have regionalized healthcare systems. The legislation confirmed the existing purchaser/provider split, i.e., LHINs—unlike their counterparts in the other jurisdictions—do not directly provide services. Also, Ontario’s legislation allowed local boards, including hospital boards, to remain—differing again from what was done elsewhere. The Act identified which programs and services are within the LHIN mandate—and which are not. Most notably, public health and primary care (with the exception of Community Health Centres/CHCs) are not funded through LHINs.⁹

A review of the LHSIA and its regulations was to be initiated in the spring of 2011. However, a legislative change by the government moved the review, to be conducted by a Select All Party Committee of the Ontario legislature, until after the October 6th 2011 provincial election.¹⁰ Meanwhile, and without benefit of review, the performance and future of the LHINs became an issue.

The election generated different ideas ranging from the reform and restructuring of the LHINs to their elimination. Post-election, the establishment of the Select All Party Committee will likely be a priority for the provincial government, so that the resulting findings and recommendations can be used to guide future reforms.

9 For more on the LHINs and healthcare regionalization in Canada, see The Change Foundation’s report from the 2008 *Meeting of the Minds, Highlights of an Invitational Exchange*.

10 The MOHLTC website states that the Review must commence by July 1, 2012.

“You’re sent for more tests, you’re adding more doctors or specialists—and then you really sit back and you have to think to yourself, ‘Well, who is the puzzle maker? Who’s getting all these pieces and putting them together?’”

—Carmen, patient and caregiver in Toronto



2. Integrating The System

Where We Are & Where We Need To Go

Ontario's healthcare system is complex, with a proliferation of channels for service delivery—and potential for service delivery problems. We know from health research literature that a more integrated system is critical to improving outcomes. And we know from listening to individuals that more integrated systems of care will improve their experience as they navigate the multiple providers, organizations and sectors of Ontario's healthcare system. Integrated care is a means to improving access to services, the quality of care processes and outcomes, patient safety, efficiency of system delivery, and the experience of patients and their caregivers.

Where are we now?

We know from listening to patients and caregivers that they strongly value our publicly funded universal healthcare system and that their one-on-one relationships with providers are generally positive. Also, people experience continuity of care—to a reasonable degree, or more—when dealing with some diagnoses, most notably cancer. The same is true in some care settings, especially in family practices where the patient has their own family physician or nurse practitioner supported by

an interprofessional team. It is when care gets complicated that the experience becomes problematic. One example is cancer care when it is not well connected to primary care, and when the patient becomes the glue between the family doctor and the cancer system. Problems also arise for people who need complicated care, such as the frail elderly, those with chronic conditions, and children and adults with disabilities. Patients and caregivers report the following challenges:

- uncertainty about system navigation—whom to call about what, and how to move from provider to provider;
- repetition and delay—repeating histories, tests, continual creation of new health records;
- anxiety over whether the information provided gets to the right person at the right time;
- particular gaps in information, communication and service at points of transition from one provider to another.

(For more information, see *Who is the Puzzle maker?*)

Where do we need to go?

What should the public expect from an integrated healthcare system? We should expect an experience in which patients and their caregivers:

- are connected to the care and support services they need in a straightforward process, regardless of how complicated and extensive the range of services may be;
- are in an environment where the coordination of care and the ease of navigation are considered to be as important as the technical quality of the services delivered;
- know who their key contact person is, to help them coordinate care to meet their changing needs;
- are aware of what comes next in their care;
- are asked for information and updates once—information is collected once and used often, without people having to repeat their stories unnecessarily;
- are communicated with in a simple, straightforward way—informed about all aspects of their care;
- are confident that their providers are communicating with each other and complementing each other's efforts; and
- are assured that there is collective responsibility for meeting needs and solving problems—i.e., the success of individual providers is subordinate to their collective success in meeting the patient's needs, and no one says "it's not my responsibility."



3. Integrating The System

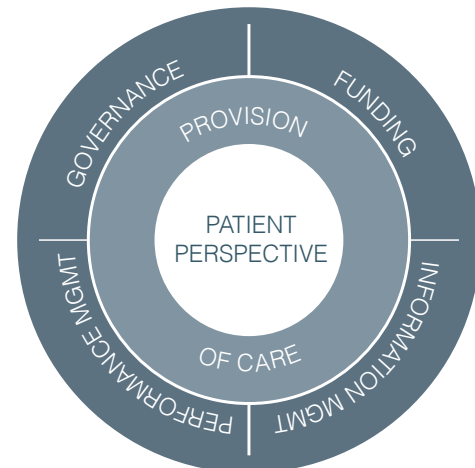
How To Get There From Here

In the following pages, we present our analysis of problems in Ontario's healthcare system and offer potential solutions, using our framework of the critical elements of integrated care.¹¹

The **patient** is the central focus of the framework—appropriately, since integrated care is focused on patient and caregiver experience and engagement. **Provision of care** surrounds the patient; it includes the elements of comprehensive care, interprofessional teams and evidence-based care. The supportive elements that shape the provision of care and hence the patient experience include **governance and relationships, funding, performance management and information management**.

We will address each critical element in turn, presenting an analysis of issues and challenges and our suggestions to government for dealing

The Critical Elements of Integrated Care (The Change Foundation)



with the challenges. Highlights of the main issues and recommended actions are later presented in the Appendix.

¹¹ This framework evolved from The Change Foundation's review of research literature and of experience in other jurisdictions, and is described in more detail in Hale L (2009) *Integrated Health Care in England: Lessons for Ontario*, published by The Change Foundation.

Provision of Care

Research tells us that integrated systems provide care through interprofessional teams with clear understanding of roles and decision-making authority for patient care. Successful health integration is supported by standardized care models with evidence-based clinical care guidelines and protocols; umbrella organizational structures; and provider networks with standardized referral procedures, service agreements, joint training and shared information systems.

It is widely believed that a well-developed primary care sector linked with the rest of the healthcare system is critical to successful health system integration. This is because it can connect patients, seamlessly, to other care they may require. In particular, well-developed primary care supports more effective health promotion and prevention, enhanced self-management of chronic diseases and other conditions, and a less reactive (and expensive) healthcare system response. We know from international data that countries with good health outcomes tend to have strong primary care systems.¹² These jurisdictions are able to produce positive population health outcomes at a lower cost per capita, ensuring the sustainability of their healthcare systems.

Also, by investing in aspects of primary care—e.g., health promotion and prevention, improved management for people who are at high risk for re-admission, and improved chronic disease management—we can reduce our dependence on hospitals, which are the most expensive form of care. People with knowledge and experience about health policy matters have argued that we should set a goal to decrease hospital beds/capita by 50% over the next 20 years through upstream investment and better-developed and better-executed disease management systems.¹³

Investments to expand and enhance primary care in Ontario have been made by the government and are starting to pay off. Of note is the expansion of Family Health Teams (FHTs), which are doctors, nurses, nurse practitioners and others working collaboratively, and the introduction of nurse practitioner-led clinics. It is worth noting that 91% of Ontarians have access to a regular family doctor, compared with 85% of people in other provinces.¹⁴

However, there is still room for improvement. Some primary care organizations—notably some FHTs—are well-developed, with strong governance and management foundations in place, while other family practice physicians have minimal infrastructure. The majority of family physicians remain in group practices that do not have the benefits of the interprofessional teams that are the hallmark of FHTs.^{15 16} There is, in other words, significant variation in the capacity of primary care organizations in the province.

12 Organisation for Economic Co-operation and Development (OECD) (2010). *Value for Money in Health Spending*.

13 Commentary from Tom Closson, president and CEO of the Ontario Hospital Association, on June 2, 2010, at the Bending the Cost Curve of the Health Care System conference.

14 Statistics Canada (June 2011). Healthcare services web page: Population with a regular medical doctor, by age group and sex.

15 Ontario Ministry of Health data presented at the Canadian Health Research Foundation conference, Picking up the Pace, November 2010, referred to solo practice physicians making up less than half of the primary care model group (see: http://www.chsrf.ca/Libraries/Picking_up_the_pace_files/SusanFitzpatrick.sflb.ashx).

16 FHTs are characterized by interprofessional teams; family physicians also practice as part of a Family Health Group (FHG), Family Health Network (FHN), or Family Health Organization (FHO) which may not include the services of interprofessional teams.

“Strong primary care is linked to better outcomes, improved equity, reduced wait times and an improved patient experience.”

— Colleen Flood, Canada Research Chair in Health Law and Policy (in *How Do We Compare? Lifting our Game on Healthcare Performance*, 2011)

As well, more egalitarian models of health human resource deployment and interprofessional collaborative practice have not progressed as quickly as FHTs. Whether this changes—and whether substantive goals for primary care can be achieved—remains to be seen. It will depend, in part, on the extent to which clinics and practitioners embrace a patient-centred culture, interprofessional care, leading-edge quality improvement methods and tools, and performance measurement systems.

It will also depend on whether Ontario develops a strategy for integrating primary care with the rest of the healthcare system. If not, we risk losing momentum for change and failing to maximize the return on our investment to date. Boundaries between primary care and other care providers can perpetuate inefficiencies and limit opportunities for the kind of patient experience that is marked by care continuity, appropriateness and quality. We know from our survey of community-based service providers that a wide gulf exists between community care and primary care in Ontario today (see *Integration of care: The perspectives of home and community providers*).

This lack of connection between primary care and the rest of the system is linked to the restricted mandate of the LHINs that was mentioned earlier. LHINs lack a clear mechanism for supporting and funding new primary care models based in the community (e.g., primary care-driven strategies for aging at home or diabetes management). An example: the Peterborough Networked Family Health Teams couldn't access the funds their LHIN had committed to them (to develop an integrated delivery model for at-risk vascular

patients), because there was no direct accounting relationship between the two. Eventually, the funds were flowed through a local hospital—six months after the project became operational—and reached the FHTs four months after that.^{17 18} Clear mechanisms to support and fund community-based care models will be required in an anticipated future environment of restricted hospital budget growth.

Examples are emerging where LHINs are making efforts with primary care providers to overcome these barriers and to attempt joint planning initiatives. For example, the South East LHIN recently signed a “Memorandum Supporting Collaboration” with 10 FHTs and other physician group practices to improve cooperative planning between the LHIN and these primary care groups.¹⁹

17 See presentation by Bill Casey (executive director of Primary Health Care Services of Peterborough) at the April 26, 2010 Change Foundation symposium *Tools for change: Levers and incentives for integrating patient care in Ontario*.

18 Despite having a sound business case and impactful results (as determined by an independent analysis) the vascular program is no longer funded by the LHIN (and was never supported by the primary care branch of the Ministry). It is now funded entirely by clinicians, the community and industry partners.

19 See October 31, 2011 news release at www.southeastlin.on.ca.

“Initiatives that try to cross traditional provider boundaries have been hindered by competing structural incentives and the lack of a clear mandate for either organization to make integration successful.”

—Peterborough Networked Family Health Teams, Annual Report 2011



Recommended Actions

Develop a strategy for integrating primary care with the rest of the health system.

Involve the LHINs—or re-configured regional planning bodies—in future strategic-level primary care planning. Even if the LHINs do not currently have a formal relationship with their primary care partners, they will need to be involved, especially if payment structures inhibit implementing system integration. Overall, the strategy must support integrated planning, resource allocation and improvement.

Accelerate investments in quality improvement in primary care settings.

Leading-edge quality improvement methods and tools and performance measurement systems must be implemented in the primary care sector. The McMaster/OCFP Quality in Family Practice program and, subsequently, the Quality Improvement and Innovation Partnership (QIIP) started the journey; the expanded mandate of Health Quality Ontario (HQP) will be a valuable platform for future investments.

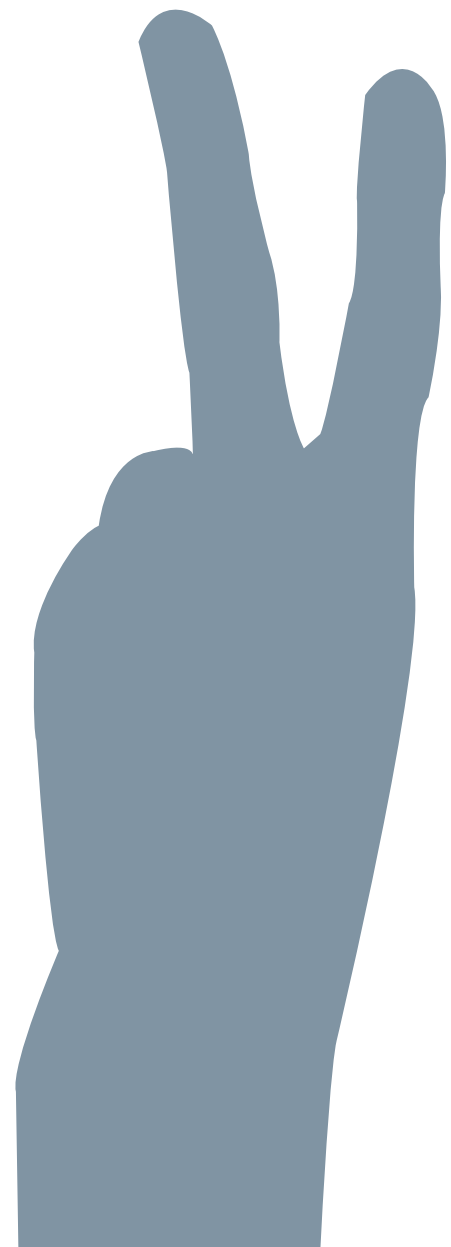
Ensure that educational and training programs promote patient-centred care, patient engagement and interprofessional collaborative practice.

Build on successful models already developed in Ontario and seek out other exemplary programs which Ontario could adapt. A culture change is required so that all healthcare workers place full value on team-based and collaborative care, and on service issues such as communication and other non-technical aspects of their patients' experiences in the healthcare system.

Re-think, re-allocate, and re-design the way services are provided.

Taking new and emerging technologies and drug therapies into account, we need to ask how people can be supported in their homes and communities, and determine which services truly need to be delivered in hospital and other institutional settings, which are more costly and often less effective. This transformation of

service provision involves both the general and the specific: Stop paying for things that don't have proven benefit; organize access to care around patients' needs rather than providers' convenience; provide care in family practices and the community; take specialist services to the practices through shared-care models and collaborative care networks; and focus attention on health promotion and disease management programs to improve the health of individuals and communities.



Governance and Relationships

A strong governance model—with decision-making authority, clear accountabilities, shared risk, opportunities for patient/community involvement in decision-making, and rostering within a geographic governance area—promotes health system integration.

Some of the governance and relationship issues we will address concern the LHINs, and would have implications for whatever iteration they may evolve into; others focus on accountability requirements for Ontario's physicians.

The LHINs have faced challenges at the board and CEO levels. In 2008, a KPMG effectiveness review advised that the *Order in Council* process to appoint LHIN board members and Chairs needed more focus on skill and knowledge competencies.²⁰ As a result, the majority of LHINs now have a merit-and-skill-based process for board recruitment. On the down side, only three of the original 14 CEOs are still in their positions. This turnover rate in a six-year period may not differ that much from the rate of turnover at the CEO level in hospitals, or at senior levels in the Ministry for that matter. However, the challenge it poses for leadership effectiveness in a time of system change should not be ignored.

As noted earlier, a unique feature of regionalization in Ontario has been devolution from the province without significant structural centralization at the local level. Here, local boards and interest groups have stayed in place—and so, presumably, have their traditional loyalties and perspectives. We assume this was done to retain social capital. But in practice, the two-tiered structure creates governance and management challenges that can hamper progress. Change can get stalled and promising initiatives remain unrealized if consensus proves difficult or impossible to achieve.

On another level, the current structure is simply too unwieldy: the 14 LHINs have, among them, more than 2,700 accountability agreements with community

agencies and hospital boards. An effort has been made to develop an accountability agreement pro forma template—i.e., the Hospital Service Accountability Agreements (H-SAAs) have been rewritten to reflect the Multi-Sector Service Accountability Agreements (M-SAAs). It's a good idea in principle. But the challenge is to find one template that works for, say, both the University Health Network in downtown Toronto and Meals on Wheels in Sioux Lookout. Observers, both within the system and from outside it, question whether and why this level of complexity—of 2,700 separate agreements—should be maintained.

Effective community engagement—properly funded, framed and conducted—is an essential lever in health system integration. Health system re-design, whether under a LHIN model or another governance model, will require more robust community engagement planning and execution.

LHINs, like their counterparts in other provinces, are formally quite powerful. In practice, though, the LHINs' authority is by no means certain—especially when they make decisions that are likely to engender opposition. Major substantive change always has been and always will be challenged, and cause conflict, but the Ministry appears to have a low tolerance level for controversy or discontent.

The disjunction between formal and de facto authority in our devolved system inevitably creates confusion, and this emerged as a key theme in the KPMG effectiveness review. The review recommended a framework to clearly identify who has decision-making authority over processes and functions.²¹

20 KPMG (2008). *MOHLTC—LHIN Effectiveness Review Final Report*.

21 KPMG (2008). *MOHLTC—LHIN Effectiveness Review Final Report*.

In addition to all the above, system accountability is challenged because neither the LHINs nor other organizations such as hospitals have a role in the negotiations that take place between the government and the province's physicians, who are represented by the Ontario Medical Association (OMA). This is true even though the decisions made at such negotiations have a major impact on these organizations' work and on the health system as a whole. It is one of many issues involving physician autonomy and the split that exists, in many respects, between physicians and the rest of the healthcare system.

You can see this split in a hospital setting. The nurses, pharmacists, radiation technologists and so on are hospital employees whose performance is assessed against institutional goals. They are clearly accountable to management. Physicians are accountable through the medical advisory committee to the board, and through their professional regulatory bodies. There is a dual accountability structure with the chiefs of staff and the CEOs as non-voting ex-officio members of the hospital board. Accordingly, physicians are less accountable for meeting institutional needs. There are exceptions: some doctors are members of hospital staff, or are reimbursed through an Alternative Payment Plan (APP) or Alternative Funding Plan (AFP), which may include more specific and enforceable contractual provisions. But most physicians, inside hospitals and out, function as independent contractors accountable to their discipline, who view themselves as being accountable to their patients.

There have been calls for change. In 2010, a joint advice paper submitted to the provincial government by three major Ontario healthcare provider groups, including the Ontario Hospital Association, noted the legacy of the physician "privileges" system that was created in the 1970s, and recommended that the hospital-physician relationship be "modernized."²²

²² Ontario Association of Community Care Access Centres (OACCAC), Ontario Hospital Association (OHA) and Ontario

Even in more fully regionalized provinces (i.e., where the LHIN counterparts have more authority in some respects), it is widely recognized that the capacity to achieve better quality, efficiency and equity is limited by the independent-contractor status of most physicians. They drive the bulk of system spending (given both their own pay scales and their role as a gatekeeper to therapies, services and tests), but their practice patterns and priorities are largely immune to outside influence.

It should also be noted that the Ontario College of Family Physicians has requested that family doctors, and those with a special interest or a focused scope of practice, be included in system planning—provincially and within LHINs.²³ This is hopefully a sign of movement in the right direction because, in Ontario and elsewhere, the current status of physicians is a major impediment to the development of an integrated healthcare system.

Federation of Community Mental Health and Addiction Programs (OFCMHAP) (2010). *Ideas and Opportunities for Bending the Health Care Cost Curve*.

²³ Ontario College of Family Physicians (February 13, 2011). Policy statement.

Recommended Actions

Implement effective governance models for integrated care.

Successful models already exist within Ontario, e.g., provincial agencies such as Cancer Care Ontario (CCO), responsible for a regionalized cancer system; provincial networks such as the Cardiac Care Network of Ontario (CCN), the Northern Diabetes Health Network, and the electronic Child Health Network (eCHN); and regional and local level networks such as the Durham Region Diabetes Network and the Shared Information Management Services Partnership (SIMS Partnership) between 17 healthcare organizations in the GTA. The challenge for government is to learn from these successes and to build on them, to establish a governance model for an integrated system of primary, secondary, tertiary, quaternary and home and community care. The review of the LHSIA legislation and its regulations should be initiated and completed as soon as possible to inform these developments.

Further refine and clarify authority and accountabilities.

Whether LHINs acquire more authority to plan and commission programs/services and allocate resources, are restructured, or are replaced by another governance arrangement, the need for clarity and communication about the respective authorities and accountabilities of regional bodies and the Ministry is paramount.

Articulate system-level strategic priorities and goals in a clear provincial plan.

Currently, each of the nearly 2,700 healthcare organizations who sign annual accountability agreements with the LHINs is undertaking its own planning function in relative independence of the others—and this needs to change. To facilitate system-level change, articulate system-level priorities and goals in a way that clearly shows the role individual organizations can play in meeting them. Integrated services for patients and their

caregivers are best supported by regional bodies and healthcare providers who are collaborative, rather than independent, in their planning and in their pursuit of strategic priorities and goals.

Consolidate, but with respect for local input.

Further consolidation of community agencies appears inevitable if regional governing bodies are to have more power and functionality, and to allow for more sophisticated management structures. Other jurisdictions have eliminated many local boards and reduced the power of those which remain, but have established new mechanisms to engage the community and give capable and engaged citizens an opportunity to take part.

Start connecting the missing pieces.

Conversations have begun about the need to deal with the missing pieces—specifically, the need to connect the primary care sector more directly with regional priorities.²⁴ Whether or not agreements are the answer, it is difficult to see how LHINs—or the next iteration of planning and governance bodies—can achieve their objectives for population health and chronic disease management without a more formal way of engaging the primary care sector. These conversations need to continue, and lead to action and results.

Provide strong central leadership and province-wide direction in key program and service areas.

LHINs or the next iteration of regional planning and governance bodies should reflect the benefits of system-wide planning authority and accountability for defined province-wide programs and services. We need to build on the success of the Cancer Care Ontario (CCO) model—i.e., a provincial authority responsible for managing the quality, coordination and accessibility of cancer programs and services throughout the province, and the quality of patients' experience.

²⁴ The Change Foundation (2009). *First Things First: Fostering Accountable, Connected, Quality Primary Health Care. (Meeting of the Minds, Toronto, June 16–17.)*

Update the relationship between physicians and hospitals.

This can be done by establishing contracts between physicians and hospitals that clearly establish two-way accountabilities, in order to align physicians' work with system-wide priorities and with the expectations of planning networks, the government and the public.²⁵

Open dialogue and encourage public engagement.

Discussions about governance are tricky—rife with sensitivities about hierarchy, control, values and authority. But lack of discussion leaves room for misunderstanding, disrespect and resistance. Discussions must begin with a dispassionate framing of the facts, with the purpose of the engagement clear and with everyone understanding how the public's input will be used and where and when it will be reflected. Before conversations begin, the role of LHINs vis-à-vis the province and local boards must be clarified, along with the relationship between LHINs and system partners not currently accountable to them. It's time to talk about these governance and accountability issues openly and systematically and come to some conclusions. The public needs to be part of these tricky discussions; they are partners in system change.²⁶ Dedicated financial support for community engagement, with sufficient time to plan, are required to make it more likely that the engagement will be meaningful and robust.

25 As recommended by the OACCAC, OFCMHAP and OHA in *Ideas and Opportunities for Bending the Health Care Cost Curve, 2010*.

26 See a commentary on Community Engagement and the LHINs by The Change Foundation, *Engaging communities in health-care change in Ontario: Mission impossible?*, and a summary report from a symposium on the same issue, *Community engagement & the LHINs: Truth and Consequences*.



Funding

A population-based funding formula applied equitably and with programmatic funding dedicated to specific priority services, contributes to successful health system integration. Comprehensive funding—coverage for services across the primary, secondary, tertiary, health promotion and population health continuum—and alignment of financial incentives have been identified as critical components of successfully integrated health systems.

Historically, Ontario has used a variety of allocation models to fund healthcare providers: global budgets for hospitals, OHIP payments for physicians, per diem rates for long-term care, etc. We know that different funding models incent different behaviours at the provider and organizational level.²⁷ But siloed funding gets in the way of integrated care. Our current provider-focused funding models are the legacy of historical developments and not part of a well thought-out system design, and our funding mechanisms are less population-focused and geographically defined than in provinces with longer traditions of regionalization.

Physician compensation is one aspect that needs updating—an important one. It comprises 23% of Ontario's healthcare funding pie (second only to hospitals).²⁸ Four in 10 of the province's doctors (41%) are funded fee-for-service (FFS) for 90% or more of their income; 34% are funded through blended payment (with components of capitation, FFS and bonus payments); 9% are on salary (most of them working in CHCs); and 3% receive 90% or more of their income through a capitation model.²⁹

Physician surveys indicate that most doctors favour alternative payment plans or blended approaches

with components of capitation, FFS and bonus payments³⁰—a potential win-win situation since this could better align physician payment with healthcare system goals. A review of high-performing health systems shows the importance of moving away from a reliance on FFS, toward blended payment models and population-based funding.³¹ Also, a recent TD Economics report advocated for a change in how Ontario's doctors are paid. It called for a blended capitation, salary and FFS structure in which the FFS component would be procedure-specific and greatly reduced.³²

In the US, a major strength of integrated delivery systems such as Kaiser Permanente and Geisinger Health System is that physicians are salaried employees who can earn bonuses. This strengthens their accountability and gives them extra incentive to deliver evidence-based care, adopt new technologies and work collaboratively with other health professionals.

On the other hand, the global-budget approach in Canadian hospital funding has a key advantage: cost containment. Some jurisdictions—including British Columbia, Alberta and our own—are hoping to combine the best of both, experimenting with models that retain the cost-containment element of a global

27 Deber R, Hollander M, and Jacobs P (2008). Models of funding and reimbursement in health care: A conceptual framework. *Canadian Public Administration* 51(3): 381–405.

28 Canadian Institute for Health Information (CIHI) (March 2010). *Analysis in Brief: 2007 National Physician Survey*.

29 College of Family Physicians of Canada (CFPC), Canadian Medical Association (CMA) and Royal College of Physicians and Surgeons of Canada (RCPSC). 2010 National Physician Survey.

30 CIHI (March 2010). *Analysis in Brief*.

31 Baker GR, et al. (2008). *High performing healthcare systems: Delivering quality by design*. Toronto: Longwoods Publishing Corporation.

32 TD Economics (May 2010). *Charting a Path to Sustainable Health Care in Ontario: 10 proposals to restrain cost growth without compromising quality of care*.

budget but incorporate activity-based funding with incentives for efficiency. In Ontario, for example, the ECFAA legislation includes plans to implement patient-based payment in large hospitals, with reimbursement to be based on type, volume and quality of care. ECFAA has also introduced pay-for-performance for hospital executives. A portion of their salaries will be linked to the achievement of improvement targets as set out in annual quality improvement plans.

A Health Based Allocation Model (HBAM) has also been under development in two sectors: acute care and CCAC/home care. HBAM is a utilization-based funding model (it calculates need based on the previous three years of usage by people in a LHIN's catchment area). It is generally accepted that such models don't capture unmet service needs or identify required improvements (i.e., a move from institutional to community-based care). Instead, their focus on what already exists may serve to perpetuate less-than-ideal delivery models. But on the positive side, one of HBAM's guiding principles is to facilitate health sector integration. Until HBAM is fully developed and ready for wider use in the acute and CCAC/home-care sector and in other sectors, there will be no population-based funding model that takes into account such factors as geographic diversity, socio-economic determinants of health, high-growth urban populations or disease prevalence.

Another issue is the lack of discretionary funding in the existing LHIN structure. LHINs are planning bodies and are technically the “funders” for healthcare providers. But in reality they serve as a route through which the Ministry flows pre-determined funds. LHINs have little opportunity to re-allocate money by shifting it, for example, from hospitals to community or alternative providers. The percentage of their budget which is discretionary is negligible; some LHIN CEOs say it is trivially low (1%), while others believe they can move at least a few percentage points around. Some LHINs have made efforts to re-allocate existing funds—for example, the Central East LHIN's “1% challenge” to move \$10.3

million of the hospital budget to community programs, through changes in the way care was provided.

Any major re-allocation is a challenging prospect for LHINs because local boards, which the government has kept in place, may be resistant—particularly in the absence of robust data to inform decisions and create space for reconsidering traditional patterns (see Performance Management section). Other challenges include dealing with a sometimes conflicted mix of community expectations, uncertainty about the extent of their mandate, and the fact that their influence is limited because physician fees and other primary care funds flow separately from the LHIN structure. A compounding factor is that physicians—due to their role in linking patients to services—drive a major portion of LHIN and system costs.

Clearly, LHINs are not yet true commissioners of health services. With the single exception of home care (where CCACs select providers), LHINs don't choose between providers. Much of the clout they may seem to have is compromised, especially when the going gets tough, by the government's unwillingness to devolve real decision-making power.

If LHINs—or future iterations of regional planning bodies—are expected to forge significant change, there will need to be an understanding of the extent to which their funding of providers is discretionary. Moreover, a reasonable amount of it will need to be discretionary. Government will have to support them in their move from being pass-through organizations, essentially, to claiming a place as authoritative purchasers of services. LHINs or their successors will need the realistic potential to re-allocate significant funds to make meaningful change in the short and longer term. In an environment where new resources are not likely to be available, it may make sense for the provincial government to establish targets, based on data, for mandatory re-allocation of funds.

The way we fund organizations and pay providers matters, as it directs activity and behaviour. Ontarians need sophisticated and aligned funding models and payment systems that incent integrated, coordinated, comprehensive and high-quality care across the continuum of primary, community, hospital and specialty care. A focus on specific funding or payment models—whether for specific providers, sectors or organizations within sectors, or specific interactions or conditions—often results in unintended consequences if other influential factors such as culture and leadership don't get adequate consideration. The Change Foundation advocates for transformational restructuring of Ontario's healthcare funding system, so that our existing resources can be put to more effective use.

“By moving to more sophisticated payment systems for physicians, pharmacies, acute care and chronic care, spending can be reduced...alternate pricing models may also curtail the growth of inappropriate and often expensive procedures.”

—Falk, W. et al “Fiscal sustainability and the Transformation of Canada's healthcare System: A Shifting Gears Report (May, 2011), Mowat Centre and the School of Public Policy and Governance (UofT), KPMG, 2011.

Recommended Actions

Launch a major cooperative effort to examine funding systems in the context of reaffirmed system goals and whole-system design.

Reshape our healthcare system into one which behaves as a single entity with subdivisions—one with incentives for patient-centred care that are compatible and aligned with one another, and that cross subdivision boundaries in support of clinical integration and collaboration between hospital and community providers.

Create a Payment and Funding Commission.

The Change Foundation recognizes that HQO has a mandate to provide advice on funding models, but we believe a more comprehensive and intensive process is needed too. We envision a Payment and Funding Commission with a strong high-profile mandate to improve funding models across the healthcare system.

Increase the proportion of discretionary funds.

Reinforce the credibility and effectiveness of the LHINs—or whatever new bodies may replace them—by reducing the proportion of funds that simply flows through them, and enhancing their truly discretionary envelopes. They will need to develop purchasing skills, and have timely access to necessary data to compare providers and monitor performance against goals. Consider expanding the use of HBAM to assist with this. And learn from purchaser-provider arrangements in other jurisdictions.

Support experimental funding models.

A number of LHINs want to create a more formal financial relationship with the primary care sector. Let them (or their possible replacements) experiment with their primary care partners and test some models for reform. **Move ahead with bundled payment models and consider budget pooling opportunities.**

Bundled payment models have been tested with wound care and palliative care. Continue to test funding envelopes for “bundles of service” to facilitate inter-sectoral collaboration. Some LHINs are in discussion with CCACs and municipal authorities regarding health and social care planning and partnerships. Let them (or their future iteration) explore the pooling of budgets as a possible catalyst to improving health and social care integration.

Increase the number of physicians who are on salary or compensated through alternative payment plans and blended payment approaches.

The purpose of payment reform must be to better align providers’ approaches with system goals and with the quality strategies embedded in the *Excellent Care for All Act*. Appropriate incentives should be developed and put into place. Use the upcoming negotiations with the OMA (to finalize the new four-year agreement) as a chance to push for such alignment.

Add non-financial incentives to the mix.

Organizations and individuals have concerns other than financial gain, i.e., different carrots for different values. Create non-financial incentives designed to appeal, for example, to a desire for excellence. Ideally, funding models and payment systems—augmented by incentives of both or either type—should support a culture of quality and continuous improvement within organizations and professions, with the ultimate goal of improved health outcomes and patient experience.

Performance Management

Integrated health systems aspire to continuous quality improvement. Performance goals are explicitly defined and there is a coordinated and aligned approach to setting, delivering and monitoring standards. The public should have access to information on the performance of the health system—health outcomes, patient and caregiver experience, and provider, organizational and inter-organizational performance.

How is our health system doing, as a whole, to help Ontarians achieve the best-possible outcomes? What quality of experience are people having as they navigate the system—and is it improving? These are core questions when considering a healthcare system’s success and sustainability. But performance information from an *integrated system perspective* is lacking in Ontario. And therefore so are the answers.

It remains to be seen whether this will change significantly due to the expanded mandate given to HQO under the ECFAA legislation, and other elements of the Act. For instance, the Act requires organizations—starting with hospitals—to post Quality Plans on their websites and provide them to HQO.

Meanwhile, there is very little data available on patient experience. To date, efforts to gauge this have tended to focus on easy-to-measure phenomena and processes rather than on more complex aspects. We know very little, in particular, about the quality of people’s transitions across providers, organizations and sectors. Few surveys or other data-gathering projects delve into the experiences of the frail elderly, people with multiple chronic conditions, or children and adults with disabilities (the ones who have the most interactions with different providers and organizations). And their quality of care as they move from one to the next is hard to determine, given that our current performance measurement framework is designed to look at quality and accountability on an *individual*

organizational level. This is true even of the Quality Plans mentioned above.

High-performing health systems have integrated performance reporting mechanisms, linked by coherent sets of indicators. In Ontario, HQO is using what it designates as “nine attributes of a high-performing health system” as a framework for organizing performance indicators.³³ New indicators are being added with each HQO annual report and tracked to reveal improvement (or lack of) over time. However, these indicators have not been well understood or universally adopted in the province, and tend to be sector-specific (e.g., hospital, long-term care, primary care) or disease-specific (e.g., diabetes, cancer, mental illness).

Currently, performance reporting in Ontario is done primarily through Ministry-LHIN accountability agreements and through service accountability agreements between LHINs and individual organizations. Once again, limitations of the current LHIN configuration arise. LHINs have acknowledged that they have insufficient resources and limited capacity to monitor or measure performance in real time, or to explore any measures or indicators beyond those included in the accountability agreements. The 2008 KPMG effectiveness review recommended a move to a strong focus on outcomes,³⁴ but indicators in the accountability agreements tend to focus on service volumes and proxy measures instead. Also, important but hard-to-track population health and health-disparities indicators are lacking, in general. The lack of analytical capacity within LHINs is an Achilles’ heel, hindering Ontario’s progress with system integration and with evidence-based decision-making.

33 HQO’s nine attributes are: accessible, effective, safe, patient-centred, equitable, efficient, appropriately resourced, integrated and focused on population health.

34 KPMG (2008). MOHLTC—LHIN Effectiveness Review Final Report.

Some LHINs have publicly acknowledged that it is difficult to achieve quality across sectors in a system where governance and accountability are measured and managed at the organizational level.³⁵ This strong statement illustrates the causal link: One’s ability to measure quality affects one’s ability to provide it.

Some sectors of our healthcare system do have more sophisticated data capacity and reporting systems: hospitals have a long history of reporting to the Ministry, prior to the establishment of LHINs; and CCACs are continually improving their data collection and reporting systems. For example, patient satisfaction surveys are routinely collected in both hospitals and CCACs. However, there is room for improvement to fully understand the patient experience. As a case in point, patient satisfaction surveys generally report high levels of satisfaction; but the same patients report problems when they are asked to comment on specific aspects of treatment or to comment, in detail, on the details of the process of care.³⁶

With the exception of CHCs (which have accountability agreements with LHINs), a primary healthcare provider in Ontario—be it a clinic, an FHT, or a doctor in group or solo practice—is largely publicly unaccountable for service or performance standards. This means for either quality of practice or health outcomes. It’s worth remembering that the College of Physicians and Surgeons of Ontario, to which doctors are clinically accountable, is in place to investigate complaints and maintain a standard of practice; its role is not to track or report quality of performance. Compare Ontario’s situation with that in the UK, where doctors are required to post quality reports.

35 Central LHIN (March 3, 2011). *Patients First—Creating Quality in the Transitions of Care: Emerging Themes.*

36 Goodrich J and Cornwell J (2008). *Seeing the Person in the Patient: The Point of Care Review Paper.* The King’s Fund.

The task of developing an integrated performance reporting and management system is complex. As we have seen, looking at organizations one-by-one and not as aspects of an integrated system means our indicators may be fragmented and narrow. It limits our thinking about what performance means, and our options for improving quality, effectiveness and efficiency. But an overall composite indicator could mask both good and poor performance on particular dimensions. A balance will need to be struck as we move ahead.

Appropriate data, metrics and public reporting on performance are widely recognized as key contributors to motivating providers and ensuring system accountability. And benefits multiply in ways that aren't immediately apparent, since people who know what they're working with—i.e., what's working, and what isn't—are better positioned to budget and plan. This can facilitate the ability of government to make longer-term funding commitments; of regional bodies to manage discretionary funding; of provider organizations to pursue bundled funding opportunities; and of primary care organizations to use targeted funding to best meet local, regional and province-wide needs.

Recommended Actions

Develop a system-wide performance management framework, including performance management in primary care.

The system needs an enhanced framework with standardized methodologies and with common reporting on a balanced and comprehensive set of performance dimensions and quality-monitoring processes. Regional bodies should report to the public on region-wide achievements in relation to provincial and regional targets; on provider- or organization-specific performance, to support comparative monitoring; and on patient experience. The performance dimensions must include the quality of cross-organization and cross-sector transitions, i.e., how patients and their caregivers are experiencing the hand-offs at transitions in care. Performance metrics must be integrated vertically and horizontally—from individual to population levels, and across sectors and geographic areas. There has to be a deep coherence to the overall performance measurement enterprise, to support decisions and accurately reflect the dimensions of performance that mean the most to patients.

Develop performance indicators that can provide a more sophisticated measurement of patient experience.

Make patient and caregiver experience an integral part of performance and accountability reporting within the requirements of ECFAA. Continually refine public experience surveys—not satisfaction surveys about specific episodes of care, but surveys to monitor ongoing experience, with a focus on those who are at greatest risk of inconvenience and/or substandard service. This data could be built into performance monitoring on a regional planning basis.

Information Management

Investments in information technology, information management systems and communication mechanisms facilitate integrated service delivery along the continuum of care. The patient experience in navigating a health system can be vastly improved through electronic health records and other electronic systems. Integrated information and communication systems are especially critical when providers are not co-located.

Ontario's uptake of healthcare-related information management technology is on the rise. In 2006, 26% of our family doctors had an Electronic Medical Record (EMR) system in their offices,³⁷ and this rose to 60% by 2011, with funding and other support from the OntarioMD program.³⁸ But we still have a significant way to go. In comparison, between 95% and 99% of family doctors in the UK, Australia and the Netherlands have EMRs.

We have even further to go in our uptake of Electronic Health Records (EHRs)—and this is where the strongest benefits of information technology are realized. EHR systems can span multiple organizations, allowing information to be pooled and shared, and allowing a patient's records to be automatically available to a specialist or new provider. The impact on patient experience is dramatic: no more worrying about data or results that might be delayed or go missing, no more need to re-tell the same stories, and no more chance of having to needlessly repeat a diagnostic test. Plus, information-sharing and improved preparedness on the providers' part stands to have a good impact on clinical care.

From a financial perspective, the long-term payback is large because most of the system's (costly) duplication and inefficiencies happen at points of transition, i.e., when patients are moving between providers and information is not conveyed on time or at all.

Unfortunately, we are still in the early stages of implementing a functioning EHR system. Only 9% of Ontario hospitals send information electronically to

other hospitals, home care or primary care providers.³⁹ When will we get to where we want to be? The Province's eHealth Strategy has set the goal of an EHR for all Ontarians by 2015. The strategy is focused on three clinical priorities—diabetes management, medication management and wait times—and has identified the engagement of clinicians as a guiding principle in moving forward. Their involvement in the design and implementation of eHealth components will be critical to the strategy's success.⁴⁰

Two other groups need to be considered: LHINs or their future iterations, and the public. The LHINs stand to benefit from greater access to high-quality, comprehensive, real-time information. It is an essential ingredient of successful governance and can aid in the development of consensus, building credibility among the various interests in the system. But at present, the LHINs' capacity to obtain and analyze information and produce decision-support reports is underdeveloped. Regarding the public, there are still only a few information portals accessible to Ontarians (online access to healthcare information is another aspect of the eHealth plan). And the public has not, to date, been significantly involved in the design or implementation of EHRs.

37 College of Family Physicians of Canada (CFPC), Canadian Medical Association (CMA) and Royal College of Physicians and Surgeons of Canada (RCPSC). 2007 National Physician Survey.

38 See <https://www.ontariomd.ca>.

39 Ontario Health Quality Council (2010). *Quality Monitor: 2010 Report on Ontario's Health System*.

40 See www.ehealthontario.on.ca

Recommended Actions

Ensure that future eHealth planning incorporates public engagement.

The controversy in 2009 over eHealth spending practices agitated public concern about efforts to date. This must and can be overcome by engaging patients and caregivers in implementation planning. There is growing demand among the public for health information that is accessible and understandable, and Ontario has an opportunity to design and implement patient-oriented approaches. Patient and caregiver engagement will—along with clinician engagement—be critical to the success of the eHealth Strategy.

Clarify and expand the role of LHINs/regional bodies in eHealth planning and implementation.

Further development of the overall provincial IT and health information plan will need regional implementation. The IT development plan should include a policy framework that secures access to anonymized data for multiple purposes, including decision support for managers, regional bodies and the Ministry.

Enhance LHIN/regional body capacity to acquire and use information.

LHINs or their future iterations will need this enhanced capacity to inform decisions, communicate with the public, purchase services on the basis of sound evidence, and monitor quality, efficiency and fairness.



Summary of recommendations to achieve integrated healthcare and better patient experiences
 —The Change Foundation

System re-design—transformation of service provision

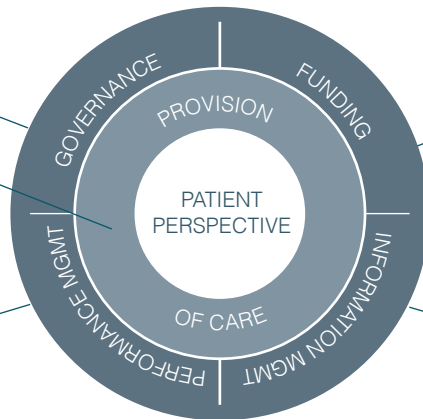
- Strategize to integrate primary care—planning, governance, funding
- Invest in QI in primary care

System-level strategic priorities and goals

- Create strong central leadership in key programs, services
- Consolidate community agencies with more sophisticated management structures
- Clarify authority and accountabilities
- Support public engagement in system re-design

Funding re-design

- Establish a Payment/Funding Commission
- Develop commissioning capacity and increase discretionary funds
- Pursue bundled payment models, budget-pooling opportunities
- Increase use of alternative payment plans, blended payment models



System-wide performance management framework

- Standardize methodologies for common reporting on performance dimensions and quality-monitoring processes
- Include the quality of cross-organization and cross-sector transitions
- Develop performance indicators for a more sophisticated measure of patient experience

eHealth development and implementation

- Engage patients and caregivers, along with clinicians
- Clarify and expand the role of regional bodies in eHealth planning, implementation
- Enhance regional bodies' capacity to acquire and use information

CONCLUDING COMMENTS

The Change Foundation believes that true system-level integration and transformation of healthcare is not possible under the current arrangements and conditions. Ontario needs to create the winning conditions to make it happen. Changes are required in all the areas reviewed in this commentary: the organization of how care is provided, governance and relationships, funding and payment models, performance management, information management and—most importantly—the embedding of the patient perspective in every aspect and every step. Our recommendations are interconnected and correlative, and should be pursued as a package rather than cherry-picked.

Changes both small **and** system-wide are needed to achieve complementary goals: better health outcomes, a higher quality of experience for individuals, and system sustainability.

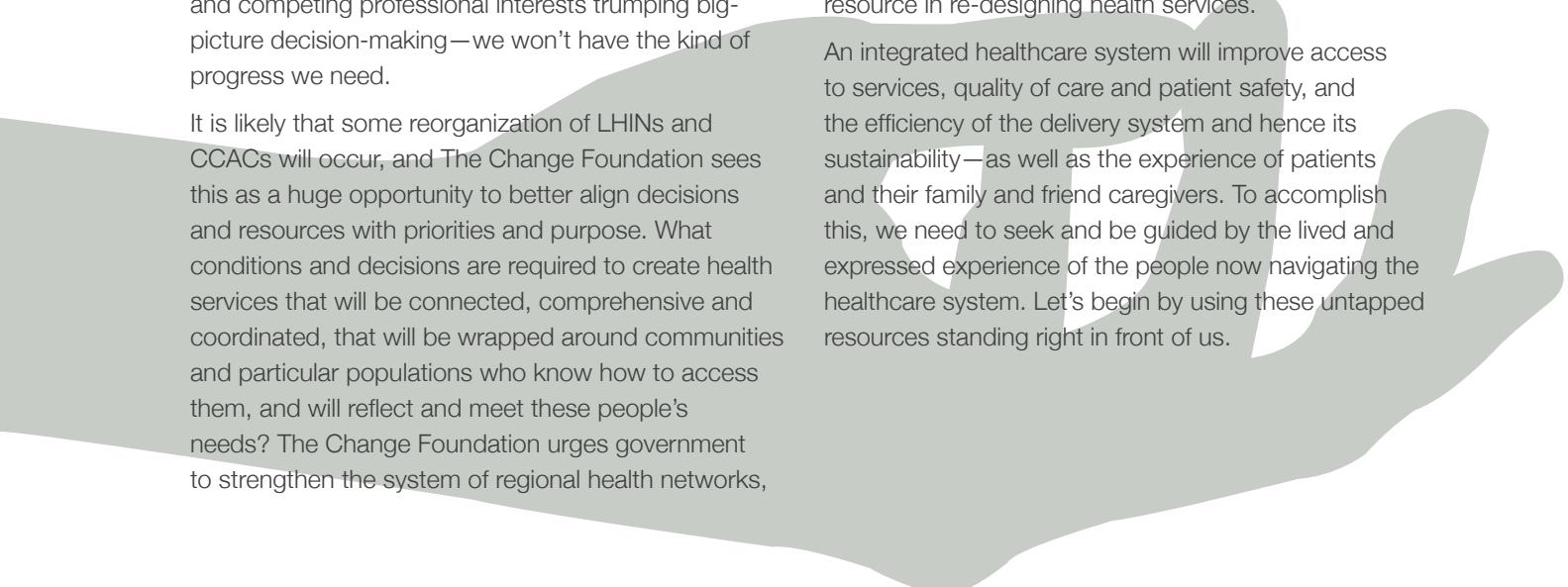
The Province is working on several fronts to improve healthcare quality, better serve patients, and use resources more strategically: the implementation of the *Excellent Care for All Act*, for instance, the expanded mandate of Health Quality Ontario, and more support for team-based primary care. But we need a game-changing shift. As long as the levers of healthcare change are grinding against each other—fee-for-service funding against team-based care; system planning without the ability to direct big chunks of the system; and competing professional interests trumping big-picture decision-making—we won't have the kind of progress we need.

It is likely that some reorganization of LHINs and CCACs will occur, and The Change Foundation sees this as a huge opportunity to better align decisions and resources with priorities and purpose. What conditions and decisions are required to create health services that will be connected, comprehensive and coordinated, that will be wrapped around communities and particular populations who know how to access them, and will reflect and meet these people's needs? The Change Foundation urges government to strengthen the system of regional health networks,

be they LHINs per se or some other iteration, with the proviso that such bodies be given the autonomy and discretionary funds—in short, the power—to do the work they are mandated to do.

It isn't a matter of money. Additional investments are not required. What is needed, instead, is to maximize the impact of existing investments through the re-allocation and better targeting of funds, along with creative and innovative thinking from a system point of view, and an openness to learn from research and from the experiences of other jurisdictions. Also required—as The Change Foundation's research has shown—is the addition of patients and their family/friend caregivers to the roster of “experts.” They can serve as a guiding resource in re-designing health services.

An integrated healthcare system will improve access to services, quality of care and patient safety, and the efficiency of the delivery system and hence its sustainability—as well as the experience of patients and their family and friend caregivers. To accomplish this, we need to seek and be guided by the lived and expressed experience of the people now navigating the healthcare system. Let's begin by using these untapped resources standing right in front of us.



APPENDIX

Highlights of Issues and Recommended Actions

The following table highlights the main issues and recommended actions that are presented in the body of this report. The same framework is used: the critical elements of integrated care.

MAIN ISSUES	RECOMMENDED ACTIONS
Provision of Care	
<p>Investments in primary care in Ontario are starting to pay off, but there is a risk of losing momentum for change and failing to maximize the return on investment because primary care is not integrated with the rest of the health system.</p>	<p>Develop a strategy for integrating primary care with the rest of the health system. The strategy needs to support integrated planning, resource allocation and improvement. We need a transformational re-think and re-design of how services are provided, so that individuals and families can be supported in their homes and communities.</p>
<p>The achievement of substantive goals for primary care will depend, in large part, on the extent to which practitioners and organizations embrace a patient-centred culture, interprofessional care, leading-edge QI methods and tools, and performance measurement systems.</p>	<p>Ensure that professional education and training programs promote patient-centred care, patient engagement and interprofessional collaborative practice. A culture change is required so that all healthcare practitioners consider issues of service, communication and other non-technical aspects of the patient experience in the health system.</p>
Governance and Relationships	
<p>There is a disjunction between formal and de facto authority in Ontario's devolved model. The Ministry/government appears to have low tolerance for discontent and conflict regarding proposals for substantive change. Successful models of provincial networks and regionalized care systems already exist.</p>	<p>Implement effective governance models for integrated care across all sectors—including primary care. Establish clear lines of authority and accountability for regional bodies and the Ministry, and strong central leadership for program and service areas that require system-wide planning, authority and accountability. Take cues from provincial networks and regionalized care systems that are already operating successfully.</p>

MAIN ISSUES	RECOMMENDED ACTIONS
<p>Ontario's regional model is characterized by devolution from the province without structural centralization at the local level. Leaving local boards in place has created a governance and management challenge for system-level change.</p>	<p>Articulate system-level strategic priorities and goals in a clear provincial plan. Undertake collaborative planning between regional bodies and healthcare provider organizations to meet these priorities and goals. Pursue further consolidation of community agencies, with more sophisticated management structures. Establish effective engagement mechanisms.</p>
<h3>Funding</h3>	
<p>Ontario has a variety of allocation models to fund healthcare providers, e.g., hospital global budgets, OHIP payments, per diem rates for long-term care. Our current provider-focused funding models are the legacy of historical developments and not part of a well thought-out system design. How we fund organizations and pay providers influences activity and behaviour.</p>	<p>Launch a major cooperative effort to examine funding systems in the context of reaffirmed system goals and whole system design. Create a Payment and Funding Commission with a strong high-profile mandate to improve funding models across the healthcare system, i.e., funding and payment models that incent integrated, coordinated, comprehensive and high quality care across the continuum of care.</p>
<p>High performing health systems are less reliant on FFS funding models, using more population-based funding and blended payment models. Surveys indicate that most physicians favour alternative payment plans or blended models.</p>	<p>Increase the number of physicians compensated through alternative payment plans and blended payment approaches. The purpose of payment reform must be to align incentives with system goals. The Ministry could use upcoming negotiations with the OMA to push for such alignment.</p>
<h3>Performance Management</h3>	
<p>To date, health system performance information from an integrated system perspective has been lacking in Ontario. It remains to be seen whether the expanded mandate given to HQO under the ECFAA will change this.</p>	<p>Develop a system-wide performance framework including performance management in primary care. The framework should include standardized methodologies and common reporting on a set of performance dimensions and quality-monitoring processes. The performance dimensions must include the quality of cross-organization and cross-sector transitions. Performance metrics must be integrated vertically and horizontally.</p>

MAIN ISSUES	RECOMMENDED ACTIONS
<p>Patient surveys are routinely undertaken in hospitals and by CCACs, but there is room for improvement to truly understand the patient experience. There are limited mechanisms for getting feedback on people's experience in primary care; and the quality of service and experience during cross-organization and cross-sector transitions is hard to address because current performance measures are at the individual organization level.</p>	<p>Develop performance indicators with more sophisticated measurement of the patient experience. Make patient/caregiver experience an integral part of performance reporting, within the requirements of the ECFAA. Public experience surveys need to be continually refined, with a focus on those at greatest risk for inconvenience and/or substandard service. This data could be built into performance monitoring on a regional planning basis.</p>
<p>Information Management</p>	
<p>Ontario still needs to make significant progress in increasing the number of family physicians who have an EMR system, and in implementing an EHR system that will allow records to be shared across organizations and providers.</p>	<p>Ensure that future eHealth planning incorporates patient and caregiver engagement, and expand the role of regional bodies in eHealth planning and implementation.</p>
<p>The capacity of regional bodies to obtain and analyze information and produce decision-support materials is underdeveloped in Ontario. This is problematic because high quality, comprehensive, real-time information is an essential ingredient of successful governance and is necessary in the development of consensus-building credibility among various interests in the healthcare system.</p>	<p>Enhance regional bodies' capacity to acquire and use information to make evidence-based decisions, communicate with the public, purchase services on the basis of sound evidence, and monitor quality, efficiency and fairness.</p>

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Vision

To be Ontario's trusted advisor advancing innovative health policy and practice.

Mandate

To promote, support and improve health and the delivery of healthcare in Ontario.

Goal

- To improve the experience of caregivers and individuals as they move in, out of, and across the healthcare system over time.

Mission

- To make caregivers and individuals in need of healthcare part of the healthcare discussion about how to find solutions to improve their experiences.
- To stimulate new ways of thinking, behaving, and interacting to foster improved health care for people, especially when they are in transitions.
- To generate robust and independent research and policy analysis of healthcare issues related to improving the experience of individuals and caregivers as they navigate the healthcare system.
- To lead informed discussion and strategic engagement with the stewards, stakeholders and users of the healthcare system.

Values

Excellence. We strive for excellence in all we do. **Innovation.** We take innovative approaches in developing new ideas. **Collaboration.** We work in partnership with others to achieve success. **Inclusivity.** We strive to include all voices and views.

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