Moving Towards *Patients First*

A Response to a Proposal to

Strengthen Patient-Centred Health Care in Ontario

Submitted by The Change Foundation

February 2016

INTRODUCTION

The Change Foundation (TCF) is a charitable foundation established in 1995 to support, promote and improve health and health care delivery in Ontario. We have spent the last five years promoting patient-centred care, and patient and family caregiver engagement.[1] We know that better integrated health and community care can improve patient experience, lead to better health outcomes, and achieve more value and quality from health system investments.

During this time period, numerous reports and reviews have underscored the fact that the design and outcomes of Ontario health's care system have not kept pace with improvements in other jurisdictions. Witness the 2012 Drummond report on reforming public services; the 2015 Primary Health Care Expert Advisory Committee report, the Expert Panel on Home and Community Care report and two reports from the Auditor General focusing on aspects of the health care system. A recent Health Quality Ontario eloquently sums up our current state of affairs:

> *"It is clear to many who work in our health care system and to those who depend on it that the system's quality falls short of our aspirations. Expected outcomes are not consistently achieved. There are wide and unexplained variations in health care delivery.* ***Patients frequently have dissatisfying and potentially dangerous experiences with the system and do not feel part of the solution."[2] (emphasis added)***

The government's discussion paper*, Patients First,* outlines the next set of reforms being proposed to deal with some of these challenges. It is the Foundation's view that we have had enough review and analysis of different parts of our health care system and that it is now time to address significant policy issues. It is time to get on with the hard work of real reform. It is not clear to us that *Patients First*, on its own, is enough. But perhaps it's a start. The language of the paper hits all the right notes but the lack of detail makes it difficult to formulate concrete recommendations. Therefore, we have structured our feedback through a series of questions for the Ministry's consideration as implementation plans are put in motion.

[1] The Change Foundation (2015) Their Experience. Our Story. Highlights from the 2010-2015 Strategic Plan. Toronto: The Change Foundation.
[2] Health Quality Ontario (2016) Quality Matters: Realizing Excellent Care for All. Toronto: HQO; p5.

INTEGRATED CARE AS THE FUNDAMENTAL BUILDING BLOCK FOR REFORM

All of the reports noted above, including *Patients First*, describe the impacts of a system that is not integrated. And, through our patient engagement work, and more recently our family caregiver engagement work, we have heard the very personal impacts of a disjointed system. *Patients First* states explicitly that "we propose to truly integrate the health care system so that it provides the care patients need no matter where they live." Therefore, our feedback on *Patients First* is offered through the lens of what we know contributes to a successfully integrated system, which in turn puts patients, and their families, first.

The Foundation has undertaken several reviews of the evidence on high performing, integrated systems and has also learned from engaging directly with Ontario patients and families. We organized the critical elements of an integrated health system under a framework presented in our *Winning Conditions* report.[3] Using the visual below, we summarized our learning as shown here:

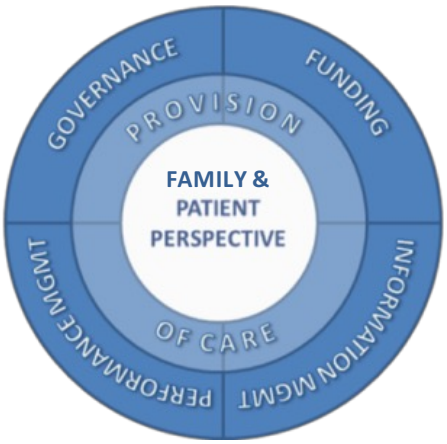

Figure 1: Key Elements of Integrated Care

Provision of Care: systems are organized in interprofessional teams that provide clinical care with a clear understanding of roles and decision-making authority; teams are supported by standardized care models with evidence-based clinical guidelines, umbrella structures and provider networks with standardized referral procedures, service agreements and shared information systems.

Governance: organizations (delivery and otherwise) have strong governance structures with decision-making authority, clear accountabilities, shared risk, opportunities for community engagement in decision-making, and planning within a geographic area.

Funding: formulas include population-based funding applied equitably and programmatic funding dedicated to priority services; comprehensive funding (for

[3] The Change Foundation (2011) *Winning Conditions to Improve Patient Care: Integrated Healthcare in Ontario.* Toronto: The Change Foundation.

services across primary, secondary, tertiary, prevention and health promotion) and alignment of financial incentives.

Performance Management: systems commit to continuous quality improvement; performance goals with a coordinated and aligned approach to setting and monitoring standards; public access to information on the performance of the health system including health outcomes, patient and caregiver experience, provider, organizational and inter-organizational performance.

Information Management: systems invest in information technology, information management and communication mechanisms; patient and caregiver experience in navigating the system is vastly improved through shared electronic health records and other electronic systems providing real time information at the point of care.

Patient and Family Perspective: valued, collected and used to improve quality and system performance. It is core to decisions related to the other elements.

THE FOUNDATION'S INPUT ON THE *PATIENT FIRST* PROPOSALS

Proposal 1: More Effective Integration of Services and Greater Equity

This is to be achieved through two actions:

A. *To provide care that is more integrated and responsive to local needs, make LHINs responsible and accountable for all health service planning and performance.*
B. *Identify smaller regions as part of each LHIN to be the focal point for local planning and service management and delivery.*

Since the inception of the LHINS, there have been calls to expand their scope as they were only given planning responsibility for parts of the health care system. As well, the original LHIN boundaries were subject to some criticism as their size varied greatly and they did not coincide with existing municipal boundaries. The proposed changes will deal with those concerns. Will they, however lead to more integrated care?

There is little detail on how these proposals will be implemented making it hard to assess their actual impact on patient-centred care. It is unknown whether giving the LHINs more responsibility and creating sub-LHIN level planning and management tables will enhance clinically integrated care teams, strengthen organizational governance, increase the comprehensiveness of funding formulas, create more robust performance management systems and integrated information management platforms. At a minimum, LHINs will need to look at their governance and management skills mix given new areas of responsibility.

We presume that these proposals present an opportunity for LHINs and care providers to develop solutions for system problems closer to the points of care. As well we assume there will be opportunities for service innovation and re-design – i.e., to actually re-think where services can and should be offered. Patients and family caregivers must be engaged in an authentic way in these local discussions to ensure that change is informed by patient needs, using a patient-centred philosophy. Flexibility within communities is essential so that local solutions meet local needs, informed by local patients and their caregivers.

Key Questions

- What additional expertise will the LHINs require at the management and governance levels? *Patients First* does acknowledge that LHINs will "need some adjustments and additional tools to take on an expanded role."

- Will this create further resource requirements to support the sub-LHIN groupings and will there be IT investments to ensure connectivity between providers across the region?

- Will the LHINs have more ability to move funding around within their regional funding envelopes to support local delivery solutions? To date this has not been the case and has hampered some patient care innovations.

- Will the geography of the sub-LHINs take into account the natural clusters of their primary care practices and public health units – both of which are now coming under LHIN planning authority?

- Will steps be taken to address the issues raised by the Auditor General's observation that LHINs were not meeting all of their existing performance metrics? On average, LHINs achieved their respective local targets in 6 of the 15 performance areas and 4 of the 11 provincial targets that measure long term goals for the LHINs.[4] Will these issues be addressed before giving LHINs added responsibilities so that future measurement demonstrates better results?

- Will there be an opportunity to look at some integration of community and social services as these are often a key support when people receive care at home?

[4] Office of the Auditor General of Ontario (2015) Annual Report 2015. Toronto: Queen's Printer. Chapter 3: 315.

When the LHINs were created in Ontario, the decision was made not to move to full regional health authorities. The proposals in *Patients First* take the Province one step further towards such a planning structure without the direct delivery responsibilities. The governance and administrative complexity of these arrangements remain. In the long term, it is not clear to us that this is optimal for improving patient experiences and patient outcomes.

Proposal 2: Timely Access to Primary Care, and Seamless Links Between Primary Care and Other Services

This is to be achieved through two actions:

A. *Bring the planning and monitoring of primary care closer to the communities where services are delivered. LHINs, in partnership with local clinical leaders, would take responsibility for primary care planning and performance management.*
B. *Set out clearly the principles for successful clinical change, including engagement of local clinical leaders.*

This proposal is moving in the right direction given that clinical engagement is essential to any health reform initiative. Connecting primary care to regional and sub-regional planning makes sense. However, it is not clear from the brief description exactly how the LHINs will carry out this planning and performance management mandate. Primary care funding (with a few exceptions) is not under LHIN authority. The main lever for change identified in the discussion paper appears to be "local clinical leaders," however defined.

Back in 1999, The Health Services Restructuring Commission identified the need for a primary care strategy that envisioned interprofessional teams consolidated into administrative groups with enrolled patients, integrated information systems and a patient-centred philosophy guiding decisions.[5] Numerous research studies and literature reviews since have stressed exactly the same thing. [6] [7] [8] [9] [10] [11] The recent Price report in Ontario proposed administrative clusters for primary care practitioners with enrolled

[5] Health Service Restructuring Commission (1999) *Primary Health Care Strategy. Advice and Recommendations.* Toronto: HSRC.
[6] Hutchison BG et al (2001) Primary Care in Canada – So much innovation, so little change. *Health Affairs.* 20(3): 116-131.
[7] Peckham S and Hutchison BG (2012) Developing primary care: the contribution of primary care research networks. *Health Policy.* 8(2): 56-70.
[8] Hutchison B (2013) Refroming Canadian primary care – don't stop half-way. *Health Policy.* 9(1): 12-25.
[9] Aggarwal M and Hutchison B (2012) *Toward a Primary Care Strategy for Canada.* Ottawa: Canadian Foundation for Healthcare Improvement.
[10] Starfield B (2008) Primary care in Canada – coming or going? *Health Papers.* 8:56-62.
[11] Starfield B (2008) Access, primary care and the medical home. *Medical Care.* 46:1015-18.

patients that would create a contractual relationship with the LHINs. These ideas do not seem to be under consideration.

Again, there is not enough detail to determine a real long term impact on the provision of care or whether patient and family experience will be strengthened.

Key Questions

- How do the proposals deal with the variation in the governance and management capacity of primary care organizations across the province? And for the practitioners who are not in any formalized group practice, what will the relationship be with them??

- How will LHINs be able to establish a performance management system for primary care when only a sub-group of primary care providers are directly accountable to LHINs?

- Is there a longer term plan to address the separation of the planning and management responsibility of the LHINs and the contract negotiation responsibility of the Ministry?

- Is there a longer term plan for funding reform in this sector?

- How are patients and family caregivers going to be engaged in these discussions? Will the reforms increase their ability to access timely, high quality care or improve the rapid flow of information?

- How will local clinical leaders be encouraged to participate and are there sensitivities regarding engagement given the current relationship between organized medicine and the government?

- Will the linkage between primary and specialty care be enhanced through LHIN involvement and will there be further investment in integrated information systems to support rapid information flow and communication?

For far too long, Ontario's primary care sector has been disconnected from other parts of the system. A strong signal that primary care should be part of local planning and system performance is very welcome. What is required next is clarification about how this will occur, who it will affect and how patients and families will benefit.

Proposal 3: More Consistent and Accessible Home and Community Care

This is to be achieved through two actions:

A. Strengthen accountability and integrations of home and community care.
B. *Transfer direct responsibility for service management and delivery from the CCACs to the LHINs.*

Many other jurisdictions link their home and community care to their primary care teams so that there is seamless care for patients and families. Ontario may not be ready for this yet and therefore, this linkage to the LHINs is a first step.

Regardless of where responsibility for home and community care service planning and management sits, Ontario is facing large, unresolved issues of policy, funding and quality metrics for this sector. Structural reform – moving responsibility from the CCACs to the LHINs – on its own will not deal with these issues. It will simply transfer the problems from one group to another.

Key Questions

- What home and community services are to be provided through public insurance? This needs to be determined relatively quickly before responsibility is transferred so that a standard basket of services is available no matter where people live.

- Will there be some alignment between community support services and services currently provided through CCAC contracts (to be transferred to the LHINs)?

- Is the current contracting system to remain in place? There are fundamental challenges with the current model of contracting for service providers. The model has been a challenge for the CCACs and it will continue to pose problems for the LHINs. We actually need to deliver home and community care services in a different way that eliminates the current fragmentation experienced by patients and families.

- Will contract rates continue to remain frozen? Will harmonized billing rates be introduced?

- Is this a first step for LHINs to take on direct case management or is this a one-off? To date, LHINs have not taken on a direct service function. They will now be employers of the "CCAC employees providing support to clients." That will put them in the direct service business, and the shift that this will require cannot be underestimated.

- Will there be a framework to assist LHINs in dealing with the dual responsibility of service planning and operational responsibility for home and community care?

- To whom will the case coordinators be accountable? The discussion paper suggests that case coordinators will be employed by the LHIN and will be deployed to community settings – family health teams, community health centres or hospitals. They will be working in another employer's work environment. Will those host organizations be able to accommodate this new relationship? Will information systems be integrated? Will they require resources to do so?

- Where will the function of establishing clinical standards and outcomes-based performance targets reside? The discussion paper states that it will be centralized. Do we assume it could be a role for Health Quality Ontario (HQO)? This should not only include public reporting but also require responses to data – we need a deep coherence in the overall performance measurement / management and quality improvement enterprise. And whatever is designed should incorporate patient and family experience measures with real-time feedback.

The discussion paper does reference the Ministry's previously released ten point plan for home and community care continuing under LHIN leadership. Perhaps some of the points raised above will be part of those discussions. Again, we raise a caution from the Auditor General's report– if the implementation is to be filtered through the LHINs, a standardized approach to policy development will be paramount.

Above all else, as this transition occurs, it will be vital that the LHINs ensure that services to patients and families who are being supported by home and community care are not disrupted in any way. Clear public communication about the changes and the impact they will have for people receiving care should be a key priority.

Proposal 4: Stronger Links between Public Health and Other Health Services

This is to be achieved through two actions:

A. Integrate local population and public health planning with other health services.
B. Formalize linkages between LHINs and public health units.

This proposal is an important acknowledgement that public health is a key part of the Ontario health system and has historically remained somewhat apart from it. LHINs will receive dedicated provincial funding for public health units while local Boards of Health will continue to set budgets.

Key Questions

- How will requirements for performance and budgets be integrated when the LHINs are responsible for the accountability agreements with public health units, while local Boards of Health are setting the budget?

- Are there potential natural linkages between the existing 36 health units and the proposal for sub-regional planning areas within the 14 LHINs?

- What is the role of the Medical Officer of Health, who has statutory authority in certain areas, in working with LHIN leadership? The discussion paper says they will be "empowered."

- How will public health's traditional relationships with non-health care services (education, housing, income supports) be brought into the LHIN environment?

- Will public health's population health approach to planning be maintained within the planning approaches of the LHINs?

Ontario can certainly learn from the experience in other provinces where public health is fully integrated into provincial regional health authorities. Experience has been mixed – in some cases there has been a better coordination of clinical services and improved planning but in others pressing demands of the acute system have siphoned funds away from the traditional public health functions of disease prevention and improved population health.[12]

Concluding Comments

Now comes the challenging part – confronting the significant policy challenges and working out the details of implementing the proposals.

Patients First presents a platform for the next set of reforms to make Ontario's health system more of a system. The proposals use the language of a patient-centred health care system yet the proposals are largely about organizational changes. Moving forward we cannot lose sight of patients and their families. They need to be actively engaged in "creating a responsive health system". If we want our system to be patient-centred and responsive to the needs of patients and their families, they need to be active partners in the process.

[12] Moloughney B (2016) The Impacts on the Public Health Function with Integration with Regionalized Healthcare System. Toronto: City of Toronto Public Health Unit.

The timing of this work is a challenge - significant proposals for system restructuring are to unfold in a restricted fiscal environment, and change fatigue in the field is evident. We know that structural reform takes a lot of effort and resources; and that it can take attention away from other improvement efforts. Again, patient and families must not get lost in this process.

Our work over the last few years has provided us with the privilege of listening to the users of Ontario health care system and their family caregivers. More recently, with the release of our new Strategic Plan: *Out of the Shadow and Into the Circle* we have tilted our focus to family caregivers. Through our work on patient engagement and with caregivers, we know that they appreciate Ontario's health care providers and the services they receive. But, they are clear that the system is not organized in way that makes it easy to access, understand or navigate. The ultimate test of *Patients First* will be whether these proposals change their experience. And they are the only ones who can tell LHINs, the government and system providers whether they have.

There are opportunities to strengthen what has been proposed – to build in more patient and family engagement on the reforms and to ensure experienced-based measurement from the start. Clear communication about why these changes are necessary and how they will benefit patients and families *in a concrete* way is needed now. If this is not done, we will have failed the very people these reforms are meant to support.

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