The LHIN I(Deal): Integrated Healthcare = Better Patient Experience

Submission to the Standing Committee on Social Policy re. Review of the Local Health System Integration Act

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2/1/2014

THE CHANGE FOUNDATION

HEALTH CARE DESERVES
OUR FINEST THOUGHT

Introduction

The Change Foundation welcomes this opportunity to comment on the review of the 2006 Local Health System Integration Act (LHSIA) currently proceeding under the auspices of the Ontario Legislature's Standing Committee on Social Policy.

The Change Foundation is a charitable, independent, non-profit, non-partisan Foundation set up in 1995 to support, promote and improve health and the delivery of healthcare in Ontario. Our current focus is concentrated on integrated healthcare systems as a way to improve patient and caregiver experiences. Improved patient and caregiver experiences lead to better health outcomes and achieve more value and quality from health system investments.

The Standing Committee is asking good questions about the Local Health Integration Networks (LHINs). What is working? What needs improvement? Is the role clear and well understood? This brief is meant to answer some of those questions.

When the LHINS were established, the fragmented nature of Ontario healthcare was widely acknowledged, even if the impact on patients and caregivers was not fully understood and accepted. The move to bring siloed services - hospital, home, community, and long-term care - together under regional planning umbrellas made sense. At the time, not all services were brought together and local provider boards were left in place. But it was a start.

LHINs—the early years

The LHINs' start-up years were not easy. They were hampered by both a lack of clarity about their authority and clarity about their lack of authority - primary care and public health outside their ambit, for instance. That lack of clarity was confounded by an array of approaches taken by the LHINs and little common understanding of some of their standards, practices and behaviours.

In addition to the predictable difficulties of setting up boards and staffing an untested structure, there were new and multiple reporting relationships and inaugural accountability agreements to establish, track and manage; an increasingly financially fragile environment; fairly high leadership turnover and stakeholders unsure of what to expect. Over time, however, the LHINs developed their culture and processes and providers got used to their new relationships.

An effectiveness review was undertaken in 2008 which looked at the operation of the LHINs and the Ministry of Health and Long-Term Care.[1] It concluded that the "transition and devolution of authority to the LHINS has been effective and an overall success." However five areas needed work and improvement and recommendations were directed to both parties to:

- increase clarity of decision making processes;
- better align resources;
- enhance collaboration and partnerships;
- refine accountabilities and processes;
- strengthen governance.

What Did the Research Say about Integrated Healthcare?

Rather than focusing on whether the LHIN structure was appropriate, The Change Foundation's early research focused on the elements of integrated healthcare systems across jurisdictions. In presentations to Ontario's healthcare community, we outlined the key components required to support integrated care - regardless of the structure. Thus, if the structure evolved or changed over time, the necessary elements would still need to be maintained. These elements are very relevant today as we try to assess the progress of the LHINs.

Our literature review identified 11 elements as necessary conditions for an integrated health system:[2]

- **Comprehensive services** – no matter where people access the system (primary care, hospital, emergency department) there is a comprehensive bundle of services;
- **A focus on patient needs** – all activity is dedicated to meeting patients' needs;
- **Geographic coverage with rostering** – patients sign up with specific healthcare providers who are then accountable for all their care;
- **Providers should be organized in interprofessional teams** – this supports the idea of comprehensiveness and meeting patient needs;
- **Standardized care** – the use of evidence-based guidelines so that wherever the patient enters the system they can be assured of high quality care;
- **Performance measurement** – care teams and system management identify desirable outcomes and measure whether or not they are being achieved;

[1] KPMG (2008) *MOHLTC-LHIN Effectiveness Review. Final Report.* Toronto: KPMG.
[2] Fooks C (2008) *An Integration Journey: Road Trips from Afar.* www.changefoundation.com.

- **IT and communication mechanisms** – an investment in information systems that can support the movement of records and information and enable rapid communication – communication between providers and communication with patients;
- **Organizational leadership and culture** – healthcare leaders have a strong vision about creating the collaborative culture needed to support an integrated system and they have the ability to sustain it;
- **Strong governance structures** – healthcare boards must be skilled, experienced and collaborative;
- **Funding models that are aligned with each other** – the way in which services are funded does not create barriers to integrated care;
- **Engaged physicians** – ensuring that clinical leaders are involved in planning integration efforts and that primary care in particular plays an important role as they are usually the initial point of access to the system for many patients.

As the Standing Committee undertakes its work, these elements should be kept front and center of any assessment.

What Did Patients and Caregivers Say about Integrated Healthcare?

Once we completed our literature review, we went and talked to Ontario patients and caregivers to try to understand how an unintegrated healthcare system was affecting them.[3]

We found that:

- Patients and caregivers have very reasonable expectations about what the system can provide and do not want to over use resources;
- Patients and caregivers strongly support their healthcare providers and professionals and understand that it is often system rules that make things difficult, not the individuals;
- Patients and caregivers understand the concern about ever-increasing resources directed at healthcare and don't want it to crowd out other important public services such as education;

BUT

- Patient and caregivers see and experience where things break down and can identify very clearly where "things don't make sense".

[3] The Change Foundation (2008) *Who is the Puzzlemaker: Patient/Caregiver Perspectives on Navigating Health Services in Ontario.* Toronto: The Change Foundation. Who is the Puzzlemaker?

In our focus groups we heard about how difficult it was for people to simply navigate the healthcare system – knowing whom to call, what to ask, how to move from one provider to the next was not so simple. We heard there was a lot of repetition, redundancy and delay and that it was frustrating. We heard that people worried about communication – was the necessary information transferred to the right person in time? These are the issues that matter to people. These are the issues integrated systems should be able to solve.

Current Ontario Landscape

Since the creation of the LHINs, there have been a number of healthcare system reforms launched. Two are of particular importance in relation to the LHINs.

The ***Excellent Care for All Act*** **(ECFAA)** came into effect in June 2010 with the 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 to establish quality committees and release annual quality improvement plans, links executive compensation to the achievement of quality targets, establishes processes for conducting patient and staff satisfaction surveys, and includes requirements for patient relations processes to address patient experience issues. These requirements were implemented in the hospital sector first and are being implemented in other healthcare organizations – Community Care Access Centres (CCACs), long-term care homes and some primary care organizations. The plans are provided to the LHINs for review.

ECFAA also expanded the mandate of Health Quality Ontario (HQO). This independent, Ministry-funded agency is 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.

ECFAA presents a legislative platform that is potentially transformative – it has been instrumental in getting the healthcare system to focus on quality. The legislation has also emphasized the importance of the patient experience - it seeks to improve the quality and value of the patient and caregiver experience through the application of evidence-based care and more robust accountability.

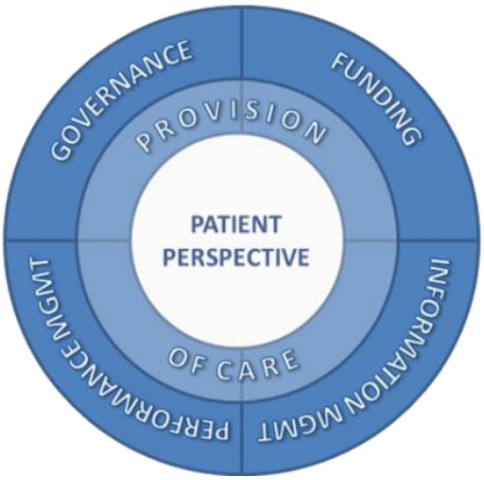
The second major development has been the emergence of **Health Links** beginning in December 2012. The Ministry of Health and Long-Term Care launched the Health Links initiative in response to the absence of integrated, coordinated care in local communities. There are now 47 Health Links across the province with a mandate to link

health service providers within a geographic area – including hospitals, primary care practitioners, specialists, home care and other community supports, and long term care homes. They will share resources and information to better coordinate care and supports for patients with complex conditions. The goal is to have Health Links across the province and to eventually serve all types of patients.

LHINs are working closely with their Health Links – both identifying new groups as the Ministry moves towards full provincial coverage and supporting existing groups as they developed their care plans for complex patients.

Future Reforms

The Standing Committee clearly has a mandate to review the legislation that governs the LHINs and thus is looking at the LHINs themselves. However, the LHINs operate within a broad policy and operational context that needs to be considered when asking whether LHINs are effective. The design of the system within which the LHINs work has to be reformed at the same time as any changes are made to the LHINs. If all that gets reformed is the structure of the LHINs, little progress will be made. The underlying fundamentals of Ontario's healthcare system need refining so that the LHINs or any other regional planning model can be as effective as possible.



The following diagram depicts the areas where The Change Foundation suggests actions are needed. It comes from our 2011 *Winning Conditions* report.[4] The patient is at the centre encircled by the providers of care who in turn are supported by strong governance, aligned funding, quality performance management and good information management.

The LHIN has a role to play in each of these areas – strengthen these elements and LHIN effectiveness will improve. The Change Foundation has a number of recommendations for each of the

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

supportive elements. The full report is available at www.changefoundation.com. Priority actions are highlighted below:

Strong Governance

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.

1. Ensure greater accountability for primary care.

LHIN governance would be strengthened if they could create accountability agreements with all primary care organizations. CHCs are currently accountable to the LHINs and there are plans to include Family Health Teams. More is required. The Committee has already heard some suggestions on this during its hearings. We strongly support the idea of better connected primary care as patients and caregivers tell us the continual disconnect is inefficient.

Boundaries between primary care and other care providers can perpetuate inefficiencies, hinder communication and limit opportunities for the kind of patient experience that is marked by care continuity, appropriateness and quality. This lack of connection between primary care and the rest of the system flows from the restricted mandate of the LHINs and should end.

However, this increased accountability can only occur if the LHINs develop the appropriate capacity and resources to undertake this new role.

2. Continue to look for opportunities for community level consolidation, but through open dialogue and public engagement.

LHINs now allocate over $24 billion in yearly operating funds, with nearly 2,000 service accountability agreements with hospital boards, CCACs, and community- based agencies and providers. That is an average of 140 accountability agreements for each LHIN. This has improved since 2011 when the LHINs had 2,700 separate accountability agreements to manage. However, the current structure remains too unwieldy, compromising functionality and the evolution of more sophisticated management structures. Observers – both within the system and from outside – question whether this level of complexity should be maintained.

Discussions about consolidating governance can be difficult – overlaid with sensitivities about hierarchy, control, values and authority. But lack of discussion leaves room for misunderstanding and resistance. Discussions must begin with a dispassionate

framing of the facts. The purpose of any engagement must be clear and with everyone understanding how the public's input will be used.

Effective community engagement – properly funded, framed, and conducted – is an essential lever in health system integration. This does not mean town halls to present a completed plan. This means early, frequent and transparent opportunities for communities to contribute meaningful input before decisions are made. The public needs to be part of these discussions; they need to be partners in system change.

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

Successful integrated care models already exist within Ontario through provincially funded agencies and networks – e.g., Cancer Care Ontario (CCO), the Ontario Renal Network (ORN), the Cardiac Care Network of Ontario (CCN). These provincial organizations are responsible for managing the quality, coordination and accessibility of services throughout the province, and ensuring a high quality patient experience. The province needs to build on the success of these models of system-wide planning and accountability for provincial programs. 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.

Aligned 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.

4. Pursue funding reform that supports quality, experience and sustainability.

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. But siloed funding gets in the way of integrated care. And different funding models incent different behaviours at provider and organizational levels. Our current provider-focused funding models are the legacy of historical developments and not part of a carefully designed system.

The Ontario government has recently introduced a series of funding reforms. Without getting into detail, it is safe to say that the shift from global budgets to patient-based funding is in its early days. We need to continue with funding reform that reshapes our healthcare system into one which behaves as a coordinated entity. Financial incentives for patient-centred care must be aligned with one another otherwise providers have

great difficulty crossing organizational or sector boundaries when trying to support a positive patient experience. As funding becomes more coordinated, the policy implications will need to be carefully considered to ensure there aren't unintended consequences.

5. Ensure flexibility in the reallocation of funds to meet system goals.

LHINs are planning bodies and are technically the "funders" for healthcare providers. But in reality, LHINs have little ability to reallocate money from hospitals to community, for example, or to providers outside of a LHIN accountability framework.

If LHINs are expected to forge significant change, the government will have to support them in moving from being pass-through organizations, to authoritative purchasers of services. LHINs will need the ability to reallocate funds to influence the performance of health system providers and to shift funds between organizations or sectors. They will also need to develop purchasing skills and have timely access to necessary data to compare providers and monitor performance against goals.

The increased ability to move funds around must be balanced against an open, fair and timely planning process. There must be a no-surprise environment within which providers can operate and function.

Performance Management and Measurement

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.

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

Performance measurement and management from an integrated system perspective is lacking in Ontario. Currently, performance reporting in Ontario is done primarily through Ministry-LHIN accountability agreements and through accountability agreements between LHINs and individual organizations. 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.

Some sectors of the healthcare system 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 continuously improving their data collection and reporting systems.

LHINs have acknowledged that they have insufficient resources and limited capacity to monitor or measure performance in real-time, or to explore measures or indicators beyond those included in the accountability agreements. This limited analytical capacity within LHINs is an Achilles' heel, hindering Ontario's progress with system integration and improved patient experience.

The system needs an enhanced framework with standardized methodologies and common reporting on a balanced and comprehensive set of performance dimensions and quality monitoring processes. LHINs should report to the public on region-wide achievements in relation to provincial and regional targets; on provider and organization-specific quality targets; and, on patient experience. A newly invigorated Health Quality Ontario will be a major support to this work.

The performance dimensions must include the quality of cross-organization and cross-sector transitions - how patients and their caregivers are experiencing the hand-off 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 within the overall performance measurement enterprise to support decisions and accurately reflect the dimensions of performance that mean the most to patients.

7. Develop performance indicators that can provide more sophisticated measurements of patient experience.

There is very little data available on patient experience. To date, efforts have focused on easy-to-measure phenomena and processes rather than on more complex aspects. We know very little 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 individuals who have the most interactions with different providers and organizations. And their quality of care as they move from one provider 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.

Patient and caregiver experience needs to be an integral part of performance and accountability reporting within the requirements of ECFAA. We need to expand patient surveys about specific episodes of care and start monitoring experiences with transitions of care. We need to measure the experience of those who are at greatest

risk of being inconvenienced or receiving 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.

8. Enhance regional and local level capacity for information management.

One of the early frustrations emerging from the experience of Health Links across the province is the inability of existing information systems to connect. Access to health records is a bit compromised which causes delay and poor communication. This is not a new frustration but one with a long history in the province. LHINs, Health Links and other partners need health information systems for planning, service delivery, performance management, and accountability purposes. Well developed and accessible information systems are critical for informing decisions, communicating with the public, purchasing services on the basis of sound evidence and monitoring quality, efficiency, and experience. We don't have them.

Conclusions

We believe there is a clear consensus in the province that a local and regional planning function is a must and that it can't be housed at Queen's Park. While not perfect, the LHINs have grown in maturity and sophistication over the last eight years. We realize there are proposals to close down the LHINs and put their functions elsewhere or to merge the LHINs with the CCACs. In our view, shutting down the LHINs would probably waste money and effort. The cost, disruption and distraction would set us back and delay dealing with significant reform issues.

Regardless of the planning structure Ontario wants, there is a need for further clarity and refinement. If the actions recommended above are considered in light of a further evolution of the LHINs, we believe the LHINs will be in a much stronger position to provide the system leadership required. We believe that better integrated care provides better patient and caregiver experiences.

The Change Foundation spent ten months travelling around the province engaging directly with seniors and caregivers. We held facilitated workshops in Ottawa, Peterborough, London, Dryden, Timmins and Toronto. We asked them about their own

experiences with all parts of Ontario's healthcare system and we asked them what would make it better. So we close with what patients and caregivers across Ontario told us they want.[5]

- **clear, consistent, reliable communication and exchange of information –** applied to all aspects of their healthcare process, including what will happen next at a transition point; information that is shared among providers and across organizations and sectors, and access to tools for self-management;

- **coordinated and connected care**—access to appropriate providers, services and supports, and caring "hand-offs" between family physicians, specialists and other providers;

- **comprehensive care**—opportunities 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 for their care with patients welcomed as active participants in decision-making, and informal caregivers treated as partners and their involvement supported;

- **respectful, empathetic and considerate interactions**—with dignified treatment as equals and partners with 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 their health, and with minimization, whenever possible, of the need to go to different locations for services.

When the LHINs are able to demonstrate that this is the experience Ontario patients and caregivers receive, we will have achieved a truly integrated healthcare system.

[5] The Change Foundation (2012) *Loud and Clear. Seniors and Caregivers Speak Out about Navigating Ontario's Healthcare System.* Toronto: The Change Foundation. http://loudandclear.changefoundation.ca/