Submission to the Standing Committee of the Legislative Assembly regarding Bill 41- *Patients First Act, 2016*

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Contents

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1 Introduction and overview

Thank you for inviting the Association of Family Health Teams of Ontario (AFHTO) to present our advice on Bill 41. AFHTO is a not-for-profit association that provides leadership to promote high-quality, comprehensive, well-integrated interprofessional primary care for the benefit of all Ontarians. It is the advocate and resource to support the spread of knowledge and best practice among 180 Family Health Teams (FHTs) and 5 Nurse Practitioner-Led Clinics (NPLCs) serving over one-quarter of Ontario's population, and welcomes all who provide interprofessional comprehensive primary care in Ontario.

This brief is grounded in evidence regarding drivers of quality and value in the health system – namely, a strong foundation of primary care. In this context, it summarizes what is most valuable in Bill 41 and further steps needed to avoid unintended consequences.

2 Comprehensive primary care is the foundation for high-quality, sustainable health system

Primary care – the long-term relationship each person has with their family doctor or nurse practitioner – is key to keeping people healthy, and to keeping health system costs in check. Evidence demonstrates that investment in primary care is associated with improved system quality, equity and efficiency (reduced cost)[1,2,3,4]. The ability of primary care providers to access and coordinate care for their patients is vital to ensuring people get the right care at the right time and don't slip through the cracks. Health resources are used more efficiently when people don't have to wind up in the hospital or emergency room unnecessarily.

3 Bill 41 puts in place key components to strengthen the foundation needed to improve health

While Local Health Integration Networks (LHINs) were set up to plan health services at a regional level, the cornerstone to accessing health care – primary care – was almost completely left off the LHINs'

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[1] Shi L, Starfield B, Kennedy BP, Kawachi I. Income inequality, primary care, and health indicators. J Fam Pract. 48 (1999), 275--84.

[2] Starfield B. Family medicine should shape reform, not vice versa. Fam Pract Man. May 28, 2009; Global health, equity, and primary care. J Am Board Fam Med. 20(6) (2007), 511--13; Is US health really the best in the world? JAMA. 284(4) (2000), 483--4; Research in general practice: co-morbidity, referrals, and the roles of general practitioners and specialists. SEMERGEN. 29(Suppl 1) (2003), 7--16, Appendix D.

[3] Starfield B, Shi L. Policy relevant determinants of health: an international perspective. Health Policy. 60 (2002), 201–18.

[4] Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Quarterly. 83(3) (2005), 457--502.

mandate.[5] The *Patients First* proposal makes primary care a focal point of the health system. The *Patients First Act* takes a step in bringing primary care to the table, by naming "A person or entity that provides … interprofessional primary care programs and services" under the definition of "health service provider".

In creating "sub-regions" within LHINs, the *Patients First Act* would also provide the mechanism to bring together all key health system players at a local level to focus on the unique health needs of people in communities across the province. LHINs, primary care, home and community care, public health and hospitals, will be better able to work together to strengthen communication within the "circle of care" for patients. LHINs will also be better positioned to distribute resources and monitor health system performance to ensure people get the appropriate care and support they need where and when they need it.

Deliberately naming "health equity" in the LHIN objects strengthens the focus on community and the health of the whole population. Requiring that each LHIN establish a Patient and Family Advisory Committee will help in maintaining the patient perspective.

The Act also provides an ***enabling*** step toward allowing and supporting primary care to fulfill its fundamental role as the coordinator of care for patients. Dissolution of Community Care Access Centres (CCACs) must proceed in order to tear down a completely unnecessary barrier to effective integration of care for patients.

4 To wrap care around patients, ensure that care coordinators will be embedded in primary care (Keep LHINs free from conflict of interest)

While Bill 41 takes the enabling step of dissolving CCACs, the transfer of service delivery and staff to LHINs must be an intermediate step and not the final destination.

As noted above, care coordination is a fundamental role of primary care. A recent report from Health Quality Ontario[6] revealed Ontario has a very low rate of home care and community services communicating with family doctors when compared to other parts of Canada and 10 other countries. It shows family doctors are experiencing many barriers when coordinating care for patients in home and community services, causing negative experiences for patients and caregivers.

[5] Since the inception of the LHIN Act, Community Health Centres, serving 2-3% of Ontario's population, have been included as "health service providers" under the LHINs.

[6] Health Quality Ontario. Connecting the Dots for Patients: Family Doctors' Views on Coordinating Patient Care in Ontario's Health System, June 2016. http://www.hqontario.ca/System-Performance/Specialized-Reports/Care-Coordination-Report-Commonwealth-Fund-Survey-of-Family-Doctors

Moving care coordinators from CCACs to LHINs does not remove barriers, it just moves them from one bureaucracy to another. if primary care providers were supported to coordinate care, it would make a significant difference for the health of patients and their experience of care. This is illustrated in an example appended to this submission.

If LHINs are to remain in the business of planning, integrating, funding and evaluating local health systems, they MUST NOT be delivering health services. Direct service delivery puts LHINs into a conflict of interest, hampering their ability to be objective in their primary role. The Province of Ontario recognized and acted on a similar conflict of interest situation in the past. In 2004-05, direct service delivery was divested from Cancer Care Ontario, and the agency was given a strengthened mandate for planning and quality improvement. Quality and access in cancer services delivery has improved tremendously since the wait time crisis in the early 2000s required patients to be sent to the US for radiation treatment.[7]

Recommended amendment to Bill 41

Bill 41 must be revised to require LHINs to develop plans to transition functions and staff from CCACs to the most appropriate health service providers within an appropriate length of time (say, 3 years), following which LHINs would be forbidden from being involved in direct service delivery.

5 To serve the public interest, ensure strategy, leadership, stewardship and a curb on bureaucracy and unilateral action

Bill 41 contains provisions intended to ensure the public interest is served. The first question is, what is the public interest? This must be defined by a vision and strategic plan for the province as a whole, with the leadership and stewardship needed to implement it in the public's interest. This is the context needed for checks and balances to be applied to serve the public interest.

Need for a provincial strategic plan

The current LHIN Act has, and will continue to contain the following requirement:

> **14.** (1) The Minister shall develop a provincial strategic plan for the health system that includes a vision, priorities and strategic directions for the health system and make copies of it available to the public at the offices of the Ministry. 2006, c. 4, s. 14 (1).

Section 12 of Bill 41 would add requirement for LHINs "to establish geographic sub-regions in its local health system for the purposes of planning, funding and integrating services within those geographic sub-regions" and "include strategic directions and plans for the geographic sub-regions".

[7] Sullivan T. Improving Quality and Performance in Ontario's Cancer Services: Lessons for Constructing a Learning Healthcare System. Healthcare Quarterly, 17(SP) January 2015: 5-9.

Unfortunately, a provincial strategic plan for the health system has yet to be delivered. Without this context, how can LHINs fulfill their strategic planning requirement and maintain some degree of consistency for Ontarians across the province? What would be the basis for the Ministry or LHINs to issue operational or policy directives, order an investigation or appoint a supervisor "where (the Minister or LHIN) considers it to be in the public interest to do so."

Need for leadership, stewardship … and less bureaucracy

If LHINs are to plan and oversee, then Ministry MUST focus on establishing vision and clear, consistent policy direction and evaluation, and get out of the direct management (at times, micromanagement) business. This will require a significant shift in the Ministry's overall orientation and staff skill sets, with a concomitant reduction in staffing numbers.

LHINs play a highly important role in leadership and stewardship at the regional level, and with Bill 41, at the more local level as well. They will be inheriting what the Auditor General of Ontario noted as overly burdensome administrative costs in CCACs.[8] As recommended in section 4 above, CCAC service delivery functions must keep moving from the LHINs to primary care and other health service providers. Without that further move, LHINs are at high risk of proliferating bureaucracy as well.

Need for checks and balances against unilateral action

Bill 41 gives strong powers to the Minister and LHINs to issue operational or policy directives, order an investigation or appoint a supervisor "where (the Minister or LHIN) considers it to be in the public interest to do so":

- In section 27 of the bill, guidelines for making a decision in the "public interest" are proposed. These are based on vague notions such as "the quality of the management and administration of the (LHIN) or the health service provider" and "the quality of care and treatment of patients".
- In section 21 of the bill, LHINs are required to "give notice of its intention to appoint an investigator to the Minister and the health service provider", but when it comes to appointing a supervisor, the only notice requirement is to the health service provider.

While there must be mechanisms in place to ensure the public interest, the current wording plus the absence of a provincial vision and strategic plan, leave too much room for arbitrary action to be taken.

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[8] Office of the Auditor General. Special report on Community Care Access Centres—Financial Operations and Service Delivery released—September 23, 2015, accessed at http://www.auditor.on.ca/en/content/specialreports/specialreports/CCACs_en.pdf

Recommended amendments to Bill 41

More specific guidance and direction is needed as to what "public interest" means. Appropriate checks and balances on the use of the powers to issue directives, initiate investigations and appoint supervisors, must also be ensured. Recommended steps:

- Provide context for the meaning of "public interest" by referencing section 14 (1) of the **Local Health System Integration Act, 2006**, i.e. the Minister's provincial strategic plan for the health system.
- Given that this 2006 requirement has yet to be fulfilled, add language to Bill 41 that would strengthen the requirement for a strategic plan, for example, consequences if the requirement is not met.
- Amend Bill 41 to add provisions to the LHIN Act requiring:
    - The Minister to engage the community in the provincial strategic plan, in the same spirit as the section 16 requirements for LHINs to do so.
    - LHINs to develop an integrated health service plan that is aligned with the provincial strategic plan
- Add to the notice of supervisor appointment the requirement to notify the Minister.
- Include a mechanism for the health service provider to request a review or appeal the appointment of a supervisor.

6 To support collaboration needed to deliver high-quality, sustainable primary care, ensure the transition of FHTs and NPLCs from Ministry to LHINs is done in an environment of respect and trust

In the current environment of mistrust and conflict between physicians and the province, the transfer of interprofessional teams to LHINs runs the risk of driving family physicians away from team collaboration.

FHTs and NPLCs were introduced over the past decade to improve access, quality and efficiency through team-based primary care. Evaluations and research studies have given evidence of the added value delivered by such teams.[9,10,11] Research evidence also suggests that primary care is most effective when

[9] Kiran T, Kopp A, Glazier R. Those Left Behind From Voluntary Medical Home Reforms in Ontario, Canada. Ann Fam Med. 2016; Nov 14

[10] Belle Brown J, Ryan BL, Thorpe C. Processes of patient-centred care in Family Health Teams: a qualitative study. CMAJ Open, June 1, 2016 vol. 4 no. 2 E271-E276

[11] Additional references available in Optimizing the value of team-based primary care: Review of the Literature. AFHTO: May 27, 2015. http://www.afhto.ca/wp-content/uploads/Optimizing-the-value-of-team-based-primary-care-LIT-REVIEW.pdf

there is a long-term, continuing relationship with a physician or NP who is working as a full collaborator in an interprofessional team.[12, 13]

Right now, Ontario has the following mix of primary care providers:

1. Salaried nurse practitioners (NPs) employed in teams – FHTs, NPLCs, Community Health Centres (CHCs), Aboriginal Health Access Centres (AHACs) and nursing stations
2. Salaried family physicians (FPs) employed in teams – AHACs and CHCs and about 10% of FHTs (<5% of all Ontario FPs)
3. Family physicians associated with a team by virtue of being in a group payment model, such as a Family Health Organization or Rural and Northern Physician Group Agreement (about 25% of all Ontario FPs) that is associated with (but not accountable to) a FHT
4. Family physicians who have no association with teams (<70% of all Ontario FPs)

Teams in the third group – FHTs with one or more associated physician groups – are living in a three-way relationship:

- Physicians are individually incorporated and loosely associated through a funding contract for their group with the Ministry of Health and Long-Term Care.
- The FHT is a not-for-profit corporation whose board is accountable to the Ministry for funding it receives to hire interprofessional health providers and associated administrative staff, and has no authority over the physician group.
- The FHT and physician group must rely on leadership, trust and their evolving culture to span the organization/funding divide and build the collaboration needed for effective team-based care.

When it comes to the fourth group – FPs outside teams – the fact that their patients (over 70% of Ontarians) currently have little to no access to teams is neither fair nor equitable. The reach of team-based care must be expanded over time so that all FPs and primary care NPs are collaborating in teams. While it would require LHINs to re-allocate funds over time, equally important, FPs would have to want to change their mode of practice to embrace team-based care. This will not happen where there is no trust.

Unfortunately, physicians are very mistrustful of the Ontario government at present. Their association has warned that the Bill 41 requirement for FHTs to operate under Service Accountability Agreements (SAAs) with the LHIN, together with the LHIN powers to issue directives, investigate and name a

[12] Howard, M., Brazil, K., Akhtar-Danesh, N., & Agarwal, G. Self-reported teamwork in family health team practices in Ontario: organizational and cultural predictors of team climate. Canadian Family Physician, 57(5), 2011; e185-e191

[13] Saba, G. W., Villela, T. J., Chen, E., Hammer, H., & Bodenheimer, T. The myth of the lone physician: toward a collaborative alternative. The Annals of Family Medicine, 10(2), 2012; 169-173

supervisor, could subject family physicians working in or with teams to requirements for data collection, patient care reporting, service prioritization and investigations.[14]

The inclusion of interprofessional teams in the definition of "health service providers" can only proceed in an environment of trust and respect:

- AFHTO's recommendation in section 5 – to ensure strategy, leadership, stewardship and a curb on bureaucracy and unilateral action – would help significantly.
- The Ministry must also take steps to ensure that LHINs have sufficient understanding and capacity to take on expanded powers with primary care, before those powers are transferred.
- When it comes to Service Accountability Agreements for FHTs, the Ministry and LHINs must recognize the three-way relationship in place, and how policies and funding practices impact that relationship. Accountability must be aligned with what boards are able to control or significantly influence.
- Of course, having a mutually accepted Physician Services Agreement in place would be ideal.

Recommended amendments to Bill 41

- Allow time for government to delay introduction of primary care organizations as "health service providers" so it can build a better relationship with physicians. Rather than coming into force upon Royal assent, add subsection 1(3) – additions to the definition of "health service provider" – to subsection 50(3), so that it could come into force on a day to be named by proclamation of the Lieutenant Governor.

7 APPENDIX – What difference would it make to place care coordinators in primary care?

This comparison is based on the story of Mrs. Smith, 80 years old, who is living alone, dealing with diabetes, and does not drive.

Current situation

CCAC care coordinators have two primary roles:

- Assessment of clients using the "Resident Assessment Instrument" (RAI)
- Placing services in the home. (They do not monitor what actually happens in the home but they do monitor complaints from the patient and from the third-party services in the home.)

[14] Ontario Medical Association: OMA Top Five concerns with Bill 41, October 13, 2016 (https://www.oma.org/Benefits/pmcphyresources/Documents/Bill41TOP5.pdf) and OMA Analysis of Bill 41, October 12, 2016 (https://www.oma.org/Benefits/pmcphyresources/Documents/Bill41OMAnalysis.pdf)

Care Coordinator visits Mrs. Smith once per year to complete the RAI assessment. Care Coordinator orders 2 nursing visits since Mrs. Smith just started basal insulin. A personal support worker (PSW) comes weekly to bathe her. Meals on Wheels service is offered, but Mrs. Smith refused as she heard from her neighbour the food is ghastly. No other assistance is provided.

NEW world of care coordination in a primary care team

Mrs. Smith is assessed, same services put in. The salient difference is the Care Coordinator has a relationship with the nurse, so she calls the nurse or the nurse calls her to ask about Mrs. Smith's blood glucose levels. Nurse mentions that blood glucose has not responded to the basal insulin, despite Mrs. Smith increasing her basal by 10 units, as directed by the Diabetes Educator. Care Coordinator calls PSW to see how Mrs. Smith is coping at home. PSW mentions that Mrs. Smith has a large abrasion on left big toe that is hot to the touch. Care Coordinator documents her concerns in the patient's EMR and messages Mrs. Smith's doctor with the concerns. Care coordinator asks doctor if:

- Mrs. Smith should be asked to make appointment with her doctor given the likelihood of an infection that would negatively impact her blood glucose control. Care Coordinator would facilitate arranging for a volunteer driver to get her to her appointment.
- The in-home team should make a visit as the Care Coordinator has not yet been able to coordinate the volunteer driver from the seniors' care centre and Mrs. Smith does not have a ride, nor funds for a taxi.

Care coordinator has also phoned the Diabetes Education Centre where the insulin was started to alert them to the salient change in Mrs. Smith's glycemic control and that Mrs. Smith will have a medical review and the care coordinator will ensure that the diabetes team also receives a copy of the medical assessment so they are aware of changes in insulin regime.

The key differences in this NEW world are:

- The Care Coordinator is working with the patient as a WHOLE person, and is not restricted to the functions of a CCAC. All of the key issues impacting the person's health, such as the ability to get to an appointment, are addressed.
- The Care Coordinator is including the primary care provider (in this case, a family doctor) and a Diabetes team in the care coordination. This enables the doctor to monitor and oversee all aspects of care for this individual.