afhto association of family health teams of ontario

Transitioning care coordination resources to primary care

Position:

We assert the role of primary care providers to lead care coordination. The Association of Family Health Teams of Ontario (AFHTO) endorses and embraces this position statement, adopted with our colleagues in the Ontario Primary Care Council.[i] Primary care providers work to ensure access to interprofessional care for patients and identify a single point of contact to help patients and families navigate and access programs and services.

Furthermore, AFHTO implores the Ministry of Health and Long-Term Care to work with primary care teams and LHINs to bring greater efficiency and patient-centredness to care delivery, through steps to:

- Support primary care teams to coordinate care for their patients, as appropriate for each person's needs and preferences throughout their lifetime, through development of appropriate policies, structures, information flows, programs and resources.
- Begin redistributing resources to fulfill this function, from CCACs to existing teams that are prepared to receive these resources.
- Ensure that CCAC staff are transitioned to primary care under an appropriate compensation and labour relations framework that includes the principle of internal equity across employee groups.
- Expand the reach of primary care teams, such that all Ontarians have access to comprehensive primary care and coordination of care through these teams.
- Transition the functions of establishing and managing contracts with home care providers, including accountability for quality and performance, from CCACs to LHINs.
- Collaborate with additional partners – hospitals and community agencies together with primary care teams and LHINs – to determine the best way to transition other functions currently carried out by CCACs – e.g. rapid response nursing, palliative care NPs, and discharge planning.
- Foster knowledge exchange and greater consistency across each LHIN and the province through appropriate primary care and care coordination networks.
- Re-invest the savings made possible through the elimination of CCAC administration and infrastructure to the delivery of effective primary care, home care and community care to keep people as healthy as possible.

Rationale:

Primary care is an anchor for patients and families, providing comprehensive care throughout their lives. Primary care providers are the first contact or entry into the system for all new needs and problems, and they directly influence the responses of people to their health needs by listening to the concerns and preferences and providing clinical evidence-based assessment and treatment recommendations.

Care co-ordination in primary care has the potential to significantly:

- Reduce the duplication and role conflict that currently exists in our health system;
- Improve patient outcomes through much greater continuity and coordination of person-centred care.

In contrast, care coordination provided through CCACs is episodic – about 60% follows from a hospitalization[ii] and misses the opportunity to keep people out of hospital in the first place. As experienced by AFHTO members, communication back to primary care providers has been very poor, although the embedding of a CCAC Care Coordinator in some teams has made some improvement.

Background:

This AFHTO policy statement is well-aligned with a number of other recommendations received by the Ministry of Health and Long-Term Care. These include:

- The Expert Group on Home and Community Care (Donner Report), which calls for a Home and Community Care Charter, to include statements – "A single care coordinator will work with the client and family to identify their needs and the most appropriate services to meet those needs," and "The care coordinator and primary care providers will communicate regularly and in a timely fashion."
- The Expert Panel on Primary Care (Baker/Price Report), which calls for the creation of Patient Care Groups (PCGs) to integrate care for populations. If implemented, PCGs would enable population-based planning and primary care-based care coordination to be provided as needed for all Ontarians.
- The newly-released *Guide to the Advanced Health Links Model*[iii] states "work will be done to situate and align the Advanced Health Links Model with the work underway to support a strengthened primary care sector." Its principles (p.8) include:
    - Regular and timely access to primary care for complex patients.
    - Effective provision of coordinated care for all of Ontario's complex patients.
    - Maximize coordinated care to generate system value, sustain the Health Links Model and strengthen care coordination processes to realize greater efficiencies.
- The Auditor General's Special Report on CCACs was accompanied by a news release stating, "The Ontario government needs to take a hard look at how the province's Community Care Access Centres (CCACs), along with their third-party service providers, deliver home- and community-based health care and related support services to patients outside hospital settings." One of the themes in the report was the high cost of administration and overhead.

Primary care teams want to coordinate care for their patients – this was clearly demonstrated by the 200+ leaders who participated in AFHTO's October 2015 session on Leading Primary Care through the Next Stage. Through their work in Health Links, many primary care teams have demonstrated readiness to take on this role, and their success when they can mobilize the resources to fulfill this role. Case studies of successful care coordination in family health teams and community health centres, in rural and urban settings, are featured in the OPCC's Position Statement: Care Coordination in Primary Care. The transition of care coordination resources from CCACs to primary care teams is the logical next step.

Recommendations to the Ministry of Health and Long-Term Care:

That the Ministry commit to the principles, desired outcomes and enablers for effective care coordination, articulated in the OPCC's Position Statement: Care Coordination in Primary Care.

That the Ministry begin immediate work with primary care teams and LHINs so that, over the next 2-5 years, all functions performed by CCACs, together with the associated resources, can be transitioned to bring greater efficiency and patient-centredness to care delivery.

About AFHTO:

The Association of Family Health Teams of Ontario (AFHTO) holds the vision that all Ontarians will have timely access to high-quality, comprehensive, team-based primary care. Its mission is to work with and on behalf of its 185 FHT and NPLC members to provide leadership and support to achieve this vision. To this end, AFHTO and its membership have given priority to strengthening governance and leadership, advancing meaningful and manageable measurement, and optimizing team capacity.

Endnotes

[i] The Ontario Primary Care Council (OPCC) is a partnership comprised of seven provincial associations that represent primary care providers in the province: Association of Family Health Teams of Ontario, Association of Ontario Health Centres, Nurse Practitioners' Association of Ontario, Ontario College of Family Physicians, Ontario Medical Association, Ontario Pharmacists Association and the Registered Nurses' Association of Ontario. The position statement on Care Coordination in Primary Care is posted at http://www.afhto.ca/wp-content/uploads/OPCC_Care-Coordination-Position.pdf.

[ii] North East LHIN (2011). LHINfo Minute. As quoted in *Enhancing Community Care for Ontarians, ECCO 2.0*, Registered Nurses Association of Ontario, April 2014.

[iii] Ministry of Health and Long-Term Care, issued November 2015.