



# Ontario Primary Care Council

## Response to *Patients First*

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## Vision for High Performing Primary Health Care System

The Ontario Primary Care Council (OPCC) has a strong vision for the evolution and improvement of the delivery of primary health care in the province of Ontario. This vision is aspirational in nature. In other words, it sets out major directions for change: changes which will significantly alter the status quo of primary care delivery in Ontario, but changes which can be phased in over the short to medium term.

The overarching principle in OPCC's *Framework for Primary Care in Ontario* is: "to improve population health, deliver people-centered services and strengthen our publicly funded health system, Ontario must create a stronger foundation for the delivery of primary care in this province."

Fundamental to achieving this overarching principle, we assert that:

- Primary care is the foundation of a high performing health system;
- Planning for the system needs to be based on equity-informed population needs;
- Programs and services must be appropriate, accessible, timely, high-quality, comprehensive, continuous, evidence-informed, equitable and culturally competent;
- Care coordination is a core function of primary care; and
- Collaborative interprofessional teams working to full scope of practice are key to success.

Primary care as the foundation of a high performing health system is fundamental to achieving a health system that truly puts patients, and people, first. Comprehensive primary care is provided across a person's lifespan – from womb to tomb – and provides care close to home, within people's communities. Comprehensive primary care is a continuous loop that grounds coordination of care and aims to ensure people move seamlessly in and out of the different parts of the health care system, and other systems, when and as they need to do so.

The OPCC's vision for a high performing primary care system is well aligned with the vision provided in the *Patients First* proposal, and we strongly recommend that the OPCC's *Framework for Primary Care in Ontario* become the foundation for a consistent approach to primary care in the province. With a strong primary care system as the foundation on which Ontario's health system firmly rests, the effectiveness and efficiency of the rest of the system will be fully realized.

## Advice on key areas in *Patients First*

### 1. Ministry stewardship and LHIN mandate

OPCC supports the proposal to expand the LHIN mandate so that LHINs have “the tools to align and integrate all health services”. In particular, the mandate should be broadened to ensure that LHINs are able to support the fundamental principles for strengthening primary care as the foundation of the system (see above); plan for the system to be based on equity-informed population needs; and enable primary care to be effectively linked and connected to the broader health and social system.

To achieve a health system that provides the care people need no matter who they are or where they live, and that also addresses the current inconsistencies across the LHINs that were identified in the 2015 Annual Report of the Office of the Auditor General of Ontario, it is fundamental that the Ministry of Health and Long-Term Care be the steward of the health system as a whole. One of the key promises in *Patients First* is that people across this province can expect equitable services no matter who they are or where they live. This promise is central to our strong request that the Minister, as steward of the health system, clearly set out the “rules of the game” for primary care evolution across all fourteen LHINs.

Equally important is the need to go beyond *patients* first to put *people and communities* first. A strong primary care foundation focuses on population health and should work to prevent sickness and improve the health of people living in Ontario, with a focus on health equity and reducing health inequities and disparities. Furthermore, people and communities must be supported to participate in their own health care and in service planning.

OPCC also strongly advises that the necessary tools in the LHIN mandate should be focused on allowing the LHINs to plan, integrate, fund, monitor and evaluate local health systems, but should not include service delivery and management. It is challenging to “row” and “steer” at the same time. Service provision and the management of service, including service allocation at the patient level, should be the focus of provider organizations that have the best understanding of patient needs.

To quote Duncan Sinclair:

*“...to transfer direct responsibility for service management and delivery from the CCACs to the LHINs...is a bad idea that will weaken the LHINs, primarily by diverting their attention from their central and most important function of providing regional governance, policy direction, leadership and planning to the providers of health and health care services in their regions.”<sup>1</sup>*

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<sup>1</sup> Sinclair, D. (2016). *Comments re: Patients First: A Proposal to Strengthen Patient-Centered Health Care in Ontario – A Discussion Paper*. Retrieved from:

[http://www.longwoods.com/content/24511?utm\\_source=eLetter&utm\\_campaign=5d5d850dc8-Longwoods+eLetter+February+9%2C+2016&utm\\_medium=email&utm\\_term=0\\_0f88455429-5d5d850dc8-%5BLIST\\_EMAIL\\_ID%5D&ct=t%28February+9%2C+2016%29](http://www.longwoods.com/content/24511?utm_source=eLetter&utm_campaign=5d5d850dc8-Longwoods+eLetter+February+9%2C+2016&utm_medium=email&utm_term=0_0f88455429-5d5d850dc8-%5BLIST_EMAIL_ID%5D&ct=t%28February+9%2C+2016%29)

Recommendations:

1. *That the Ministry embrace its stewardship role, including:*

- A strong and explicit commitment to strengthen primary care in Ontario and make it the foundation of the system, through guiding principles aligned with OPCC's Framework for Primary Care in Ontario.
- Strong stewardship by the Ministry to ensure the application of values, principles, policies and standards in the planning of primary care are applied in a consistent way across the province at the LHIN and local level.
- A long term vision and plan, co-designed with primary care and patients, for how people, institutions and resources in primary care be organized and governed to ensure the best possible health and wellbeing for everyone living in the province.
- Systematic strategies to ensure people-centred services that enable people to participate actively in their own health care, as well as the design and planning of community-based health services.

2. *That the LHIN mandate be expanded to explicitly ensure LHINs:*

- Will make and support primary care to be the foundation of the system;
- Plan for the system to be based on equity-informed population needs; and
- Enable primary care to be effectively linked and connected to the broader health and social system, including public health.

3. *That the LHINs' roles be planning, integrating, funding and evaluating local health systems, not service management and delivery. It is inappropriate and a conflict of interest for them to take on a service delivery role.*

## 2. Access to interprofessional health care providers and access to teams

To move towards the *Patients First* vision of “all Ontarians should have better access to interprofessional providers...” (p.21, *Patients First*) and “ensure that services are distributed equitably across the province and are appropriate for patients” (p. 2, *Patients First*), a short, medium and long-term vision is needed for delivering and expanding interprofessional care in the province.

Ontario has a strong foundation of interprofessional team-based primary care from which to start. Currently, 25-30% of Ontarians can access such care through CHCs, FHTs, AHACs, or NPLCs. Some other groups of family physicians have access to certain IHPs (e.g. RNs, social workers) for patients.

Because primary care has many different functions and health issues can be very complex, people need access to interprofessional teams staffed with different types of providers with complementary roles and responsibilities (e.g. pharmacists, registered nurses, social workers, dietitians, health promoters). Collaborative interprofessional teams working to full scope of practice across all subLHINs are key for primary care to serve as a strong foundation for the health system, and thus for the effectiveness and

efficiency of the whole system to be fully realized.

In the short term, a mechanism is needed for people served by family physicians and nurse practitioners (FPs/NPs) who are not affiliated with an interprofessional team and do not have access to interprofessional health providers. It is important to note that OPCC is not proposing a referral or consultation model, but rather, shared care and coordination. FPs/NPs remain the primary care providers and their patients have access to the full scope of interprofessional team services, as appropriate.

The good news is that, from our review of publicly-available information from LHINs, it appears there is only one subLHIN region in the whole province that has no interprofessional teams from which to build (i.e. Bolton-Caledon in Central West LHIN). Current availability and reach of interprofessional primary care teams must be examined within each subLHIN – the Ministry must ensure that planning for this shared care solution is based on equity-informed population needs and availability of sufficient human resource capacity such that additional demand can be managed without causing unacceptable increases in waits for appointments and/or decreases in quality of care.

Recommendations:

4. *That the Ministry develop a medium and long-term vision of how to improve access to interprofessional primary care in Ontario to extend its benefit and reach to all Ontarians, as appropriate.*
5. *That, as a first step, the Ministry support and encourage shared care solutions for increasing access to interprofessional teams across Ontario, for people whose family physician or nurse practitioner (FP/NP) is not affiliated with an interprofessional team and does not have access to interprofessional health providers.*
  - The shared care solution must be based on formation of a deliberate relationship between the FP/NP and interprofessional team.
  - Recognizing the work involved in setting up productive shared care arrangements, the Ministry must create a funding envelope and direct LHINs to have an application process where primary care organizations and practices can apply for funding.
6. *The Ministry give priority to ensuring that each sub-LHIN has a foundation of at least one interprofessional primary care team. Over time, that the distribution of interprofessional team resources be based on equity-informed population needs.*

### **3. Embedding care co-ordination in primary care and the next steps to support implementation**

A clear and transparent province wide transition plan must be developed to locate and/or embed care coordinators in primary care organizations in consultation with primary care, including the OPCC. OPCC opposes the proposal to “transfer direct responsibility for service management and delivery from the CCACs to the LHINs.” As expressed above, the LHINs should not be involved in direct service

management and delivery.

This transition plan would need to include labour relation and change management considerations for current CCAC care coordinators and for primary care organizations that do not currently have care coordinator or system navigator roles. SubLHIN networks can be leveraged, focusing first on those primary care organizations that have the capacity to embed the role and then make expansions where needed.

OPCC strongly urges the Minister to focus on enabling primary care to provide comprehensive “womb to tomb” care co-ordination and system navigation as foundational roles of primary care. As articulated in the [OPCC Position Statement on Care Co-ordination in Primary Care](#), while the level and extent differs over the course of a person’s journey through the health care system, everyone needs care co-ordination. It is a consistent and resourced care coordination and system navigation knowledge base and skillset that are required in primary care to improve quality, not a brokering of services. Care co-ordination is predicated on collaborative interprofessional teams working to full scope of practice. A key aspect of this is primary care teams being able to recruit and manage the performance of care coordinator and system navigator roles.

A foundational element of care co-ordination is a holistic care perspective that includes addressing clinical/medical as well as the broader determinants of health. This includes a palliative approach to care that builds a strong and integrated foundation in primary care, enables robust interprofessional care and thrives through proactive evidence-based clinical engagement. A more integrated primary care system where primary care co-ordinates and helps navigate services around the needs of people will enable timely, continuous and effective palliative care, not just end-of-life care. An integrated primary care system involves close connections with other sectors, including public health, home care, community support, mental health, addictions, specialist, hospital, long-term care, and hospice.

#### Recommendations:

7. *That a clear and transparent province wide transition plan (including change management considerations) to locate and/or embed care coordinators in primary care organizations be developed in consultation with primary care, including the OPCC.*
8. *Given the critical role of care coordination in Health Links, primary care should be the lead for Health Links and be recognized and resourced appropriately to succeed in this role. This can also include the opportunity to transfer the leadership of Health Links currently led by CCACs.*
9. *That the comprehensive strategy on palliative and end-of-life care, led by Parliamentary Assistant (PA) John Fraser and supported by Cancer Care Ontario through the provincial palliative care network, emphasize a palliative approach to care throughout the chronic illness journey that builds a strong and integrated foundation in primary care, enables robust interprofessional care and thrives through proactive evidence-based clinical engagement.*

#### 4. The interface between primary care, mental health and addictions

OPCC has identified the interface between primary care, mental health and addictions as a priority area and recognizes the significant gaps in service and coordination. There is a spectrum of mental illnesses, addictions and concurrent disorders which can develop at any point in life from childhood into old age. They range in degree from mild to severe and from temporary to chronic or recurrent in duration. People with a diagnosis of serious mental illness such as schizophrenia or bipolar disorder have unique needs, as do those who have both mental illness and addiction. In addition to serious mental illness, there is a great need for a coordinated mental health and addictions approach to serve children and adolescents that should be inclusive of all existing services; primary care, pediatricians, schools, public health and families. These differences require different strategies and the need for supports from a range of government ministries in addition to the Ministry of Health and Long-Term Care, including the Ministry of Children and Youth Services, Ministry of Community and Social Services, and Ministry of Municipal Affairs and Housing.

It has long been known that people living with mental health and/or addictions have difficulty accessing and maintaining high quality primary care for their physical and mental health needs; increased rates of illness and death for people with mental health and addictions issues are partly due to poor primary health care.<sup>2</sup> Vice versa, people's access to mental health and addictions services is also a key gap for primary care providers. As noted by the Ontario Mental Health and Addictions Leadership Advisory Council, Ontario does not have a seamless system of mental health and addictions services. People trying to navigate the system have trouble finding where to get help and transitioning from one provider to another.

*Patients First* recognizes the barriers to care experienced by people living with mental health and addictions and invites advice on how to better coordinate community mental health and addictions services, while looking to the Mental Health and Addictions Leadership Advisory Council to ensure changes improve overall system performance. The goal is collaborative and integrated service delivery of primary care, mental health and addictions services to ensure a continuum of prevention, promotion, treatment and support services for people wherever they live in the province.

With regard to Proposal 2 in *Patients First* for "timely access and seamless links between primary care and other services", OPCC identifies distinct layers to be examined and addressed:

- Ensuring timely and consistent access to primary care for people living with mental health and/or addictions challenges at any age.
- Acknowledging and reinforcing that primary mental health and addiction services are core functions of primary care.
- Supporting people living with mental health and addictions challenges through shared care approaches with primary care providers needing access to teams with relevant resources.
- Clearer and better pathways, and more timely access to more specialized services – community

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<sup>2</sup> Parkes, J, et al (2006) Morbidity and mortality in people with serious mental illness. Virginia: National Association of State Mental Health Programs Directors. As cited in CAMH Policy Report 2015, "Access to Primary Care"

mental health programs, psychiatry and hospital services – for people living with more serious mental illness and addictions.

Care for people living with mental illness and addictions cannot be done in siloes. As part of their responsibilities for primary care planning and performance management, the LHINs must ensure a coordinated approach to primary care and mental health and addictions services based on the following principles:

- Primary health care should be equitable and accessible to people with mental health and addictions problems.
- High quality primary care should be provided by interprofessional teams practising to full scope to people with mental health and addictions problems in collaborative and integrated environments.
- Primary care teams have sufficient funding to hire a mix of health care professionals to best meet the basket of services for primary care and ensure integrated and seamless care with mental health and addiction services.
- Primary care mental health programs should be based on evidence and best practice, and research in the area of mental health and addictions should be supported.

LHINs should also be encouraged to build synergies across the spectrum of service providers in the area of mental health and addictions services. There are many examples where primary care providers are working closely with mental health and addictions partners. The LHINs can share these best practices to help bridge the sectors and encourage further partnerships between primary care providers and the mental health and addictions sector across the province.

Recommendations:

*10. That the Mental Health and Addictions Leadership Advisory Council specifically address the important intersection between mental health and primary care for children, adolescents and adults and that primary care representation be increased, especially in the system alignment subcommittee.*

*11. Recognizing that mental health and addictions is a core function of primary care, that the LHINs ensure a coordinated approach to primary care and mental health and addictions services, and build synergies between primary care and community providers of mental health and addictions services.*

## 5. Clinical leadership

*Patients First* describes the need for clinical leadership to deliver the system transformation expected in primary care in the coming months and years. Based on literature and the experience of other jurisdictions that have implemented significant health system transformation, meaningful engagement of clinical leaders is a critical element to successful change strategies. However, it is important to note the distinct types of leadership required:

- Most Responsible Provider Leadership –The clinical lead each person requires for their on-going comprehensive primary care – i.e. a family physician or a nurse practitioner.
- Clinical Leadership - Providers who are leaders in their setting of care (i.e. MRP, RNs, social workers, pharmacists, etc.) and in their communities. Clinical leaders understand system direction, engage and influence peers, and support quality improvement. Clinical leaders look out from their practice and engage with their peers and support practices to meet the needs of the populations.

Leadership in system improvement and change is further broken down into four domains:

- Clinical practice: using their clinical experience and skills to ensure the needs of the patient are the central focus in the organisation’s aims and delivery.
- Research: includes adopting a quality improvement mindset and using knowledge translation and evaluation among peers and colleagues to advance best practices.
- Education: promoting high-quality clinical care and transforming services to achieve higher levels of excellence. Includes preceptorships, mentoring and teaching.
- Management/governance: setting, inspiring and promoting values and vision. Also includes enterprise risk management, compliance with legislation, regulations and standards and financial acumen (cost reduction/avoidance).

In seeking to engage primary care clinical leaders, careful consideration must be given to the roles to be played, the competencies best suited for the specific roles, the leadership capacity and the pool of leaders within primary care. Regardless of the leadership role assumed, to become a high performing health care system requires leadership “...to be distributed across the system, with agreement on the methods and strategies to drive this change, and local leaders, champions, and change agents with the potential to accomplish this.”<sup>3</sup> In primary care specifically, clinical leadership may involve formal roles, but may also be “distributed”, recognizing that no one individual is the ideal leader in all circumstances.<sup>4</sup>

In Ontario’s team-based context (e.g. FHTs and NPLCs) it has been anecdotally identified that optimized linkages and relationships among the “leadership triad”, i.e., the clinical leader, the practice management leader (executive director/senior administrator) and the board chair, are key supports for effective clinical leadership. This leadership triad is important for system planning roles since the collective of individual perspectives brings the complete picture to planning efforts.

## Recommendations

*12. That the LHINs have a consistent and transparent framework for primary care clinical leaders to co-develop and design solutions in LHIN and sub-LHIN planning. Leaders should not only be consulted, but intimately involved in linking clinical or practice-based evidence with larger system improvement initiatives.*

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<sup>3</sup> Baker & Axler, 2015 p. 6

<sup>4</sup> Bolden, Distributed Leadership

13. That the LHIN framework for clinical leadership explicitly recognize that:

- Leadership must be distributed and go beyond the LHIN Primary Care Physician Lead.
- Clear roles and competencies for clinical leadership must be identified, that go beyond advising to being part of decision-making processes.
- Leadership roles must be aligned with clear goals, expectations, appropriate governance and accountability measures.
- Leaders identified for these roles can be family physicians, nurse practitioners, executive directors, registered nurses, or other providers who have the required competencies and attributes identified for the role.

14. That Ministry and LHINs tap into existing leadership capacity in high performing team-based models such as FHTs, CHCs, AHACs, NPLCs, and in other practice models such as FHGs, the RNPGA, and ensure clinical leaders receive support, including protected time, to meaningfully engage and cultivate their leadership skills.

## 6. Governance, performance and accountability

*Patients First* states: “We must create a responsive health system where someone is accountable for ensuring that care is coordinated at the local level.” (p.7, *Patients First*) It also proposes:

- To “make LHINs responsible and accountable for all health service planning and performance” (p.13). For primary care, this would be “in partnership with local clinical leaders” (p.15), and “physician compensation and primary care contracts would continue to be negotiated by the government and administered centrally.” (p.16)
- “LHINs, in partnership with local clinical leaders, would take responsibility for primary care planning and performance management.” (pp.5+15).
- “To help drive continuous quality improvement in primary care, the Ministry would more methodically measure patient outcomes in primary care to help understand the patient experience accessing primary care, including same-day and after-hours care, and satisfaction with service.” (p.16)
- “LHINs would collect, assess and publish performance indicators at a sub-region level and share that information with health care providers and managers to support performance improvement, as well as to help inform the organization of primary care in each LHIN sub-region.” (p.16)

It is important to recognize that 75% of primary care providers (i.e. those outside of the four interprofessional team models) have not begun to report performance, have no contractual obligation to do so, and will need support to get started. Furthermore, only 700 family physicians out of 11,000 have signed up for their individual primary care practice reports– this is a huge gap to fill. As outlined in the Critical Enablers section below, adequate investment is essential – in data, technology and the necessary skillsets to enable primary care providers to extract and meaningfully use data to achieve

outcomes.

The recommendations below build upon the governance mandates recommended in section 1 of this paper.

Recommendations:

15. *That subLHINs adopt an approach that brings together disparate players with varying accountability arrangements, with members of the community (for example, through the collective impact framework.<sup>5</sup>) Do NOT introduce an additional governance layer.*
16. *That the Ministry ensure clarity and consistency across all LHINs and with Health Quality Ontario (HQO) on what is to be measured, while allowing adaptability for the local context.*
17. *That the Ministry, LHINs and HQO learn from the field what matters for outcomes, and therefore collaborate with patients and primary care associations to determine the approach and measures (e.g. AFHTO's D2D work, AOHC performance reporting, NPAO indicator work, RNAO's NQuIRE).*
18. *That the Ministry proceed with its commitment -- "To help drive continuous quality improvement in primary care, the Ministry would more methodically measure patient outcomes in primary care to help understand the patient experience accessing primary care," (p.16) and in so doing, review the approach to measuring timely access to ensure it tracks the facets that are meaningful and important to Ontarians.*
19. *That the Ministry and LHINs define desired outcomes and targets in collaboration with primary care providers and people in their communities, while:*
  - Maintaining a clear distinction between tracking for improvement versus tracking for accountability, and system performance versus individual performance.
  - Giving sufficient support to primary care providers so they can succeed in meeting targets.
20. *That Ministry and LHINs review:*
  - Funding and performance requirements set out in contracts with primary care organizations (e.g. AHACs, CHCs, FHTs, NPLCs), individual or groups, hospitals, pharmacists and other health care organizations, to promote alignment to achieve the desired outcomes for the population and the health system.

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<sup>5</sup>This approach is built upon the following features:

- A common agenda for change
- Consistent data and measurement for alignment and accountability
- A plan of action that outlines and coordinates mutually reinforcing activities for all participants
- Open and continuous communication to build trust, assure mutual objectives, and continually learn together
- Backbone support with staff with specific skillsets to serve and coordinate the entire initiative.

A simple diagram describing the Collective Impact approach can be found at - <http://www.collaborationforimpact.com/collective-impact/> .

- Funding mechanisms to promote alignment with evidence-based practice (where available) to achieve the desired outcomes and avoid penalizing providers for actions that are outside their control.

## 7. Critical enabler: data and information management

Almost all that is presented in this response – optimal use of interprofessional team resources, effective care coordination, primary care interface with mental health and addiction care, clinical leadership, governance and performance improvement – require availability, collection and meaningful use of data as well as information technology. Effective integration across providers and settings means sharing necessary patient information across the circle of care. Performance management and quality improvement require real-time data for feedback.

### Recommendation

*21. That the Ministry and LHINs continue to give priority, and ideally accelerate, support for data capacity, effective data sharing and information management across sectors.*

## Conclusion

Primary care is ready and willing to partner – with the Ministry, LHINs, other sectors, people and communities – to strengthen people-centred health care in Ontario. Ontario’s primary care sector has the capacity and expertise upon which to build the strong foundation of the health care system. Best practices are in place in various parts of the province that can be spread.

We look forward to achieving the vision for a high performing health system resting upon a high performing primary care sector.

## References

[OPCC’s Initial Response to Minister’s Patients First Proposal](#) (January 22, 2016)

[Ontario Primary Care Council’s Framework for Primary Care](#)

[OPCC Position Statement on Care Co-ordination in Primary Care](#)

OPCC response to Cancer Care Ontario regarding Palliative Care (January 15, 2016) – attached.