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Integrating Primary Care, Home Care, and Community Health Services in Ontario

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Abstract

The *Patients First Act* is the legislative piece of a large-scale reform in Ontario's health systems governance. Prior to 2017, home and community care in Ontario was managed by Community Care Access Centres (CCACs), which were overseen by Local Health Integration Networks (LHINs) in each region. Both the CCACs and the then provincial government had come under public criticism for inefficient spending, lack of coordination between health care providers, exacerbating existing inequalities with regards to home and community care, and adding an unnecessary layer of bureaucracy to an already strained health care system. The *Patients First Act* was introduced in 2016 in order to better integrate home and community care with primary care, and to improve efficiency, transparency, and continuity of care for patients. This organizational reform was achieved by abolishing the CCACs and transferring their duties to the LHINs, along with the authority to issue policy directives to other health services providers. The *Patients First Act* is a recent development in Ontario health systems reform, and ongoing evaluation is needed to determine the full impact of this policy. While the strengths of the Act include its focus on access and accountability for patients, there are significant gaps that remain to be addressed, including the role of LHINs in working with physicians and hospital boards, and in framing equity issues beyond geographical difference to include growing ethnocultural and linguistic diversity.

La Loi de 2016 Donnant la Priorité aux Patients *est l'élément législatif d'une importante réforme structurelle de la gouvernance des systèmes de santé de l'Ontario. Avant 2017, les soins à domicile et en milieu communautaire étaient administrés par les Centres d'accès aux soins communautaires (CASC), des organismes gérés par les réseaux locaux d'intégration des services de santé (RLISS) dans leurs régions respectives. Les CASC et le gouvernement provincial du jour ont fait l'objet de critiques publiques en raison de dépenses inutiles; d'un manque de coordination entre les prestataires de soins de santé; de l'aggravation d'inégalités préexistantes en matière de soins à domicile et en milieu communautaire; et de l'ajout d'un niveau de bureaucratie supplémentaire à un système de santé déjà surchargé. La* Loi de 2016 Donnant la Priorité aux Patients *a été introduite en 2016 afin de favoriser l'intégration des soins à domicile et en milieu communautaire aux soins primaires. Son deuxième objectif était de permettre aux patients de jouir d'une efficacité, d'une transparence et d'une continuité des soins accrues. Cette réforme organisationnelle a été réalisée en abolissant les CASC et en déléguant leurs fonctions—ainsi que le pouvoir d'émettre des directives aux autres prestataires de soins de santé—aux RLISS. Le plan* Priorité aux Patients *est une évolution récente dans la réforme des systèmes de santé de l'Ontario; une évaluation continue est nécessaire afin de déterminer le véritable impact de cette politique. Bien que l'importance accordée à l'accès et à la redevabilité envers les patients constitue l'une des forces de la Loi, de sérieuses lacunes—concernant notamment le rôle des RLISS auprès*

des médecins et des conseils d'administration des hôpitaux et la conception des questions d'équité au-delà des différences géographiques afin d'inclure l'accroissement de la diversité linguistique et ethnoculturelle—restent à combler.

Key Messages

- In the past decades, Ontario's health system has been challenged by a lack of coordination and communication between primary care and home and community care, leading to a lack of transparency and decreased continuity of care for patients.
- A 2015 report that found too little was being spent on direct care, and that geographic variation in quality of care presented an issue to equity, led to public concern surrounding the role of Ontario's 14 Community Access Care Centres (CCACs).
- Proposals for health systems reform in Ontario identified the need to integrate primary care with home and community care, and to focus on patient-centred service delivery and responsiveness to a changing landscape of health needs in the province.
- The *Patients First Act*, passed in 2016, reforms the Ontario health system by removing the CCACs, transferring their duties to the LHINs, and granting more authority to LHINs in their capacity to integrate health services and issue policy directives.

Messages-clé

- *Au cours des décennies écoulées, le système de santé de l'Ontario a été handicapé par un manque de coordination et de communication entre les soins primaires d'une part et les soins à domicile et communautaires d'autre part, ce qui a conduit à un manque de transparence et a dégradé la continuité des soins pour les patients.*
- *Un rapport publié en 2015 avait montré que la part de la dépense consacrée aux soins était trop faible et que les variations géographiques dans la qualité des soins posaient un problème d'équité, ce qui a conduit le public à se poser des questions sur le rôle des 14 Centres Communautaires d'Accès aux Soins (CCAS) de l'Ontario.*
- *Les propositions de réformes du système de soins en Ontario citaient de besoin d'intégrer les soins primaires aux soins à domicile et communautaires, et de développer un système de soins hautement réactif et centré sur le patient pour s'adapter aux besoins changeants de soins dans la province*

- *La* Loi de 2016 Donnant la Priorité aux Patients *transforme le système de soins de l'Ontario en supprimant les CCAS et en transférant leurs responsabilités aux RLIS, ainsi qu'en donnant plus d'autorité aux RLIS pour intégrer les soins et émettre des directives de politique.*

1 BRIEF DESCRIPTION OF THE HEALTH POLICY REFORM

The *Patients First Act* (2016) is part of an ambitious organizational reform in Ontario's health system. Notably, the legislation makes significant changes to the *Local Health System Integration Act* (2006) as well as the *Home Care and Community Services Act* (1994). It also repeals the *Community Care Access Corporations Act* (2001), removing the Community Care Access Centres (CCACs) and giving Ontario's 14 Local Health Integration Networks (LHINs) increased authority over the management and funding of home and community care.

This reform is largely a response to growing concerns over the effectiveness of provincial spending on health services administration, responsiveness to local needs, and continuity of care for patients. Although Ontario's LHINs have held a mandate to integrate[1] primary and home and community care since their inception in 2006, the *Patients First Act* is meant to help improve the LHINs' capacity to accomplish this mandate, as well as improve both accountability and transparency to the public (Ontario Ministry of Health and Long-Term Care 2015).

2 HISTORY AND CONTEXT: HEALTH SYSTEMS GOVERNANCE IN ONTARIO

Ontario's LHINs were established in 2006, in the wake of a national movement to create systems of regional health authorities. Established with the belief that they would be better able to respond to local needs, better coordinate health services, and be more cost effective, the LHINs, which report to the provincial Ministry of Health and Long-Term Care (MOHLTC), have a mandate to manage, fund, and integrate health services in their region. They are responsible for hospitals, CCACs, long-term care, mental health and addiction services, family health teams (FHTs), nurse practitioner-led clinics, and other community health services (Peckham, Ho, Marchildon 2018). Their jurisdiction does not cover pharmaceuticals, public health, ambulance, provincial networks such as Cancer Care Ontario, or physicians who practice outside of FHTs (Born and Sullivan 2011).

Since 2006, the LHINs have faced a number of barriers in their ability to fulfill this mandate. LHINs have had little direct control over the funds they are meant to manage: although the LHINs have the authority to distribute funding to hospitals and other health care providers (including CCACs), the funds are allocated to health care providers directly from the provincial government (Born and Sullivan 2011). The persistence of independent hospital boards has also caused tensions in decision-making and division of authority (Born

[1]Integration in this context is defined as involving the coordination, amalgamation, or partnership of entities in the provision of health care services

and Sullivan 2011). Both the LHINs and the CCACs (which were responsible for coordinating home and community care) have come under criticism in the past decade for lack of transparency to the public, and as an added source of bureaucracy in a system still failing to comprehensively integrate services in many regions. In particular, the CCACs were the subject of a 2015 special report from the Auditor General of Ontario, criticizing the amount spent directly on home care services and disparities in quality of care from region to region.

Ontario's health system has also been increasingly strained by an aging population, and the rising costs associated with primary care and hospital stays. Home and community care presents a less costly alternative that is also preferred by patients (CIHI 2017). Home care has been identified as a priority area for federal funding to the provinces, with specific funds earmarked to increase access to home care announced in 2016 (Boily 2016).

Parallel to the highly publicized criticism of the CCACs and their role in home care delivery, a comprehensive report by David Price and Elizabeth Baker, *Patient Care Groups: A New Model of Population Based Primary Health Care for Ontario* (2015), highlighted several opportunities for health systems reform, including proposals to increase access to primary care, and to better integrate primary care within the health system at large (Price *et al.* 2015). Much of the Price-Baker report formed the basis for the 2015 *Patients First: A Proposal to Strengthen Patient-Centered Care in Ontario* discussion paper, a precursor to Bill 41, which became the *Patients First Act* in 2016 (Glauser, Tierney, Bournes 2016). However, Price and Baker's proposals to better integrate primary care also arose concurrent with an ongoing dispute between the Ontario Medical Association (OMA) and Ontario's provincial government over physician fees and contract conditions (including increased reporting requirements). This dispute may have made some aspects of the report more challenging to incorporate into the final policy proposal. For example, the *Patients First Act* does not transfer authority to the LHINs over physicians who practice outside of FHTs, making it more challenging for the LHINs to fulfill their mandate to integrate primary care (Glauser, Tierney, Bournes 2016).

3 GOALS OF THE REFORM

The explicit goals of the *Patients First Act* are ambitious: to improve Ontarians' access to primary care; improve connections and communication between primary health providers, hospitals, home and community care, and public health units; reduce bureaucracy and spending on health system administration; improve accountability to patients; improve equity of care; empower patients in making health care decisions; and increase capacity to deliver culturally sensitive services to Indigenous and francophone communities in Ontario (Ontario Ministry of Health and Long-Term Care 2016). While the LHINs already had a mandate that included the integration of primary, home, and community care, the *Patients First Act* gives them greater authority over health care providers, which may help them in achieving this mandate, particularly in regard to home and community care by dissolving

the CCACs and transferring their responsibilities to the LHINs (Glauser, Tierney, Bournes 2016). The Act also seeks to expand technological and communications infrastructure within the health system, though not necessarily as a preliminary step in the reform.

Situating this reform in the broader context of federal politics helps to highlight the implicit goals of the *Patients First Act*. In particular, concurrent changes in the federal distribution of health care funds to provinces in 2016 (a reduction in the annual increase of federal funds distributed to the provinces for health care, despite requests from provincial health ministers to increase funding), and the subsequent focus of funding on specific priority areas for health (including funds explicitly directed to expanding home care), meant that provinces were looking for opportunities to promote cost-effectiveness and efficiency within their health systems (Boily 2016). An additional implicit goal may have been to accelerate the transition of physicians from solo practice models to FHTs (Glauser, Tierney, Bournes 2016).

4 FACTORS THAT INFLUENCED HOW AND WHY THE REFORM CAME ONTO THE GOVERNMENT AGENDA

In Kingdon's (2003) model of policy process, the first stage in an issue coming onto a government's agenda involves public recognition of, and interest in, the problem, followed by the development and identification of viable policy proposals. In the case of the *Patients First Act*, a September 2015 special report from the Auditor General of Ontario on the CCACs found that too little was being spent directly on home and community care, and that discrepancies existed in terms of quality of care by geographic region, presenting a problem for equity. These findings subsequently put pressure on the provincial government to act quickly to improve efficiency, consistency, and access to home and community care for patients (Church 2017).

Two months following the release of the Auditor General's report, the *Patients First* discussion paper was released, outlining a policy proposal that involved dissolving CCACs and transferring their duties to the LHINs, which would be granted greater authority in their existing roles. The renewed role of the LHINs in Ontario's health system falls in line with another area of policy priority (increasing local governance of health services), and is based on both expert evidence, such as the 2015 Price-Baker report, and over 184 submissions from various stakeholder groups as part of a lengthy public consultation and feedback process (Ontario Ministry of Health and Long-Term Care 2016).

5 FACTORS THAT INFLUENCED HOW AND WHY THE FINAL DECISION WAS MADE

Politically, motivation for introducing the reform can be framed as the Ontario government demonstrating support for the LHINs (established under a prior Liberal majority) over the CCACs (which were established by the Progressive Conservatives in 2001), in response to imminent shifts in federal funding (Boily 2016). The political will to enact the proposed *Patients First Act* also came up against ongoing and difficult negotiations between OMA and the provincial government, along with the influence of hospital boards, presenting added challenges as to which aspects of the proposed policy were able to come onto the government agenda (Picard 2016).

The evidence established by the 2015 Price-Baker report, along with public consultation and stakeholder input, allowed key priorities for health care reform to be clearly identified within the context of the government's overall agenda. The structure of the provincial government at the time the Act was passed in 2016—a Liberal majority—was also an important factor.

6 HOW THE REFORM WAS ACHIEVED

In December, 2016, the *Patients First Act* received Royal Assent in the Ontario provincial legislature. This legislation represents an organizational policy reform: a restructuring of the way the provincial government manages, funds, and delivers health services. Specifically, the Act transfers assets and duties of the CCACs to the LHINs, effectively dissolves the CCACs, and gives LHINs the authority to issue operational/policy directives to health service providers with the exception of hospitals and long-term care homes (*Patients First Act* 2016). The Act also establishes a number of "sub-LHINs" to further promote localized governance, with the ability to distinguish between the unique needs of each neighbourhood (Ontario Ministry of Health and Long-Term Care 2016). These changes came into effect in early 2017, shortly after the *Patients First Act* was passed.

7 EVALUATION

The Ontario Ministry of Health and Long-Term Care has released yearly reports on the progress of their *Patients First* action plan, which includes the *Patients First Act* passed in 2016. In the April 2017 year-two report, the Ministry identified many successes under four main indicators (improving access to health care, and connecting, informing, and protecting Ontarians, respectively). These successes included shorter wait times, more hours of care at home, and more Ontarians with a primary health care provider (Ontario Ministry of Health and Long-Term Care 2017). However, as the *Patients First Act* itself is still very newly

implemented, ongoing evaluation will be necessary in order to determine the full impact of the legislation.

A 2017 report by Nazeefah Laher, a fellow with the Wellesley Institute in Toronto, titled *Diversity, Aging, and Intersectionality in Home Care*, identifies a key shortcoming in the *Patients First* framework with regards to equity in access to care. Laher reflects on the way that *Patients First* currently focuses on equity in terms of poverty, homelessness, and geographic region, with little attention paid to ethnocultural and linguistic diversity—factors which are growing in importance along with Ontario's aging population. As the *Patients First* reform begins to take effect, it will be critical to take note of how the policy is able to respond to these gaps, and for the LHINs and other stakeholders to establish a meaningful process for both evaluation and transparency in reporting to the public.

Several initiatives have arisen as a result of the implementation of *Patients First*. These include: the establishment of local care coordinators who provide advice and services in connecting patients to health care services; an online referral system that reduces wait times for specialist care and other health services; and the creation of a patient and family advisory council in one region (Ontario Ministry of Health and Long-Term Care 2017).

8 STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS

Table 1 summarizes the strengths, weaknesses, opportunities, and threats of the *Patients First Act.* .

Table 1: SWOT Analysis

Strengths	Weaknesses
• Improves accountability to patients. • Improves access to primary and home and community care, as well as continuity of care for patients. • Increases governance capacity of LHINs by granting authority to issue policy directives. • Eliminates a layer of bureaucracy and improves integration of health services by bringing home and community care and primary care under full jurisdiction of the LHINs.	• LHINs may be lacking the technological and communications infrastructure to facilitate a transformation of this scale. • Does not give LHINs authority over physicians. • Potential to increase administrative burden for physicians. • Excludes hospital boards from requirement to follow policy directives issued by LHINs.

Strengths (Cont'd)	Weaknesses (Cont'd)
• Transfer of staff from CCACs to LHINs may increase capacity of LHINs. • Responds directly to public criticism of CCACs along with calls for reform in the provincial health system, in response to changes in population needs. • Need for more localized health services governance addressed by establishment of sub-LHINs.	• Does not establish clear metrics for measuring performance. • Addresses only structural (as opposed to capacity, funding) issues—of key concern to nurses, personal support workers, and other frontline health care professionals. • Lacks response to disparities in terms of ethnocultural and linguistic diversity. • LHINs may choose to offer contracts for community support services to for-profit companies—effectively resulting in less funding for non-profit community support services.
Opportunities	**Threats**
• Timeliness with regards to changes to federal health funding and priority areas for health, including home care. • Could accelerate the transition of physicians from a solo practice model to the creation of FHTs. • Remaining potential to respond to disparities in terms of ethnocultural and linguistic diversity. • Presents an opportunity to evaluate the role of for-profit health services providers within the publicly funded health care system.	• Negotiations with Ontario Medical Association over physician fees and other contract conditions; concern from physicians over increased reporting and potential threats to self-regulation, including accelerated creation of primary health teams, which now fall under the authority of the LHINs. • Hospital boards maintain relative autonomy, potentially resulting in challenges to authority of LHINs. • Growing concern over need to prioritize equity in home and community care, beyond differences in income and geographic region. • Recent election of a Progressive Conservative government may present a threat to structure of LHINs, previously criticized as a source of added bureaucracy within the health care system.

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