Achieving true health system transformation

Ontario's health system is being transformed. There is great potential to improve access, safety and effectiveness when it comes to health service delivery. Will you support an integrated health system that is anchored in primary care?

Do you agree care co-ordinators and the care co-ordination function should be located in primary care settings so that patient care is more seamless and costly hospital re-admissions can be avoided?

Do you agree that home care agencies, instead of the Local Health Integration Networks (LHIN), should assume responsibility for the allocation of home care services?

Between May and June 2017, the functions of all 14 former Community Care Access Centres (CCAC) transferred over to the 14 LHINs. According to the health minister's mandate letter, LHINs are now "responsible for creating an integrated service delivery network that includes primary care providers, inter-professional health care teams, hospitals, public health, mental health and addictions and home and community care to ensure a more seamless patient experience".[1] It is critical that health system transformation not end with this change because much more is needed to ensure Ontarians have an effective health system.

Health system anchored in primary care

The Ontario Primary Care Council (OPCC), of which RNAO is a founding member, strongly encourages anchoring the health system in primary care. High performing health systems around the world already do this.[2] Ontarians need a better integrated health system where primary care is the patient's main contact with the health system, and where connections are automatically made between different health sectors and providers. There is ample evidence that integrated health systems anchored in primary care deliver the best health outcomes and are the most cost-effective.[3] [4] [5] [6]

Better integrated and co-ordinated care at all levels will enable Ontarians to live healthier lives. Primary care practitioners provide comprehensive first contact and continuing care to patients.[7] Vulnerable populations such as the elderly, people with chronic conditions, severe physical disabilities, developmental or cognitive impairments, and serious mental illnesses and addictions easily fall through the cracks without properly integrated and comprehensive care.[8] Those with high-risk and complex conditions would benefit from primary care co-ordinating their care, including chronic disease prevention and management, on an ongoing basis.[9]

Benefits of care co-ordination in primary care
Mrs. Lee, recently diagnosed with end-stage cancer, decided palliative care was the best way to cope with her terminal diagnosis. The oncologist, respectful of Mrs. Lee's decision, sent her home with medications to manage her pain while a referral to the Local Health Integration Network (LHIN) for palliative care was forwarded to a centralized location. Although oral pain medications were readily available, Mrs. Lee increasingly suffered with cancer-related pain for three weeks while she waited for palliative services to begin. If a LHIN care co-ordinator had been located at Mrs. Lee's local Community Health Centre, where she sees the nurse practitioner for ongoing primary care, she could have obtained home care services with minimal delay, and her primary care practitioner would be linked in with these services.

Locating care co-ordination and care co-ordinators in primary care settings
Now that CCAC functions have been transferred to the LHINs, RNAO wants the government to move forward with their commitment to relocate the 3,100 former CCAC care co-ordinators (this number excludes those working in hospitals) and the care co-ordination function into primary care settings with salary and benefits intact. In the health minister's 2017 mandate letter, LHINs are expected to "develop and implement a plan with input from primary care providers, patients, caregivers and partners that embeds care co-ordinators and system navigators in primary care to ensure smooth transitions of care between home and community care and other health and social services as required."[10]

Moving care co-ordination and care co-ordinators to primary care will expand the reach of primary care practitioners to community care. This shift will facilitate seamless transitions for patients and families, reduce duplication, increase quality of care, facilitate access, and reduce costs.[11] Increasing the workforce capacity of primary care will significantly improve primary care's ability to deliver comprehensive person-centred health services. This will result in improved co-ordination, continuity and transitions, reduce service delays, avoid costly hospital re-admissions, improve overall quality and personal health outcomes, and empower patients and families.[12]

The majority of care co-ordinators are registered nurses (RN). RNs possess a comprehensive understanding of the health system and a person's holistic health status, including physical, mental, social, emotional and spiritual needs. Their competencies, knowledge and clinical skills make them naturally suited to function as leaders in the co-ordination of care and navigation of the system. As profiled in RNAO's *Primary Solutions to Primary Care*[13] and in *Enhancing Community Care for Ontarians (*ECCO)[14], RN-led and primary care-based co-ordination result in positive patient and health system outcomes.

Role of LHINs
In addition to planning, integrating, funding, monitoring service, and being ultimately accountable for local health system performance, LHINs are now engaged in direct service provision – a function CCACs previously carried out (e.g. Rapid Response, Mental Health and Addiction, and Palliative Care). It is not effective to fund and monitor a system while also providing direct service. These roles should be shifted into the community.

LHINs must also move away from the former CCAC function of case management brokerage, where home and community service hours are allocated to patients based on recommendations of LHIN staff who then assign these levels to service providers. The functions of service provision and management, including allocations at the patient level, should become the responsibility of Ontario's 160 third-party service provider organizations that have contracts with the LHINs for provision of home health care services. They would have the best understanding of people's needs given that they are directly providing care on a regular basis.

The role of the LHINs must be shifted towards allocating funding and service agreement accountability. Furthermore, all contracted home care providers should be required to provide the full spectrum of services to patients, including nursing, personal support, and therapies, in order to eliminate the dysfunctional fragmentation of their care. Having services delivered by one provider ensures continuity of service, better communication with the patient and less opportunity for error.

Public health
Public health units (PHU) have expertise in health promotion and disease prevention, as well as in analyzing population health needs and delivering community engagement. That's why RNAO believes PHUs should assume a leading role to advance health equity by integrating with Ontario's LHINs. In January 2017, the government of Ontario established the Expert Panel on Public Health to develop recommendations on proposed structural, organizational and governance changes for Ontario's public health sector in order to achieve an integrated health system, which actively promotes health, reduces health disparities, and improves access to health-care services.[15] The expert panel report recommended the existing 36 public health units be reorganized into 14 distinct entities that work closely with their LHIN counterparts to ensure more frequent and effective communication at all levels and better integration of services.[16] This will benefit the LHINs' system planning efforts, since positioning public health units within the LHIN boundaries will better align public health with the rest of the system, and can stimulate a broader reach of health promotion principles in other sectors.

Although this presents an important first step in aligning public health units with the rest of the system, as recommended in RNAO's *Enhancing Community Care for Ontarians* (ECCO 2.0) report, including all sectors within the mandate of each LHIN will advance co-ordination and integration of service to more effectively meet the needs of people as well eliminate duplication

of services.[17] RNAO believes that geographically aligning public health and the LHINs is insufficient. While it may stimulate collaboration, it will be unsuccessful in facilitating whole system integration and won't fully extend the health promotion capacity of public health throughout the system. Therefore, as previously expressed, public health units must be encompassed within the LHIN mandate.

RNAO's HEALTH SYSTEM TRANSFORMATION ASKS

- Anchor the health system in primary care, and ensure care co-ordination and care co-ordinators be located in primary care settings. Eighty per cent of care co-ordinators should be located in primary care settings by the summer of 2018
- LHINs must serve an administrative/oversight role. LHINs should be enabled to plan, integrate, fund, monitor, and be accountable for local health system performance, while refraining from service delivery and management
- Integrate public health units with Ontario's LHINs

NOTES FOR RNAO LEADERS

They say, we say

Primary care is not ready to anchor the system.

RNAO knows there is strong capacity already in place within Ontario's primary care sector and greater capacity must be encouraged. RNAO has identified several strategies to achieve this: expanding the workforce by locating the 3,100 care co-ordinators in primary care, fully utilizing interprofessional care, remedying outstanding scope of practice barriers for NPs, and implementing independent RN prescribing. Community health centres (CHC), family health teams (FHT) and NP-led clinics are excellent examples of interprofessional collaboration within primary care. In these models, same-day, next-day, evening and weekend appointments are available to patients, which means increased access to care. CHCs and most NP-led clinics are eager and ready to locate care co-ordinators in their clinics.

Sole practitioners cannot accommodate care co-ordinators.

RNAO urges that care co-ordinators be located within primary care settings. They do not necessarily have to be co-located in the offices of sole practitioners who may not have the space for them. In these situations, care co-ordinators can be located within large family practices and/or CHCs and serve patients attached to sole practitioners.

Public health cannot be included within the LHIN mandate; it must remain a separate entity.

True system integration goes beyond treating illness and disease. Public health units must be integrated with the LHINs. This would allow LHINs to perform whole system planning at the regional level and make it possible for public health units and other sectors to focus on evidence-based population health planning priorities. Formalizing alignment between public health and the LHINs is insufficient. While it may stimulate collaboration, it will not help achieve whole system integration and will not fully extend the health promotion capacity of public health throughout the system.

Care co-ordinators are unionized employees and thus cannot be moved into primary care.

We respect existing collective agreements and encourage the ministry, unions, and primary care organizations to work together to develop a transition strategy that is fair to workers and in the best interest of Ontarians. RNAO calls for a matrix reporting structure: while the collective agreement and funds would be held by the LHIN, we encourage the government to ensure that primary care organizations serve as the operational employer, involved in recruitment/retention and performance management.

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