Strengthen Primary Care and Integrate Delivery to Optimize the Health System

As Premier Ford, Minister Elliott and Dr. Devlin redesign Ontario's health system, RNAO continues to urge that primary care be its anchor. This is the only way that Ontarians will attain a more accessible, efficient, and effective health system.

- **Do you support an integrated health system anchored in primary care?**
- **Do you agree that care co-ordinators be located in primary care?**
- **Do you agree that any oversight agency not provide direct services?**

When health care is better co-ordinated and integrated, Ontarians will live healthier, more productive lives. This is especially true for vulnerable and high risk populations, such as the elderly, people with chronic or complex conditions, and those with serious mental illness and addiction who can fall easily through the cracks without co-ordinated and comprehensive care.[1]

Ontario's health system must be anchored in primary care

In its report titled *Enhancing Community Care for Ontarians (ECCO)*, released in 2012 and 2014,[2] [3] RNAO called on the government of Ontario to strengthen our health system by strengthening community care.[4] [5] The ECCO report presents a model to transform our health system by anchoring it in primary care that becomes the centre of an integrated network of health services.

In the years since, the government took the first step towards greater integration when in 2017 it eliminated 14 former Community Care Assess Centres (CCAC) and transferred their oversight to Local Health Integration Networks (LHIN), a shift supported by RNAO. Now, the next step must be taken, one promised but not delivered by the previous government, whose health minister wrote that LHINs would be "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, seniors care, palliative care, and home and community care to provide a more seamless patient experience".[6] To achieve this goal, further work is urgently needed to strengthen primary care within an integrated health system.

The Ontario Primary Care Council (OPCC), of which RNAO is a founding member, developed a framework to strengthen primary care in Ontario. In-line with high performing health systems around the world, OPCC urges that the health system be anchored in primary care.[7] Ontarians need a better integrated health system where primary care becomes the main point of entry point for patients who can connect seamlessly among different health providers. This approach delivers the best health outcomes and is the most cost-effective, evidence strongly shows.[8] [9] [10] [11] **RNAO calls on MPPs to support an integrated health system anchored in primary care.**

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. Her 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 care co-ordinator had been located in primary care, all aspects of Mrs. Lee's care would have been coordinated at the local Community Health Centre (CHC) where she has been a patient for more than two decades and has an ongoing relationship with a nurse practitioner who looks after her primary care needs. Within the CHC, a care co-ordinator could have obtained palliative care for Mrs. Lee quickly while linking her to her primary care practitioner. That existing connection would provide her with a familiar resource should she have questions or concerns about her health and would promote a more seamless integration of services.

Locating care co-ordinators in primary care settings
Ontarians will greatly benefit from care co-ordinators placed in primary care settings, as RNAO outlined in *Primary Solutions to Primary Care* and in *Enhancing Community Care for Ontarians*.[12] [13] Primary care ought to be a person's first point of contact with primary care practitioners providing comprehensive and continuing care to patients.[14]

Locating care co-ordinators in primary care will expand capacity, speed access and enhance health system navigation. Increasing workforce capacity will bolster primary care's ability to deliver comprehensive, person-centred health services. This will reduce service delays, empower patients and families, avoid costly hospital re-admissions and improve co-ordination, overall quality and personal health outcomes.[15]

Locating care co-ordinators in primary care also will promote health, prevent disease, better manage chronic disease, and better support people with mental health and addictions.[16] This is important to all Ontarians, and especially necessary for vulnerable and high-risk populations.[17]

Most 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. RNs' skills, knowledge and competencies make them naturally suited to function as primary care co-ordinators and system navigators, both as members of interprofessional teams, and also by working with groups of physicians.

The evidence is conclusive: When RNs based in primary care lead care co-ordination, outcomes improve for patients and the health system.[18] [19] A recent Cochrane review found that nurses in primary care provided "equal or possibly even better care" compared to doctors and did so using no more resources than doctors.[20] RN care co-ordinators enable seamless transitions for patients and families, reduces duplication, increases quality of care, facilitates access, and reduces costs.[21]

Action must be taken to fulfill mandate letters to LHINs in 2017 from a previous health minister to embed care co-ordinators in primary care settings to "ensure smooth transitions of care between home and community care and other health and social services."[22] **RNAO urges the Ontario government, in the coming fiscal year, to relocate the care co-ordination function and the 4,500 co-ordinators working in the LHINs into primary care, with their salary and benefits intact.**

The role of LHINs in an integrated health system

The time has come to better integrate the health system by tasking LHINs or an alternative oversight agency to plan, fund and hold accountable all health sectors, as RNAO outlines in its *ECCO* report.[23] The transfer of CCACs into the LHINs in 2017 was an important step toward better integration, but, LHINs took on direct service provision and management – a major mistake that delayed services and created a bureaucratic burden. Those delays and that burden are made worse because LHINs also provide services in rapid response, palliative care and mental health and addiction. It is a long standing view of RNAO that it is not feasible for LHINs or any other oversight and funding agency to fund and monitor health system performance while also providing direct service. We urge the government to shift the provision of services and staff roles to the community.

LHINs – or any other oversight agency – must also move away from how the former CCAC brokered case management. This brokerage involves staff recommending the allocation of home care and community service hours to patients, and then assigning these levels to service providers. This function, including allocations at the patient level, should become the responsibility of Ontario's 160 third-party service provider organizations. These organizations, in coordination with the patient and his/her family, primary care and hospital discharge planners, are better placed to understand and determine the health and care needs of patients.

Full integration of all health sectors

With the original aim of LHINs to become the single health system planner and funder, RNAO strongly advocates that any oversight agency – LHINs or otherwise – be charged with integrating the whole health system.

RNAO further urges government to create a minimum of 80 and ideally 120 local health networks that will better co-ordinate and integrate services, eliminate duplication, and more effectively meet the needs of people.[24] [25] [26] These integrated networks of service delivery should be formally composed of primary care, hospital care, and home health care; and have agreed upon linkages to community support services, mental health and addictions, rehabilitation, complex and residential care, and public health.

Public health units (PHU) in particular play a key role in the health system, having developed an expertise that enable them to prevent disease, engage communities, support health equity, promote health and improve population health. In efforts to better align the public health sector with LHINs, in 2017, the government formalized the relationship between leadership of LHINs and PHUs through legislative changes, and established the Expert Panel on Public Health. The expert panel produced the report *Public Health within an Integrated Health System*, which recommended the optimal structural, organizational and governance changes for Ontario's public

health sector.[27] The expert panel recommended reorganizing the existing public health units into 14 distinct regional entities and additional local service delivery sites that work closely with their LHIN counterparts to ensure improved communication at all levels and better integration of services.[28]

Although this presented an important first step, RNAO believes further changes are imperative. Aligning PHUs and LHINs geographic boundaries may stimulate collaboration, but it is insufficient to integrate the whole system. Those who oversee the health system must engage PHUs to advance priorities for population health that are based on evidence and extend throughout the system the health promotion capacity of public health.

RNAO's HEALTH SYSTEM TRANSFORMATION ASKS

- Support an integrated health system anchored in primary care.
- Relocate the care co-ordination function and all 4,500 care co-ordinators working in LHINs into primary care settings, with their salary and benefits intact, within a year.
- Create a minimum 80 and ideally 120 local health networks that will integrate services by enabling and enhancing co-ordination, eliminating duplication, and more effectively meeting the needs of people.
- Ensure integrated networks of service delivery be formally composed of primary care, hospital care, and home health care; and have agreed upon linkages to community support services, mental health and addictions, rehabilitation, complex and residential care, and public health.
- Mandate the LHINs – or any future oversight structure - to refrain from direct service delivery and management.
- Enable the full integration of all health sectors, including public health, within the mandate of any oversight and health system planning agency.

NOTES FOR RNAO LEADERS

"They say, we say"
This section is for RNAO leaders only. It provides additional information and suggested responses for statements we may receive about this issue.

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: Expand the workforce by locating the 4,500 care co-ordinators in primary care, fully utilize interprofessional care, remove outstanding scope of practice barriers for NPs, and implement independent RN prescribing. Community Health Centres (CHC), Aboriginal Health Access Centres (AHAC), 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 increases 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 interprofessional primary care organizations (e.g., CHCs and NPLCc) and serve patients attached to sole practitioners.

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.

References:

[1] Kodner, D. (2012). ECCO- A disruptive health-care innovation whose time has come. Retrieved from http://rnao.ca/sites/rnao-ca/files/Kodner_-_ECCO_-_A_Disruptive_Health-Care_Innovative_Whose_Time_Has_Come.pdf.

[2] Registered Nurses' Association of Ontario (RNAO). (2012). *Enhancing community care for Ontarians (ECCO) v. 1.0*. Retrieved from https://rnao.ca/sites/rnao-ca/files/RNAO_ECCO_WHITE_PAPER_FINAL_2.pdf

[3] RNAO. (2014). *Enhancing community care for Ontarians (ECCO) v. 2.0*. Retrieved from http://rnao.ca/sites/rnao-ca/files/RNAO_ECCO_2_0.pdf

[4] RNAO. (2012). *Enhancing community care for Ontarians (ECCO) v. 1.0*. Retrieved from https://rnao.ca/sites/rnao-ca/files/RNAO_ECCO_WHITE_PAPER_FINAL_2.pdf

[5] RNAO. (2014). *Enhancing community care for Ontarians (ECCO) v. 2.0*. Retrieved from http://rnao.ca/sites/rnao-ca/files/RNAO_ECCO_2_0.pdf

[6] Ontario Ministry of Health and Long-Term Care (MOHLTC). (2017). *Ministry mandate letter to LHINs*. Retrieved from http://www.lhins.on.ca/Pan-LHIN%20Content/LHINs%20Accountability.aspx.

[7] Ontario Primary Care Council. (2015). *Position statement: Care co-ordination in primary care*. Retrieved from https://www.afhto.ca/wp-content/uploads/OPCC_Care-Co-ordination-Position.pdf.

[8] Wodchis,W., Dixon, A., Anderson, G. & Goodwin, N. (2015). Integrating care for older people with complex needs: key insights and lessons from a seven-country cross-case analysis. *International Journal of Integrated Care, 15*(6).

[9] RNAO. (2014). *Enhancing community care for Ontarians (ECCO) v. 2.0*, p25. Retrieved from http://rnao.ca/sites/rnao-ca/files/RNAO_ECCO_2_0.pdf.

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

[11] Institute for Clinical Evaluative Sciences. (2012). Comparison of primary care models in Ontario by demographics, case mix and emergency department use, 2008/09 to 2009/10. Retrieved from http://www.ices.on.ca/flippublication/comparison-of-primary-care-models-in-ontario-by-demographics/index.html#7/z.

[12] RNAO. (2012). *Primary solutions for primary care*. Retrieved from http://rnao.ca/sites/rnao-ca/files/Primary_Care_Report_2012_0.pdf.

[13] RNAO. (2014). *Enhancing community care for Ontarians (ECCO) v. 2.0*. Retrieved from http://rnao.ca/sites/rnao-ca/files/RNAO_ECCO_2_0.pdf.

[14] Wodchis,W., Dixon, A., Anderson, G. & Goodwin, N. (2015). Integrating care for older people with complex needs: key insights and lessons from a seven-country cross-case analysis. *International Journal of Integrated Care, 15*(6).

[15] Ontario Primary Care Council. (2016). *Framework for primary care in Ontario*. Retrieved from http://www.afhto.ca/wp-content/uploads/OPCC-Framework-for-Primary-Care-2016-01-13.pdf.

[16] Kodner, D. (2012). ECCO- A disruptive health-care innovation whose time has come. Retrieved from http://rnao.ca/sites/rnao-ca/files/Kodner_-_ECCO_-_A_Disruptive_Health-Care_Innovative_Whose_Time_Has_Come.pdf.

[17] Kodner, D. (2012). ECCO- A disruptive health-care innovation whose time has come. Retrieved from http://rnao.ca/sites/rnao-ca/files/Kodner_-_ECCO_-_A_Disruptive_Health-Care_Innovative_Whose_Time_Has_Come.pdf.

[18] RNAO. (2012). *Primary Solutions for Primary Care*. Retrieved from http://rnao.ca/sites/rnaoca/files/Primary__Care_Report_2012_0.pdf.

[19] RNAO. (2014). *Enhancing community care for Ontarians (ECCO) v. 2.0*. Retrieved from http://rnao.ca/sites/rnao-ca/files/RNAO_ECCO_2_0.pdf

[20] Laurant, M., van der Biezen, M., Wijers, N., Watananirun, K., Kontopantelis, E. & van Vught, A. (2018). Nurses as substitutes for doctors in primary care. *Cochrane Database of Systematic Reviews*, 7.

[21] Ontario Primary Care Council. (2016). *Framework for primary care in Ontario*. Retrieved from http://www.afhto.ca/wp-content/uploads/OPCC-Framework-for-Primary-Care-2016-01-13.pdf.

[22] Ontario Ministry of Health and Long-Term Care (MOHLTC). (2017). *Ministry mandate letter to LHINs*. Retrieved from http://www.lhins.on.ca/Pan-LHIN%20Content/LHINs%20Accountability.aspx.

[23] RNAO. (2014). *Enhancing community care for Ontarians (ECCO) v. 2.0*. Retrieved from http://rnao.ca/sites/rnao-ca/files/RNAO_ECCO_2_0.pdf

[24] RNAO. (2014). *Enhancing community care for Ontarians (ECCO) v. 2.0*. Retrieved from http://rnao.ca/sites/rnao-ca/files/RNAO_ECCO_2_0.pdf

[25] RNAO. (2012). *Enhancing community care for Ontarians (ECCO) v. 1.0*. Retrieved from https://rnao.ca/sites/rnao-ca/files/RNAO_ECCO_WHITE_PAPER_FINAL_2.pdf

[26] RNAO. (2014). *Enhancing community care for Ontarians (ECCO) v. 2.0*. Retrieved from http://rnao.ca/sites/rnao-ca/files/RNAO_ECCO_2_0.pdf

[27] Minister's Expert Panel on Public Health. (2017). *Public health within an integrated health system*. http://www.health.gov.on.ca/en/common/ministry/publications/reports/public_health_panel_17/expert_panel_report.pdf.

[28] Minister's Expert Panel on Public Health. (2017). Public health within an integrated health system. http://www.health.gov.on.ca/en/common/ministry/publications/reports/public_health_panel_17/expert_panel_report.pdf.