

About This Document

This primer provides a concise introduction to Ontario's healthcare system. It is optimized for online viewing, so you can learn more by referring to the side bars or clicking on hyperlinks throughout the document. This will connect you to **Healthy Debate** stories, opinion pieces or other important resources.

The document was prepared by Ayodele Odutayo, Jeremy Petch and Andreas Laupacis from **Healthy Debate**, in consultation with the **Association of Ontario Health Centers**.

Primary Health Care

Primary health care is the first point of contact a person has with the health care system. "It is essential health care... made universally available to individuals and families in the community through their full participation." (5)

It can include medical care, health promotion, disease prevention, public health, equity and the social determinants of health.

Health care in Ontario is delivered by a complex network of health service providers. With the Ministry of Health and Long Term Care (MOHLTC) as the steward and primary funder, each service provider (e.g. Community Health Centers and Family Health Teams) has its own distinct rules and regulations. This means that Boards must not only understand their own organization, but must have a broad understanding of Ontario's health care system and be aware of potential changes to the system that will impact their organization. With a focus on community governed primary health care organizations (PHCOs) — Community Health Centres (CHCs), Community Governed Family Health Teams (CFHTs), Nurse Practitioner Led Clinics (NPLCs) and Aboriginal Health Access Centres (AHACs) — this document provides an updated summary of the current health services landscape in Ontario and critically examines current policies and initiatives.

WHAT IS PRIMARY HEALTH CARE?

Primary health care emphasizes a holistic view of health, with consideration of physical, mental and social wellbeing. It also provides safe and culturally competent care including the provision of traditional aboriginal traditional healing for First Nations communities. The social determinants of health — broadly defined as the condition in which people are born, grow, live, work and age (1) — are key drivers in the way primary health care is delivered. Social determinants include shelter, education, and income (2) and this means that primary health care cannot be limited to the treatment of acute disease (3). Instead, it should also include preventative medicine, health promotion, health education, healthy public policy and supportive environments (2). Primary health care is therefore a multi-faceted field and often involves health service teams with professionals from different disciplines (2).

In addition, the community being served should also be at the centre of primary health care. At its best, primary health care supports communities to shape their own health (4, 5). Involving community members in the governance of PHCOs is an important part of this process and is intended to help PHCOs meet the needs of their community (See *Board and PHCO Relations with Stakeholders: Community Engagement*).

Governance refers to the authority and responsibility for making decisions and taking action. It is comprised of the structure and processes used to direct or “govern” the affairs of an organization. A governance structure defines the manner in which affairs of an organization are managed and supervised, and provides a shared understanding of roles and responsibilities.

Accountability is the obligation to answer for results on matters you are responsible for.

Governance and **Accountability** are related. The governing body of an organization is accountable for the organization’s performance.

-Ministry of Health and Long Term Care

GOVERNANCE OF PRIMARY HEALTH CARE IN ONTARIO

Governance is the process, rules or structures used to guide an organization. It specifies how power is exercised, how decisions are taken and who is accountable (6). As health service providers in Ontario, PHCOs are incorporated under the Not For Profit Corporations Act and are mandated to establish a Board of Directors (now referred to as “Boards” or “Directors”) to oversee their organization. These Boards serve in a governance capacity and have a fiduciary responsibility to the PHCO. Accordingly, they must work in the best interest of the community, PHCO, and the health system when fulfilling their primary duties: community engagement, developing a mission, vision, and strategic plan for the organization and providing financial oversight. A more complete list of the Board’s governance roles and responsibilities is provided in Table 1.

Table 1: Board Roles and Responsibilities (7)

Board Roles (Approaches to Tasks)	Board Responsibilities (Tasks to Complete)
Strategic Direction	Community Engagement
Policy-Making	Strategic Planning
Decision-Making	Quality
Community Engagement	Financial Oversight
Oversight	Risk Management
	Board Effectiveness
	Human Resource Oversight
	Dispute Resolution

Given these wide-ranging responsibilities, Boards delegate operational management to an Executive Director (now referred to as “Management”). This approach provides the advantage of allowing the Board to focus strictly on “policy formulation, decision-making and oversight”, while Management guides operations in a manner consistent with policies set by the Board (7). These Boards are often

About Healthy Debate

Canadians want to know more about their health care system but there are few places to go for factual, easy to understand information. **Healthy Debate** provides analysis and commentary about Canada’s health care system in order to fill this gap with unbiased information that will lead to thoughtful deliberation and informed opinions.

We hope that accessible information about a wide variety of issues in health care will prove interesting and useful to both the general public and health care workers and that we can work together to make health care better.

“Fiduciary Duty”

means that “directors are required to act honestly, in good faith and in the best interest of the hospital and to apply the level of skill and judgment that is reasonable to expect of a person with their knowledge and experience” (7).



Primary Care at a Critical Juncture

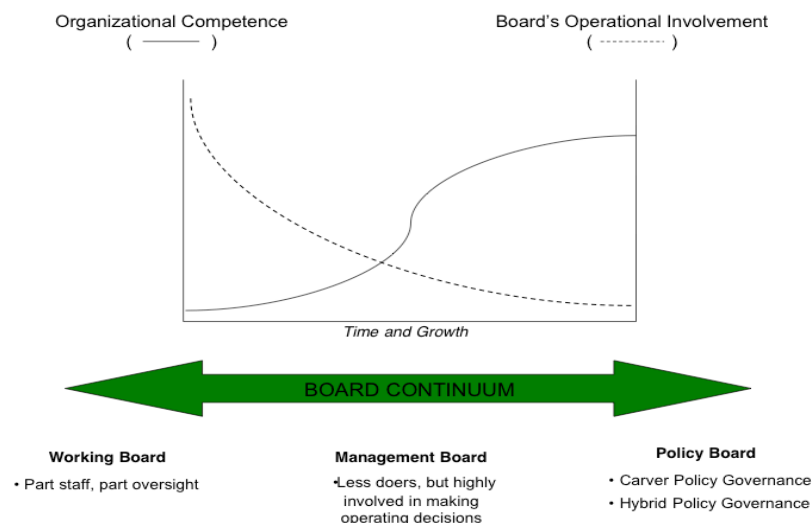
By Brian Goldman

When Commissioner Roy Romanow handed down his report on the Future of Health Care in Canada, he had this to say about primary care: “There is almost universal agreement that primary health care offers tremendous potential benefits to Canadians and to the health care system.”

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referred to as Policy Making Boards. It is noteworthy that Boards of small or newly established PHCOs with limited human resources may have Directors undertake some management responsibilities and become involved in the operation of the organization (6). However, as the PHCO grows, Boards should move toward becoming a Policy Making Board (Figure 1).

Figure 1 (6, 7): Governance Structures



Community Governance

Community engagement is central to the governance of primary health care organizations. PHCOs are often established to serve communities and improve service delivery to populations that have been historically disadvantaged or marginalized. Incorporating community engagement into the governance structure of PHCOs helps the organization serve its community appropriately. This practice is known as community governance.

While legislation regarding how Boards must practice community engagement is limited, the minimal standard is for PHCO Boards to “reflect the community being served” (8). Most Boards fulfill this responsibility by sourcing Directors from the community being served or ensuring Directors have a close connection to the community. Some primary health care organizations may also establish a community advisory council to allow the community to communicate with the Board (See *Board Composition* and *Board and PHCO Relations with Stakeholders: Community Engagement*).

Board Composition

Assembling a Board of Directors with diverse but complimentary skills is key to creating an effective governance body. Legal requirements in this regard are few



The Importance of Using a Health Equity Impact Lens to Analyze Public Policy

by Lori Kleinsmith

Policy decisions on everything from childhood education to housing can have unintended consequences on the public's health. A Healthy Equity Impact Assessment (HEIA) is a decision support tool designed to identify these unintended consequences.

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except that the [Not For Profit Corporations Act](#) requires that Boards be limited to a fixed number of directors, not fewer than three. As well, board size should generally be adjusted to the requirements of the PHCO with consideration for the workload associated with overseeing the PHCO and the skill sets required by the Board to provide good governance (7). Finally, consideration should be given to the quality of Board discussions and how Board size impacts on each Director's opportunity to contribute (7).

Boards are self-renewing entities and Directors are selected through a competency-based and community-focused selection or nomination process. This means that new Directors are assessed based on their connection to the community served by the PHCO and the skill sets they can bring to the Board. Directors may also be selected by members of the PHCO's community (see *Board and PHCO Relations With Stakeholders: Community Engagement*).

Each Director may bring multiple skills and perspectives to the Board and it may be useful for Boards to have Directors with competency in the following areas: financial literacy, law and governance, and quality improvement (7). Identifying the skill requirements for the Board can then be accomplished through evaluation of Directors and assessments of Board performance. Evaluation is a key component of good governance and informs decisions to reinstate or replace Directors. Current guidelines recommend an annual evaluation of Board performance (9).

FINANCING OF PRIMARY HEALTH CARE CENTERS

Financing for Health Services

CHCs receive operational funding from the MOHLTC to provide pre-specified primary health care services to the communities they serve (See *Board and PHCO Relations with Stakeholders: Health Service Providers and Human Resource Planning*). This core funding is first provided to [Local Health Integration Networks](#) (LHINs) by the MOHLTC and LHINs are the final decision makers regarding the funding received by CHCs. The funding includes compensation for staff and health service providers; all of whom are paid within a pre-specified salary range that is "commensurate with their skills and experience" (8). CHCs can also provide additional programming beyond what has been negotiated with the MOHLTC, but revenue for these programs must be obtained through other sources such as grants from other branches of government or charitable donation (10). In some CHCs, the extent of supplemental funding exceeds the core funding from the MOHLTC (10).

LHINs are also responsible for enforcing accountability for CHC funds through a Multi-Sector Accountability



LHINs and Ontario's Health Care System

by Karen Born & Terrence Sullivan

In many provinces across Canada, governance of health care has been moved to regional boards based on the belief that local authorities can better integrate and coordinate services, and contain costs. Ontario created 14 LHINs in 2006, with the mandate to plan, fund and integrate health care services for more efficient care in their regions.

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Agreement (MSAA) that must be signed by CHCs (11, 12). Accordingly, the allotment provided to CHCs is re-evaluated based on whether CHCs achieve the requirements outlined in this agreement. In providing financial oversight, Boards must ensure that CHCs meet the commitments of this agreement. For CHCs that fail in this regard, LHINs may provide an opportunity for CHCs to remedy their concerns, discontinue funding or request repayment of unused MOHLTC funds (11).

CFHTs are not currently accountable to LHINs, although the MOHLTC has plans to make this change in the near future (13). Instead, CFHTs are funded through two MOHLTC mechanisms. The first funding allotment is a Family Health Team Fund, which covers operational expenses associated with the CFHT (14). This funding is used to pay for a pre-specified number of interprofessional and administrative staff (See *Board and PHCO Relations with Stakeholders: Health Service Providers and Human Resource Planning*) and may also be used to cover overhead expenses depending on the type of funding received by doctors within the CFHT. Doctors in CFHTs are paid through a separate funding mechanism that combines capitation (a monthly payment for each patient on a doctor's roster) with fee-for-service payments (15).

The funding model for doctors in CFHTs also provides for a variety of financial incentives. For instance, doctors may receive one-time or ongoing payments for **providing care to persons with mental illness** or enrolling complex and vulnerable persons (15). Whether these incentives translate into improvements in health services is unknown.

NPLCs have a single mechanism of funding wherein interprofessional health staff, including nurse practitioners (NPs), receive a monthly payment (16). The MOHLTC provides predetermined salary ranges for interprofessional health staff and the final salary is determined by Management based on the experience and qualifications of the particular staff member.

Finally, AHACs are primarily funded directly by the MOHLTC for their core primary health care budget. Some AHACs also sign MSAA's with LHINs for community support or mental health and addictions funding.

Capital projects for PHCOs, including construction and equipment may also be funded by the MOHLTC. Depending on the nature of the project, up to 100% of the expenses may be covered. External funding opportunities and community partnerships can also be used to supplement MOHLTC funding for capital projects (8, 12, 17, 18).

Identifying the funding model that improves access and produces the best outcomes for persons requiring primary



Are Ontario's Primary Care Models Delivering on Their Promises?

by Karen Born & Andreas Laupacis

In the last decade, efforts to improve access to primary care in Ontario have led to major changes to how family doctors practice and are paid. A recent report suggests that these newer models of primary care are not meeting the needs of vulnerable populations, and that Community Health Centres (an older model of care) do a better job.

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health care is an ongoing challenge. For instance, it is unlikely that a “one-size fits all” approach will work for compensation arrangements in primary care and the diversity of MOHLTC payment arrangements for doctors reflects the challenge of tailoring [primary care models to the needs of communities](#).

Nonetheless, Boards must understand the funding models within their PHCO and ensure their organization fulfills its service agreement with the MOHLTC, LHIN and/or other funders. Where necessary, Boards must also take corrective action to ensure their PHCO is providing care in accordance with their contract.

BOARD AND PHCO RELATIONS WITH HEALTH SYSTEM STAKEHOLDERS

Boards are responsible for providing oversight and guidance to Management in fulfilling the PHCO’s accountability requirements and maintaining its relationships with stakeholders. This section discusses how the Board and PHCOs interact with their community, the MOHLTC, LHINs, Community Support Service Organization and Community Mental Health and Addiction Agencies, CCACs, hospitals and health service providers.

1. Community

Community engagement is among the primary responsibilities of PHCO Boards. Within the framework of the [Local Health System Integration Act](#), “community” includes persons and individuals, health service providers and employees within the geographical area of the PHCO. However, this definition can be expanded to include organizations with which the PHCO shares common interests, characteristics, experiences, beliefs or mandates (19). Otherwise, legislation prescribing how Boards must practice community engagement is limited and the minimal standard is for PHCO Boards to reflect the community being served (see *Primary Health Care Governance*).

Many PHCOs include “Members” within their governance structure as a strategy to engage their communities (19). Members have a vested interest in the operation of the PHCO and can contribute by attending general meetings, raising issues to the PHCO Board for consideration and participating in the work of the PHCO’s committees. Most importantly, Members are often responsible for electing the Directors of the Board from a pool of candidates nominated by the Board itself (19). In some PHCOs, the bylaws provide for broad-based open community Membership wherein any individual who lives in the community and fulfills pre-specified criteria could become a Member (19).



Accessing Primary Care in Ontario

by Karen Born & Andreas Laupacis

Increasing access to primary care providers, such as family doctors or nurse practitioners, has been a government priority. Better access to primary care is also associated with improved population health. However, fewer than half of Ontarians can see their primary care provider in a timely fashion when they are sick.

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Screening for Poverty

by Naheed Dosani

The evidence shows that poverty is a major health condition and the biggest determinant of health, especially for those who live on low incomes. One only needs to scratch the surface of the growing body of research evidence to see the importance of poverty on health outcomes.

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Challenges for Primary Care in Ontario

By Jeremy Petch & Joshua Tepper

Over the last year, reports have suggested some of Ontario's new primary care models, which are significantly more expensive than older practice models, have had limited success in improving access and quality. In response, the Ministry of Health and Long Term Care is conducting a review of these models, and recently instituted a temporary freeze on the hiring of new physicians for group practices.

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This approach is often employed as a community engagement strategy and in these instances, PHCOs may have a Membership over 200 individuals (19). However, this approach is not a prerequisite for effective community engagement and other PHCOs successfully engage their communities while maintaining a limited Membership (19).

2. Ministry of Health and Long Term Care

The MOHLTC is the steward of the health care system in Ontario and provides guidance through legislation and strategic planning (13). The MOHLTC is also the primary funder of health services and capital projects. In the case of FHTs and NPLCs, accountability for these funds is directly enforced by the MOHLTC, although Ontario's Auditor General's report indicated that there was limited accountability monitoring of FHTs in 2011 (20, 21). In the case of CHCs, accountability is enforced by the LHINs (see *Local Health Integration Networks*) and Boards are accountable for ongoing monitoring and reporting of performance in relation to the services that are being funded. In providing oversight for their organization, Boards should understand the contractual obligations of their PHCO and ensure their organization is providing care in accordance with their agreement with the MOHLTC or LHIN.

3. Local Health Integration Networks

Fourteen [Local Health Integration Networks](#) were formed in 2005 to devolve health care administration from the provincial level to the regional level. The MOHLTC ensures consistency in the delivery of health services across LHINs through providing strategic goals and priorities for Ontario's health system.

LHINs are directly accountable to the MOHLTC through an annually revised Ministry-LHIN Performance Agreement (MLPA) (22). Broadly, the MLPA provides LHINs with a plan for the use of MOHLTC funds and details the performance goals and reporting requirements. Although the MLPA should be an agreement between the MOHLTC and LHIN, the terms can be unilaterally set by the MOHLTC where consensus cannot be achieved (23).

Oversight of LHIN operations is provided by its own Board of Directors, which must be appointed by the Lieutenant Governor of Ontario (23). A three-tier model of health care accountability therefore exists in Ontario, with provincial-level stewardship provided by the MOHLTC, region-level governance provided by the Board of LHINs and organizational-level governance provided by the Boards of health service providers such as PHCOs. LHINs are a key part of this three-tier model of governance and clarity regarding their function and responsibilities is essential for the effective delivery of health care.

“Who is Overseen by the LHIN?”

- Community Health Centers
- Community Support Service Organizations
- Community Mental Health and Addiction Agencies
- Community Care Access Centres
- Long Term Care Facilities
- Hospitals
- Other organizations as directed by government and/or legislation

Strategic planning by LHINs is detailed within an Integrated Health Service Plan (IHSP), which is developed with input from their constituent health service providers and communities. The IHSP details the vision for the LHIN and identifies priority areas for action. It also aligns local LHIN priorities with the MOHLTC's strategic plan.

With respect to CHCs, LHINs have multiple avenues to ensure accountability for funding (11). First, CHCs must sign a Multi-Sector Accountability Agreement (MSAA), which ultimately guides interactions between CHCs and LHINs. Within the framework of the accountability agreement, CHCs must engage in a multi-year planning process and produce a strategic planning document that details the result of this activity. Formally known as the Community Accountability Planning Submission (CAPS), CHCs must involve their community (See *Board Composition and Board and PHCO Relations with Stakeholders: Community Engagement*) in the development of this document and must incorporate multi-year financial forecasts, risk management strategies and strategies for the achievement of performance targets. The CAPS must also align with the strategic priorities identified by the LHIN in its IHSP and reflect LHIN priorities.

The requirements for CHC performance reporting are also detailed within the MSAA. In addition to a year-end report, CHCs must inform the LHIN of any concerns regarding their performance targets. In this event, CHCs and LHINs either engage in a performance improvement process to achieve the pre-specified targets or adjust the goals accordingly.

CHCs are also accountable for voluntarily identifying opportunities to integrate their services with those of other health service providers (11). Integration is a key aspect of participating within a LHIN and provides a way to improve coordination and efficiency in health care.

At a minimum, voluntary integration efforts conceived by Management should be approved by the Board before a proposal is forwarded to the LHIN (25). Approval of a proposal for voluntary integration must also be obtained from LHINs before any action can be taken by CHCs. Increased Board involvement will then be required depending on the extent to which services are being integrated. LHINs therefore provide a formal pathway for potential collaboration between CHCs, CSSOs, CCACs, CMHAs and hospitals.

4. Community Support Service Organizations and Community Mental Health and Addiction Agencies

Community Support Service Organizations (CSSOs) are

“Who Is NOT Currently Overseen by the LHIN”

- Doctors (including family doctors)
- Public Health
- Laboratories
- Ambulance Services
- Provincial Networks

“Types of Integration”

1. To co-ordinate services and interactions between different persons and entities
2. To partner with another person or entity in providing services or in operating
3. To transfer, merge or amalgamate services, operations, persons or entities
4. To start or cease providing services
5. To cease to operate or to dissolve or wind up the operation of a person or entity



Strengthening Primary Care for Child and Youth Mental Health

by Jeremy Petch & Joshua Tepper

Reports released over the last decade paint a bleak picture of child and youth mental health services at both the national and the provincial level. In 2006, the senate released its report which identified numerous problems with child and youth mental health services.

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not-for-profit agencies that help people live comfortably and safely at home (26). Services provided by CSSOs range from bereavement support and caregiver education to homemaking and transportation services. Similarly, Community Mental Health and Addiction agencies (CMHAs) provide support services to people with mental illness or addiction and their families (27, 28). Services provided range from mental health and addiction assessments to assisting persons with housing or legal concerns. Although some services may be provided at no cost, others may require a financial assessment and payment. Persons requiring the services of CSSOs and CMHAs may contact the organization directly or may be referred by their local CCAC.

CSSOs and CMHAs receive funding from LHINs and may also receive external funding through philanthropic donations or direct payment from those using their services (29). Similar to PHCOs, CSSOs CMHAs are overseen by a Board of Directors who provide oversight for the organization. Collaboration between CSSOs, CMHAs and PHCOs are frequently established to improve coordination of care for patients within their community.

5. Community Care Access Centres

Community Care Access Centres (CCACs) are the coordinators of access to home care and long-term care in Ontario. There are 14 CCACs in Ontario, all of which are governed by Boards and accountable to LHINs through service agreements. The costs of CCAC approved services are completely covered by the government and anyone, including doctors or patients, can contact their local CCAC.

Collaboration between CHCs and PHCOs can improve community services. One example of successful collaboration between CCACs and PHCOs is a program for persons with chronic obstructive pulmonary disease (COPD) that was established between the Erie St. Claire CCAC and their local CHCs and FHTs. Through this program, persons with COPD were identified by the CCAC and rapidly triaged to receive home care and interprofessional care for any acute illness. Ongoing care was then provided through a program designed by CHCs and FHTs, which focused on preventative care, client health education, and psychosocial services (30).

6. Hospitals

Ontario has 211 hospital sites (31). “Of that number, 155 are hospital corporations and an additional 56 facilities are hospitals under an umbrella corporation” (31). Hospitals are focused on acute and tertiary care and provide services ranging from surgery and inpatient medical services to outpatient and primary health care services.



Let's Talk About a Comprehensive Mental Health System

By Jeremy Petch

Pharmaceuticals have become the default treatment for all mental illnesses in Canada, even when the evidence suggests that medications are not effective for all of the conditions for which they are prescribed.

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Similar to PHCOs, [Ontario hospitals are overseen by a Board of Directors](#), who have a fiduciary responsibility to their hospital and to the health care system. They are primarily responsible for providing financial oversight, strategic planning and overseeing the quality of care within hospitals. Hospitals are accountable to specific LHINs and must sign accountability agreements.

7. Health Service Providers

Interprofessional teams are an key aspect of primary health care. With diverse but complimentary skill sets, these teams can help address the physical, mental and social wellbeing of persons within their community.

Nurses, social workers, pharmacists, and doctors are among Ontario's [23 self-regulated health professions](#). Self-regulation means that each of these professions has their own regulatory college, which establishes and enforces professional and educational standards for their members. Their core mandate is to protect the public and each college provides a complaints and discipline process to investigate concerns from the public and other members of the profession. These colleges operate under Ontario's [Regulated Health Professions Act](#).

All health service providers within PHCOs must be licensed or professionally qualified to provide their service in Ontario. PHCOs should have a credentialing process in place to document and confirm the credential of individuals providing health services within their organization (8).

Members of the Interprofessional Team

Nurses are a key part of the human resource infrastructure within PHCOs. PHCOs may have up to three levels of nursing staff within their organization: registered practical nurses (RPNs), registered nurses (RNs) and nurse practitioners (NPs).

Both RPNs and RNs receive training based on the same philosophy of care. However, RPNs undertake a more focused program leading to a college diploma in practical nursing over two years while RNs receive broader and more comprehensive training in a 4-year degree. In practice, "this means that RNs are able to autonomously meet the nursing care needs of persons whose needs are not well defined or are changing whereas the RPNs can independently care for persons whose care needs are well defined and the health condition is well controlled" (32).

[Nurse practitioners are registered nurses](#) who have undertaken advanced training in clinical decision-making, diagnosis and prescription of medications (32). They also have advanced knowledge of health service management



Controversies about Community Care Access Centres and Home Care

by Karen Born and Andreas Laupacis

Shortened hospital lengths of stay, and a growing number of people living with chronic diseases has meant that more Ontarians than ever are receiving health care services in their homes.

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Fewer Hospital Staff on Weekends Puts Some Patients at Risk

by Jeremy Petch, Christopher Doig & Irfan Dhalla

In the modern economy, many industries, such as aviation, retail and manufacturing, no longer slow down over weekends. Yet hospitals have mostly resisted this trend, even though demand for many forms of health care is no less on weekends than on weekdays.

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and can provide services including health promotion, preventative medicine and rehabilitation (32). The MOHLTC is also undertaking a new initiative to expand the scope of practice for nurses and these changes would allow RNs to prescribe certain medications and NPs to prescribe controlled substances (33).

Registered Dietitians are also present on the interprofessional team in some PHCOs and their training involves the completion of a Bachelor's degree in food and nutrition in a program accredited by the Dietitians of Canada (DC). Those with undergraduate training in a non-DC program must complete a Masters practicum in dietetics (34). Registered Dietitians primarily focus on assessing and counseling persons on their nutrition. They can also advise persons on how to change their nutritional habits to address a nutrition related disorder and maintain a healthy lifestyle (32). Registered Dietitians are important contributors to preventative medicine, health education and health promotion aspects of primary health care.

Social Workers are experts on community resources and **important members of the interprofessional team**. Their training involves the completion of a 4-year Bachelor of Social Work degree with the option of an additional year of study to obtain a Masters of Social Work (MSW) degree. Those with an undergraduate degree unrelated to social work must complete at 2-year MSW (35). Social workers focus on improving social functioning through assessing and evaluating individual, interpersonal and societal problems and developing a management plan to help individuals overcome these challenges (36). In practice, this can include a wide range of services, from connecting persons with different resources within the community to serving as an intermediary between persons and other organizations.

Health Promoters and Community Health Workers are also important members of the interprofessional team and have similar responsibilities. "Health promotion is the process of enabling people to increase control over, and to improve, their health" (37). Health promoters design, coordinate, implement and evaluate health promotion programs for the communities served. For instance, Access Alliance, a CHC in Toronto, provides a Newcomer Education program aimed at promoting newcomers' health by improving the knowledge and self-efficacy of recent immigrants to Canada. Health Promoters often have a diploma or bachelor's degree in a health related field or 3-5 years of experience in health education or health promotion within a community or public health setting.

Pharmacists are the medication experts on interprofessional teams. Their training involves the completion of a Bachelor's or Doctor of Pharmacy degree and **their scope of practice has also been expanded** to



Lower Pay Hampers Nurse Practitioner Recruitment in Primary Care

by Ann Silversides & Andreas Laupacis

Nurse practitioners are a key plank of government efforts to improve access to primary care. However, a continuing gap in pay and benefits for nurse practitioners who choose to work in primary care compared to those who work in hospitals, limits recruitment and retention to community settings.

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Include the prescription of drugs for smoking cessation, renewing and adapting prescriptions and administering the flu vaccine (38). Pharmacists therefore have a key role in preventative medicine, health education and health promotion.

Doctors are also members of interprofessional teams. Their training involves the completion of a Doctor of Medicine degree with at least two years of residency training, depending on their chosen specialty. Doctors are involved in the “assessment of the physical or mental condition of an individual and the diagnosis, treatment and prevention of any disease, disorder or dysfunction” (39). Although many primary care doctors work within centers or hospitals, some may also provide house calls.

Depending on the PHCO, an interprofessional team may include other self-regulated health professions such as clinical psychologists, chiropractors, and dentists. As well, many PHCOs may also have non-regulated professionals as part of the care team, such as traditional healers, personal support workers, and volunteers, all of whom play a vital role in service provision. Clients and their families are also important members of the team.

QUALITY OF CARE

Within Ontario, there has been steady trend towards making Boards accountable for the quality of care within their organization. In 2010, the Excellent Care for All Act (ECFA) legislated quality of care as a core responsibility for the Boards of hospitals. Although the ECFA did not include specific mention of PHCOs, Boards for primary health services can anticipate an increasing responsibility for quality of care within their organization in coming years.

Recent research has identified key drivers of effective governance for quality and patient safety (40).

These include:

1. Clarity regarding MOHLTC expectations for quality and safety in PHCOs; clarity regarding the role of PHCO Boards in this regard;
2. Knowledge of quality and safety within the Board;
3. Relevant and accurate measures of quality and safety within their organization;
4. Ongoing updates to the Board regarding performance on quality and safety measures;
5. Collaborative relationship with Management for quality and safety;
6. Development of quality and safety plans;
7. Cultivation of a culture conducive to quality and safety reporting; and
8. Effective governance in support of quality and safety



Retail Pharmacy Evolution Beset by Implementation Challenges

by Ann Silversides & Mike Tierney

Reforms to the way that Ontario community pharmacies are compensated for professional services, combined with an expanded scope of practice for pharmacists, are presenting major implementation challenges for the profession. [Learn More...](#)



Changes Called for as 1% of Population Accounts for 1/3 of Health Care Spending

by Ann Silversides & Mike Tierney

Ontario's Health and Long-term Care Minister is calling for a change in how health care costs are scrutinized in light of research showing that a tiny proportion of the Ontario population accounts for a very large proportion of health care expenditures. [Learn More...](#)



What Do We Mean by Quality

By Mark MacLeod

No one speaks of health care at the moment without talking about quality – better quality, quality measures, pay for performance, quality metrics, publication of quality data – the list goes on and on. But, what do we mean by quality?

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Health Links: Ontario's Bid to Provide More Efficient and Effective Care For Its Sickest Citizens

By Ann Silversides & Andreas Laupacis

Ontario's Health Links initiative is a "big manoeuvre" in a complex provincial system, acknowledges Helen Angus, associate deputy minister with the transformation secretariat of the MOHLTC. The initiative aims to facilitate coordination of care at a local level for high needs patients.

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Each of these drivers has been broadly discussed by the Canadian Patient Safety Institute in their [Toolkit for Effective Governance for Quality and Patient Safety](#). An in-depth discussion of these drivers in the context of the MOHLTC's plan to improve the quality of primary health care is provided below.

Emerging Trends in Health Care: Integration and Quality of Care

Within their strategic plan for health services in Ontario, the MOHLTC has put forward a multi-faceted strategy to improve primary health care. Broadly, this involves better integration within primary health care and between sectors and improved reporting on quality of care.

1. Integration

Improving integration is an important element of the MOHLTC's strategy. Administration of health services were devolved from the provincial to the local level with the passage of the [Local Health System Integration Act](#) (See *Local Health Integration Networks*) and LHINs became responsible for transferring funds to health service providers, enforcing accountability for these funds and overseeing integration and collaboration among health service providers. Currently, CHCs are the only PHCO within the LHIN mandate and the MOHLTC has retained responsibility for enforcing accountability agreements for FHTs and NPLCs. Although still in its nascent stages, the MOHLTC has expressed the intent to integrate FHTs and NPLCs into the LHIN system (13).

The Ministry of Health and Long Term Care has also introduced a new program aimed at improving coordination of care at the local level. This initiative, known as Health Links, appoints specific health service providers, [including some primary health care organizations](#), to help coordinate care for high needs individuals. This can range from individuals with chronic conditions such as heart failure and COPD to those with [mental health conditions](#). Nonetheless, what is common among these individuals is that when they access the health care system, they may be in the top 5% of people who account for 66% of health service spending. By providing comprehensive and well-coordinated care to these persons, Health Links are intended to reduce costly hospital admissions and avoidable emergency department visits.

Thus far, 77 Health Links have been planned for Ontario, with the size and number based on natural referral patterns between doctors and hospitals in local areas. However, the initiative has received limited development funding from the MOHLTC and each Health Link will require the voluntary participation of organizations in its catchment area. Ongoing

evaluation of Health Links will therefore be important to ensure the initiative is targeting the right population and [improving quality of care for high needs individuals](#). PHCO Boards must therefore provide oversight as Management enters into the role of a Health Link or begins working with the Health Link in their catchment area.

2. Reporting on Quality of Care

Improving reporting on quality of care is the second element of the MOHLTC strategy to enhance quality in primary health care. Most notably, this involves the introduction of annual quality improvement plans (QIPs) as a reporting requirement for PHCOs (41). QIPs will not serve as formal “performance management tools” but instead provide a standardized mechanism to encourage priority setting and strategic planning for quality of care (41, 42). As well, QIPs are to be developed at the level of the organization as opposed to the individual health service provider level.

The Board, Management, clinicians, administrative staff and community members can all be engaged in the development of the QIP, where appropriate (42). Establishing a Quality Committee that collates quality measures, develops the QIP and monitors performance can also facilitate assessments of quality of care. This Quality Committee should report to the Board, who hold final accountability for overseeing the development and approval of the QIP (42). QIPs are to be submitted to Health Quality Ontario (HQO), which serves as a central hub where QIPs are assessed, compared and feedback is provided to PHCOs. HQO can also provide support to PHCOs in completing their QIP.

Three areas have been identified by the MOHLTC and HQO as priorities for PHCO QIPs and these include: Access, Integration and Person Centered Care (43). However, the approach to measuring quality of care within each of these priority themes (Appendix 1) has not yet been standardized, although work on the Common Quality Agenda is moving quickly, including the development of a Primary Care Performance Measurement Framework.

Although guidelines exist to ensure consistency in measuring quality improvement indicators in the QIP, differences may still exist in how each PHCO collects this data. This presents an opportunity for Boards to understand how quality metrics are obtained at their PHCO and carefully monitor results. Consider the following example within hospitals, wherein remarkably divergent hand washing rates were reported in Ontario hospitals: [“Are Hand Washing Rates Posted by Ontario Hospitals Believable”](#).



High users of health care: are we asking the right questions?

by Christopher Stone, Laura Rosella & Vivek Goel

There is little doubt that system transformation is necessary to achieve sustainable and high-quality health care for Canadians. In recent years, the care and management of high users (HU) of health care has emerged as a focal point for developing a sustainable health care system. Despite the focus on this group, one question has received surprisingly little attention: what is the relationship between high use of the health care system and population health – and more specifically, the social determinants of health (SDOH)?

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Oakville Clinic Sets an Example for Quality and Accountability in Primary Care

By Ann Silversides & Irfan Dhalla

Primary care is the foundation of Ontario's health care system and more than 137,000 patient care visits are made every day to primary care providers – family physicians, general practitioners and nurse practitioners – in the province. However the quality of care that patients receive in primary care is largely unknown. Even primary care providers who evaluate their own care have virtually no way to compare the quality of the care they deliver with that of their peers, or to other benchmarks.

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Accreditation

In addition to the requirements outlined by the MOHLTC, CHCs also undergo a voluntary **accreditation process every three years**. Accreditation is coordinated by the Canadian Centre for Accreditation (CCA), a national not-for-profit organization “tailored to community-based and social service organizations” and by Accreditation Canada (AC) (44). Accreditation provides CHCs with the opportunity to compare and “evaluate their services and systems against acknowledged standards of good practice” (45). Boards can contribute to quality improvement in their PHCO by ensuring quality improvement efforts also align with the standard set by the CCA or AC.

CONCLUDING STATEMENTS

Boards have an important role to play in primary health care. Not only are Boards responsible for the financial viability and stakeholder accountabilities in PHCOs, but there is now a greater emphasis on their role in improving quality of care. An understanding of PHCO relationships with stakeholders and the ever-changing health service environment is an indispensable asset to Directors of Ontario's primary health care organizations.

Appendix 1 (30)

Priority Theme	Approaches to Measurement	Measurement Outcomes
Access	Patient/Client Survey	<p>Daily demand: Number of appointments requested today, for any day</p> <p>Daily supply: Number of appointments available in the schedule</p> <p>Daily activity: Number of appointments used</p>
Integration	Patient/Client Survey Health System Administrative Data	<p>Number of patients/clients admitted to hospital in last 12 months</p> <p>Percent of admitted patients/clients that were known at time of admission</p> <p>Number of known discharges and how learned (i.e., from patient/client/family versus hospital.</p>
Person/Patient Centred Care	Patient Survey	<p>When you see your doctor or nurse practitioner, how often do they or someone else in the office give you an opportunity to ask questions about recommended treatment?</p> <p>When you see your doctor or nurse practitioner, how often do they or someone else in the office involve you as much as you want to be in decisions about your care and treatment?</p> <p>When you see your doctor or nurse practitioner, how often do they or someone else in the office spend enough time with you?</p>

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