Chapter 1
Section
1.03

Ministry of Health

Community Health Centres

Follow-Up on VFM Section 3.03, *2017 Annual Report*

RECOMMENDATION STATUS OVERVIEW						
		Status of Actions Recommended				
	# of Actions Recommended	Fully Implemented	In the Process of Being Implemented	Little or No Progress	Will Not Be Implemented	No Longer Applicable
Recommendation 1	2	1	1			
Recommendation 2	3	1	2			
Recommendation 3	2			2		
Recommendation 4	2		1	1		
Recommendation 5	4		4			
Recommendation 6	3	1	1	1		
Recommendation 7	3	1	2			
Recommendation 8	1		1			
Recommendation 9	2	1	1			
Total	**22**	**5**	**13**	**4**	**0**	**0**
%	**100**	**23**	**59**	**18**	**0**	**0**

Overall Conclusion

As of October 31, 2019, the Ministry of Health, previously known as the Ministry of Health and Long-Term Care (Ministry), and the Local Health Integration Networks (LHINs) had fully implemented 23% of actions we recommended in our *2017 Annual Report*. The Ministry and the LHINs had made progress in implementing an additional 59% of the recommendations.

The Ministry and the LHINs had fully implemented recommendations such as establishing a timeline of transitioning the funding and oversight responsibilities of all inter-professional primary-care models to the LHINs and streamlining the number of performance indicators that Community Health Centres (CHCs) need to report in their quality improvement plans. They were in the process of implementing recommendations such as developing and putting in place a way to obtain and regularly update capacity and utilization information. They were also in the process of assessing whether

all CHCs should offer a core set of services and updating the accountability agreement between the CHCs and the LHINs accordingly.

However, the Ministry and the LHINs had made little progress on 18% of the recommendations, such as requiring CHCs that do not provide 24/7 on-call services to do so and making governance training available and promoting it to CHCs.

The status of actions taken on each of our recommendations is described in this report.

Background

Ontario's 76 (75 in 2016/17) Community Health Centres (CHCs) provide health care and community programs and services designed specifically for their communities. CHCs are mandated to serve populations that have traditionally faced barriers in accessing health services, including the homeless, seniors, refugees, new immigrants and low-income individuals. CHCs are also mandated to provide services at no charge to people without a health card. In the 2018/19 fiscal year, CHCs received $454 million ($401 million in 2016/17) from the Ministry of Health (Ministry) through Ontario's 14 Local Health Integration Networks (LHINs).

CHCs offer a wide range of services, examples of which include check-ups, immunizations, diabetic foot care, nutrition counselling, needle exchange, youth leadership training and skills development, parent and child programs, and outreach to isolated seniors. CHC physicians and nurse practitioners are salaried and do not bill the Ontario Health Insurance Plan for health services they render.

CHCs serve vulnerable populations and can contribute to reducing the strain on the health-care system and other provincial government programs. However, we found that the Ministry and the LHINs lacked critical information to make informed decisions on whether CHCs are cost-effective in providing quality care to their target population groups, and whether the Ministry should expand the network of CHCs or reallocate funding among existing CHCs.

The following were some of our other significant observations:

- Because there had not been a comprehensive assessment of all primary-care models in Ontario, it was difficult to know how CHCs fit strategically within the primary-care system and the overall health-care system, and how the various models, such as CHCs, Family Health Teams, and fee-for-service practitioners, could best be used to effectively deliver primary care to Ontarians.
- We found that 16% of the CHCs were responsible for more patients than their capacity allowed; in contrast, about half of the CHCs were serving less than 80% of their targeted number of patients. We found that on a weekly basis in 2016/17, each CHC physician or nurse practitioner averaged 31 patient encounters, but some had as few as 16 encounters and some had almost 60 encounters. Without examining this data, the Ministry and the LHINs could not identify areas where resources could be reallocated to make the best use of the investment in the CHC sector.
- Four LHIN sub-regions, which are smaller geographic areas located within existing LHIN boundaries, did not have a CHC or any other form of primary care that offered inter-professional care under one roof.
- Neither the Ministry nor the LHINs defined what professionals, at a minimum, should be included in each CHC, and what minimum services the inter-professional teams should provide to CHC clients. Defining the staffing model and the core services that should be offered at each CHC could increase the efficiency and effectiveness of inter-professional teams and improve clients' access to their services.
- The annual base funding that LHINs provided to CHCs was predominantly based on historical funding levels and not tied to the number

of clients the CHCs served. The LHINs did not increase base funding to those CHCs that exceeded their targeted number of clients.

We made nine recommendations, consisting of 22 action items, to address our audit findings.

We received a commitment from the Ministry and LHINs that they would take action to address our recommendations.

On June 6, 2019, the *Connecting Care Act, 2019*, came into force. The legislation is designed to integrate multiple provincial agencies, including the LHINs, into a single agency, called Ontario Health. The Ministry has said it will review the transitioning of funding and oversight of all interprofessional primary-care models to the LHINs, or to the new single agency, to ensure alignment with the overall health system transformation.

Status of Actions Taken on Recommendations

We conducted assurance work between April 1, 2019, and June 10, 2019. We obtained written representation from the Ministry of Health (Ministry) and the four Local Health Integration Networks (LHINs) we visited during our 2017 audit (Champlain, North Simcoe Muskoka, South West and Toronto Central) that effective October 31, 2019, they have provided us with a complete update of the status of the recommendations we made in the original audit two years ago.

Lack of Evaluation on Whether CHCs Are Meeting Needs of Communities

Recommendation 1

To inform decisions on how to use investment in Community Health Centres (CHCs) to better meet the needs of Ontarians, we recommend that the Local Health Integration Networks:

- *develop and implement a process to obtain and regularly update capacity and utilization information, considering how many people the CHCs actually serve compared to the number of people they are expected to be responsible for, wait-list information, and the growing populations of targeted client groups;*

  Status: In the process of being implemented by April 2020.

Details

In our 2017 audit, we reported that neither the Ministry nor the four LHINs we visited required CHCs to report wait-list data. Even though the Ministry periodically reviewed opportunities for new or expanded CHCs across the province, it had not assessed utilization by and the unmet needs of the communities. As of March 31, 2017, CHCs across Ontario had registered about 335,300 patients, or 83% of the targeted panel size, which is the number of patients each CHC is supposed to be responsible for, into primary care. Of these CHCs, 16% were at or above their expected target, and about half were at less than 80% of their expected target.

At the time of this follow-up, we found that the LHINs had begun requiring CHCs to report certain indicators through their revised accountability agreement with CHCs. Some examples of the capacity and utilization data that will be reported to the LHINs by April 2020 include:

- Access to primary care: an indicator that measures the current number of CHC clients provided clinical services as a percentage of the total number of clients the CHC is expected to serve;
- Specialized care: the percentage of staff time spent on specialized care, including specialty clinics such as palliative care, obstetrics and may include priority populations (such as geriatric); and
- Non-insured clients: an indicator that measures the percentage of clients who do not have coverage under the Ontario Health Insurance Plan.

In addition, the LHINs started in 2018/19 to collect the following wait-list and wait-time data from the CHCs through the Community Accountability Planning Submissions, an annual submission that focuses on service planning and the measurement and evaluation of services:

- whether the program offered by the CHC has a wait list;
- total individuals on a wait list at the end of the previous fiscal year; and
- average wait time to access the program offered by the CHC.

- *examine the appropriateness of implementing the recommendation by the Primary Healthcare Planning Group to attach all Ontarians to inter-professional primary care, and develop and implement a plan in this regard if considered appropriate.*
  Status: Fully implemented.

Details

In our 2017 audit, we noted that the Primary Healthcare Planning Group in 2011 recommended to the Ministry that all Ontarians be attached to inter-professional primary care and that "it is not recommended to develop new delivery models" beyond CHCs, family health teams, nurse practitioner–led clinics and Aboriginal Health Access Centres. The Primary Healthcare Planning Group was chaired by an Assistant Deputy Minister and included membership from the Ontario Medical Association, Registered Nurses' Association of Ontario, Ontario College of Family Physicians and the Association of Ontario Health Centres, which is now called the Alliance for Healthier Communities. This planning group was established to draft and build consensus on a strategy for strengthening primary health care in Ontario.

At the time of this follow-up, the LHINs managed only CHCs but not the other three inter-professional primary-care models—family health teams, nurse practitioner–led clinics and Aboriginal Health Access Centres. The LHINs considered the Primary Healthcare Planning Group's recommendation for CHCs, and with funding totalling $22.8 million in 2017/18 and 2018/19, the LHINs expanded attachment to inter-professional primary-care providers in 19 CHCs across the province. The Ministry indicated that nearly 28,000 patients benefited from this funding.

Recommendation 2

To ensure Local Health Integration Networks (LHINs) can support primary-care services planning as soon as possible in accordance with the Patients First Act, 2016 and to inform decisions on how to use investment in Community Health Centres (CHCs) to better meet the needs of Ontarians, we recommend that the Ministry of Health and Long-Term Care:

- *document the rationale for continuing capital projects that are part of the 2004 and 2005 CHC expansion announcements that are not yet under way, and, if appropriate, allocate any available resources to areas of greater need;*
  Status: In the process of being implemented by March 2023.

Details

We reported in 2017 that of the total of 49 CHCs and satellite site expansions that were announced in 2004 and 2005, 30 were substantially complete, 12 were in progress, and seven had not submitted required documentation to the Ministry to proceed with their expansion. The Ministry explained that the CHC projects still in progress more than a decade later were either still in the project planning phase or under construction. We also noted that the Ministry could not produce its analysis back in 2004 and 2005 to determine where these new CHCs and satellite locations should be located.

At the time of the follow-up, the Ministry confirmed that of the 12 projects listed in 2017 as "in progress," four projects were at least 95% completed and are now occupied by health-service providers. Another seven projects are still at the planning stage and one project is under construction. The Ministry

estimates that they will be substantially completed by March 2023.

The eight CHCs that had not submitted requests for capital projects to support the service expansion announcement at the time of our 2017 audit still had not done so at the time of the follow-up. The Ministry informed us that it did not set aside specific funding for any of the capital expansion projects announced in 2004 and 2005. These CHC sites can still submit a proposal to their LHIN; the Ministry will then assess these projects along with other community capital project submissions through the annual capital allocation process.

- *establish timelines to transition the funding and oversight responsibilities of all inter-professional primary-care models to the LHINs;*
  Status: Fully implemented.

Details

We reported in 2017 that the LHINs, under the *Patients First Act, 2016*, have the authority to fund and manage some elements of primary care in Ontario. But at the time of our audit two years ago, the Ministry had not begun transitioning funding and managing responsibilities of the family health teams, nurse practitioner–led clinics and Aboriginal Health Access Centres to the LHINs and had not established any timelines for doing so, as allowed under the *Patients First Act, 2016*.

We found at the time of our follow-up that the Ministry completed an analysis in August 2018, which established the timelines to transition all inter-professional primary-care models to the LHINs, should the Ministry initiate the process to do so. The analysis included a review of the agreements managed by the Ministry, the funding allocations across all inter-professional primary-care models, the human resources and the information technology changes. At the time, the Ministry estimated that the timeline for transitioning funding and oversight responsibilities to the LHINs would take approximately 18 to 24 months, from the time that the process is initiated. However, the Ministry had not yet initiated the transition process, and had indicated that funding and oversight responsibilities to LHINs will require further consideration given the integration of LHINs into Ontario Health that was under way.

- *develop performance metrics to measure achievement of and progress toward the goals stated in the primary care component of* Patients First: Action Plan for Health Care*, and evaluate how the various primary-care models, including CHCs, can best be used to effectively deliver primary care to Ontarians and meet these primary-care goals.*
  Status: In the process of being implemented by March 2020.

Details

We reported in 2017 that even though the Ministry indicated that the provincial plan for primary care in a component of Patients First: Action Plan for Health Care, the plan does not specify how CHCs fit strategically within the primary-care system and lacks performance metrics to measure achievement of and progress toward the stated goals of the plan.

At the time of our follow-up, the Ministry had worked with Health Quality Ontario (HQO)—a provincial agency that reports to the public on the quality of the health-care system—to improve reporting on the primary-care sector. Through HQO's annual report on health-system performance, *Measuring Up*, the Ministry identified metrics to measure achievement of and progress toward the primary-care goals stated in the *Patients First: Action Plan for Health Care*. HQO reported on the following new metrics in the 2018 Measuring Up report: access to specialist care and co-ordinated care for patients with complex conditions.

In April 2019, *The People's Health Care Act, 2019*, received royal assent. This legislation allows for the establishment of Ontario Health Teams that are designed to connect health-care providers and services around patients and families, and the integration of multiple existing provincial agencies into

a single health agency—Ontario Health. With these changes, the Ministry said it plans to assess existing primary-care metrics and may develop new metrics by March 2020.

CHCs Fall Short of Consistently Providing Timely and Accessible Services to Clients

Recommendation 3

To ensure that Community Health Centre (CHC) clients have timely and equitable access to health and community services, we recommend that the Local Health Integration Networks:

- *collect and review wait-list information on CHCs' primary-care and other significant programs to address unmet needs;*
  Status: Little or no progress.

Details

In our 2017 audit, we noted that neither the Ministry nor the LHINs had complete information on how many people are waiting to become CHC clients. Four of the eight CHCs we visited during the audit indicated that they were not able to meet the primary-care demand in their community. As well, clients at five of the eight CHCs experienced delays in receiving care from the interdisciplinary health team, such as from a dietitian, a foot care specialist or a physiotherapist. These CHCs had between 25 and 83 clients waiting to receive this type of care, with wait times ranging from two to five months at the time of our audit.

At the time of our follow-up, the Ministry was undertaking a review of the current data collection and reporting methods that are available to the LHINs so that the LHINs can learn how to improve data sharing regarding CHCs. The LHINs plan to consider further steps regarding collecting and reviewing wait-list information after the Ministry's review is completed by December 2019. The role of the LHINs in collecting and sharing CHC data may be impacted by the health system transformation and the establishment of Ontario Health Teams.

- *identify which CHCs do not provide 24/7 on-call services and require them to do so.*
  Status: Little or no progress.

Details

In our 2017 audit, we found that two of the eight CHCs we visited do not provide 24/7 services even though the CHCs' accountability agreement with the LHINs requires CHCs to provide and actively promote on-call physician services on a 24/7 basis. Although CHCs can obtain written consents from the LHIN to be exempted from this requirement, one did not obtain exemption and its LHIN was not aware of this.

At the time of our follow-up, the LHINs are exploring integration opportunities with CHC partners, such as nurse practitioner–led clinics, to fulfill their obligation to provide 24/7 on-call services for their existing primary-care clients. The LHINs expected to complete such integrations by September 2020. The ability to facilitate these integration opportunities may shift from the LHINs to the Ministry, Ontario Health and Ontario Health Teams as a result of the health system transformation that is under way.

Minimum Services and Staffing Model Not Defined

Recommendation 4

To ensure Community Health Centre (CHC) clients across Ontario have access to the full range of health services and interdisciplinary health professionals and to better direct workforce planning, we recommend that the Local Health Integration Networks, in conjunction with the Ministry of Health and Long-Term Care:

- *assess whether all CHCs should offer a core set of services and update the accountability agreement between the CHCs and the LHINs accordingly;*
  Status: In the process of being implemented by May 2020.

Details

In 2017, we reported that neither the LHINs nor the Ministry provided guidance on a minimum set of interdisciplinary services beyond those included within the accountability agreement between the LHINs and the CHCs.

We found during our follow-up that in March 2019 the Ministry completed a jurisdictional analysis regarding whether all CHCs should offer a core set of services. The analysis compared Ontario with other Canadian provinces, as well as Australia, England, and the United States. The Ministry's analysis found that community health services varied in most jurisdictions, depending on the needs of the local area.

The LHINs indicated that they will support the outcomes of the Ministry's analysis and implement any necessary changes to the accountability agreement by May 2020.

- *develop a mechanism to better understand the range of services offered by CHCs' interdisciplinary health professionals, and determine whether CHCs should employ a core complement of staff that offer interdisciplinary health services.*
  Status: Little or no progress.

Details

In our 2017 audit, we found that beyond capturing the number of interactions that CHC interdisciplinary health professionals, such as physiotherapists, social workers and dietitians, have with their clients, the Ministry does not track or analyze the activities of these professionals as recommended by the Primary Healthcare Planning Group, as explained in **Recommendation 1**. The types of interdisciplinary health professionals that were available at CHCs varied widely. For example, according to data from 2016, 43% of CHCs had physiotherapists and 20% of CHCs had occupational therapists.

At the time of our follow-up, the LHINs indicated that CHCs provide community-based services that are tailored to reflect the unique needs of the local communities that they serve. The LHINs indicated they will work with the Ministry and CHCs to consider an appropriate core set of services that CHC inter-professional teams can provide to clients.

Ministry and LHINs Lack Useful Information on CHCs

Recommendation 5

To ensure it has useful and complete information to measure the effectiveness of Community Health Centres (CHCs), we recommend that the Ministry of Health and Long-Term Care (Ministry), in conjunction with the Local Health Integration Networks (LHINs):

- *develop and implement mechanisms to obtain and analyze information from CHCs that operate electronic medical record systems that may not be compatible with the main system used by most CHCs;*
  Status: In the process of being implemented by March 2021.

Details

In our 2017 audit, we reported that the Association of Ontario Health Centres (now Alliance for Healthier Communities) combined data from the CHCs across the province to generate demographic information such as clients' income level and age. The Alliance also collected data from health-care providers employed by the CHCs to generate statistics such as the number of physicians or dieticians and the number of patients they saw. However, we found that data from three CHCs could not be collected—two of them did not use an electronic medical record system that was compatible with the Alliance's system, and the remaining CHC was not a member of the Alliance.

At the time of our follow-up, there were still two CHCs that did not contribute data to the Alliance's system. The Ministry was in the process of implementing a new approach to collect patient, clinical, and non-clinical information from all CHCs. Having access to this information will allow the Ministry

to plan, fund and evaluate CHCs' programs and services more effectively. Specifically, the Ministry was working on a data-sharing agreement with the CHCs at the time of our 2017 audit and, during our follow-up, said it expects to have an agreement signed with the CHCs by December 2019. The two CHCs will be included in the agreement once they begin to contribute data to the Alliance's system. However, the Ministry informed us that there is no formal date for either CHC to be contributing data to the Alliance's system, but we plan to follow up with the Ministry by March 2021.

- *finalize the data-sharing agreement with CHCs and assess the feasibility of sharing the data with LHINs;*
  Status: In the process of being implemented by December 2019.

Details

In our 2017 audit, the Ministry was in the process of implementing a data-sharing agreement with the CHCs. The LHINs are not a party to this agreement.

At the time of our follow-up, the Ministry was in the process of implementing, by December 2019, a new approach to collect data from CHCs, as mentioned in the action item above. This approach includes data-sharing agreements between the Ministry and each CHC. In addition, the Ministry is currently conducting a review of data collection and reporting methods available to the LHINs. This review will allow the Ministry to assess the optimal way to share data, which does not include patient personal health information, with the LHINs. The Ministry expects to complete this review by December 2019.

- *establish timelines for collecting information for the remaining measures the Ministry has prioritized according to the Primary-Care Performance Measurement Framework;*
  Status: In the process of being implemented by March 2021.

Details

In our 2017 audit, the Ministry indicated it had prioritized and adopted a subset of the performance measures established by Health Quality Ontario (HQO), involving 18 practice-level measures and 12 system-level measures (at the community, regional and provincial levels) in the Primary-Care Performance Measurement Framework. However, data was not available for all of these measures and the Ministry had not established the timelines for implementing all of the prioritized measures.

At the time of our follow-up, the Ministry and HQO had not established a timeline to implement 11 of the 18 practice-level measures and two of the 12 system-level measures. They explained that these measures either do not have a consistent data source or would require a significant investment to collect the data. As the Ministry and HQO are currently working through the transition of HQO to Ontario Health, the assessment of what needs to be done and the priority for development of the remaining indicators will be part of the work considered by Ontario Health. The timeline for when this work will be finished depends on when the transition of HQO to Ontario Health is completed. We plan to follow up with the Ministry by March 2021.

- *develop performance indicators that measure outcomes of CHC clients for all types of services provided, collect this information and analyze the results.*
  Status: In the process of being implemented by December 2019.

Details

In our 2017 audit, we found that while the CHCs report certain information to the LHINs as required in the accountability agreement, the indicators for the most part measure CHC outputs. The LHINs do not require CHCs to track outcome-based indicators, such as reduced social isolation and number of days spent in hospital by CHC clients. Some CHCs we visited during the audit explained that

collecting information to evaluate patient outcomes is difficult because CHCs cannot easily access data from hospitals and other primary-care providers due to privacy concerns. In addition, the Association of Ontario Health Centres (now Alliance for Healthier Communities) was working on new indicators or measurements that will help evaluate the impact of community programs and initiatives.

At the time of our follow-up, the Ministry was developing a standard performance measurement framework that will include a set of indicators on patient outcomes such as improved patient experience of care and improved population health. The Ministry said it expects to have this framework in place by December 2019.

Limited Oversight of Community Health Centres

Recommendation 6

To improve their oversight of Community Health Centres (CHCs), we recommend that the Local Health Integration Networks:

- *monitor accreditation statuses of all CHCs; for those CHCs that are not accredited, encourage them to either achieve accreditation or put in place alternative mechanisms for quality assurance;*

  Status: In the process of being implemented by April 2020.

Details

In our 2017 audit, we reported that the LHINs relied on the accreditation process in lieu of conducting formal site inspections of CHCs. However, we found the LHINs did not require CHCs to be accredited and did not monitor their accreditation status. But guidelines by the Association of Ontario Health Centres (now Alliance for Healthier Communities) indicated that "it is expected that all CHCs commit to participate in an accreditation process." Two of the eight CHCs we visited were not accredited but expected to be accredited within the next few years.

At the time of our follow-up, the LHINs were monitoring CHCs' accreditation status including whether accreditation was completed, the name of the accreditation body and the length of the accreditation term. The LHINs are planning to include a requirement in CHC accountability agreements to employ a method or tool to measure performance and support improved quality, such as through accreditation or an alternative mechanism. The LHINs plan to implement the new requirement by April 2020.

- *identify areas that accreditation reviewers suggested should be improved through a review of CHCs' accreditation reports and work with CHCs to rectify the issues;*

  Status: Fully implemented.

Details

In our 2017 audit, we found that the LHINs do not require CHCs to submit accreditation review reports, or report any issues noted by the accreditors. As a result, the LHINs could not use this opportunity to identify systemic issues and encourage CHCs to rectify them.

At the time of our follow-up, the LHINs monitored CHCs' accreditation reports, where available, in addition to other sources of information, such as quarterly performance reports, to determine priority areas for quality improvement. As the primary objective of a CHC is to meet the specific needs of the patient population it serves, the identified areas for improvement will vary based on the CHC and may not be applicable across all LHINs. The LHINs will decide individually on the review of accreditation reports with their CHCs and complete this work within each LHIN.

- *make available governance training and promote it to CHCs.*

  Status: Little or no progress.

Details

In our 2017 audit, we noted that two of the four LHINs we visited offered governance training to

health-service providers in their regions but the other two did not. Governance training for CHC community-based boards helps assist board members who may not have board or governance experience and lends support to the governance portion of the accreditation process.

At the time of our follow-up, one of the four LHINs we visited during the 2017 audit had governance training available to CHCs through the LHIN Governance-to-Governance Forums. Specifically, it conducted a session with its CHCs on good governance practices in December 2017. In addition, the Association of Ontario Health Centres (now Alliance for Healthier Communities) publishes governance-related training materials on its website.

Recommendation 7

To optimize the value of the quality improvement plans and to promote performance improvement in Community Health Centres (CHCs), we recommend that the Ministry of Health and Long-Term Care, in conjunction with Health Quality Ontario:

- *identify systemic issues through a review of the submitted quality improvement plans and provide feedback to the CHCs;*
  Status: In the process of being implemented by December 2019.

Details

In our 2017 audit, we noted that the Ministry did not review the individual quality improvement plans in detail to identify quality issues at specific CHCs, or follow up with CHCs on these annual results to ensure under-performance was corrected. This review and follow-up was inconsistent among the LHINs we visited.

At the time of our follow-up, Health Quality Ontario (HQO) had developed a plan to review and analyze quality improvement plans submitted by CHCs, identify systemic issues and provide feedback to them on those plans via webinars and guidance and, in some cases, outreach targeted to low-performing CHCs. As of October 2019, HQO had provided webinars and help sessions to some CHCs. HQO considers the Ministry's feedback and refreshes the analysis plan every year. For the 2019/20 fiscal year, HQO has developed the analysis plan and expected to complete the review of submitted quality improvement plans by December 2019.

- *streamline the number of performance indicators that CHCs need to report in their quality improvement plans;*
  Status: Fully implemented.

Details

In our 2017 audit, we noted that CHCs chose their own performance indicators and reported almost 100 unique indicators in their quality improvement plans combined in 2016/17, rendering comparison almost impossible.

At the time of our follow-up, HQO had identified three priority indicators and seven additional indicators for CHCs to submit in their 2018/19 quality improvement plans. For the 2019/20 fiscal year, HQO has further streamlined the indicators by eliminating the category of "additional indicators" and focused on the following five priority indicators:

- seven-day post-hospital discharge follow-up;
- timely access to a primary-care-provider;
- patient involvement in decisions about care;
- percentage of non-palliative patients newly dispensed an opioid; and
- early identification: documented assessment of palliative care needs for an early, at-risk cohort.

- *establish common performance targets across all CHCs.*
  Status: In the process of being implemented by December 2019.

Details

We reported in 2017 that CHCs set their own performance targets, unless the indicators were specified in their accountability agreement with their

LHIN, in which case the LHIN-developed target was used. We noted examples where some CHCs set a high standard for their performance while others set a much lower standard.

At the time of our follow-up, the Ministry was conducting an internal evaluation of the merit of establishing common performance targets across all CHCs. Taking into account the health system transformation, the Ministry plans to engage Health Quality Ontario and the LHINs or Ontario Health to determine how performance and quality targets should be set for CHCs. The Ministry said it expects to issue formal recommendations by December 2019.

LHINs Do Not Adjust CHC Base Funding According to Number of Patients Served

Recommendation 8

To ensure that Community Health Centres (CHCs) can appropriately plan their operations and serve clients, we recommend that the Local Health Integration Networks review overall operating funding to CHCs to ensure each CHC's funding is commensurate with patient complexity, number of people served, geography and other relevant factors.

Status: In the process of being implemented by April 2020.

Details

In our 2017 audit, we reported that CHCs still received the same level of base funding year after year despite the fact that half of them were at less than 80% of their expected patient caseload. The accountability agreement between the LHIN and the CHC did not explicitly require each CHC to report to its LHIN the number of patients registered against the expected patient caseload. As a result, three of the four LHINs we visited did not collect data from their CHCs on the actual number of patients served. The LHINs also did not track the number of clients who accessed community programs only, limiting the LHINs' ability to evaluate whether funding for these programs should be adjusted.

At the time of our follow-up, the Ministry was in the process of implementing a new data-sharing agreement with CHCs. This work may affect the provincial funding formula, and is expected to be completed by December 2019.

The LHINs now require CHCs to report on the performance indicator for "Access to Primary Care" through the accountability agreements. This indicator captures the number of clients provided clinical services as a percentage of the total number of clients the CHC is expected to serve. The LHINs will take this indicator, in addition to information collected from other sources, into consideration when reviewing CHC funding by April 2020. While the LHINs still do not require CHCs to report the number of clients who access community programs only, some CHCs report this information through the annual Community Accountability Planning Submissions. The LHINs continue to review funding allocation on an annual basis.

Ministry's Role in Sharing Best Practices on CHC Operations Is Limited

Recommendation 9

To facilitate dissemination of best practices to allow Community Health Centres (CHCs) to innovate, reduce inefficiencies, and provide more effective and higher quality services, we recommend that the Ministry of Health and Long-Term Care, in conjunction with the Local Health Integration Networks:

- *implement best practices promotion efforts under the* Patients First Act, 2016*;*
  Status: Fully implemented.

Details

In our 2017 audit, we found that not all LHINs had appointed clinical leads, whose responsibilities include the promotion of clinical standards that are developed by Health Quality Ontario (HQO). In a

2001 Ministry-commissioned review, the consultants recommended that the Ministry support the dissemination of best practices. We found that the Ministry could do more to facilitate the sharing of best practices across primary-care models or within the CHC sector. Other inter-professional primary-care models, such as nurse practitioner–led clinics and family health teams, might also be using practices that could benefit the CHCs.

As of May 2019, HQO had developed 20 clinical care standards, 17 of which are relevant to the primary-care setting—10 of these 17 standards were developed since our 2017 audit. While all LHINs had funded their clinical lead positions, three LHINs had not been able to recruit these positions due to the provincial freeze on hiring and four LHINs had not been able to renew their contracts with clinical leads. With the recent government announcement on health system transformation, the LHINs will review the need for clinical lead positions by December 2019.

- *develop and implement a mechanism to compile and share best practices from all inter-professional primary-care models, including CHCs.*
  Status: In the process of being implemented by December 2019.

Details

In our 2017 audit, we noted that the Ministry had had direct oversight of most of Ontario's inter-professional primary-care models for many years and these models might be using practices that could benefit the CHCs.

At the time of our follow-up, the Ministry was reviewing best-practice sharing mechanisms submitted from the Association of Ontario Health Centres (now Alliance for Healthier Communities), the Association of Family Health Teams Ontario and the Nurse Practitioner Association of Ontario. The Ministry will determine if it needs to develop a new mechanism to compile and share best practices from all inter-professional primary-care models, or if current mechanisms are sufficient, by December 2019.