Auditor General Report: Community Health Centres

Auditor General Report 2017 (section 3.03)

Auditor General Report Overview

- In 2017, the Auditor General reviewed the CHC program & developed Recommendations. The MOH has responded in 2019 and reported on progress to-date . Additional progress & details are provided in this PowerPoint.
- In her press conference, Auditor General Bonnie Lysyk was asked what stood out from her review of 5 different health care sectors -- She said it was CHCs & the comprehensive services they provide under one roof: "*They are pretty neat. It was most surprising to understand that type of operation exists in Ontario*."
- AG Report comments included:

"CHCs stand out from other models of primary care...because they deliver medical services under the same roof, such as health promotion and community programs" (p. 180).

"By serving vulnerable people, CHCs can contribute to reducing the strain on the health care system and other provincial government programs" (p. 185).

"The goal of CHCs is to keep people in the communities where they live in good health" (p. 184).

The report acknowledges CHC's' leadership in serving medically and socially complex clients, identifies their role in reducing social isolation, meeting the needs of refugees and uninsured populations, and describes them appropriately vis-a-vis other primary care models (p. 220).

Key Findings in the Auditor General Report

1. There is **no overall evaluation of primary care** models in Ontario that will help inform how CHCs strategically fit within the primary care system
2. The MOH/LHINs **do not request utilization data** on CHCs & have no way to inform funding & programming decisions
3. MOH **does not have patient and provider data** & therefore cannot assess the effectiveness of the CHC model, despite the CHCs routinely collecting this information
4. MOH/LHINs **have not defined what providers/services** should be delivered to CHC clients
5. No LHIN requirement for **accreditation**

Key Finding # 1.
Primary care evaluation across Ontario

- CHCs serve a population 70% more complex than the average Ontarian. Despite this they have lower than expected ED utilization, resulting in ~$20-30M per year costs adverted
- Unique CHC programming has been shown to avert ED visits, including Social Prescribing, Team Care, system navigators, dentistry, trans services, safer supply
- Several studies including CHCs show positive results, including superior chronic disease management, prevention, client experience, community orientation, team climate (see references and infographic link)

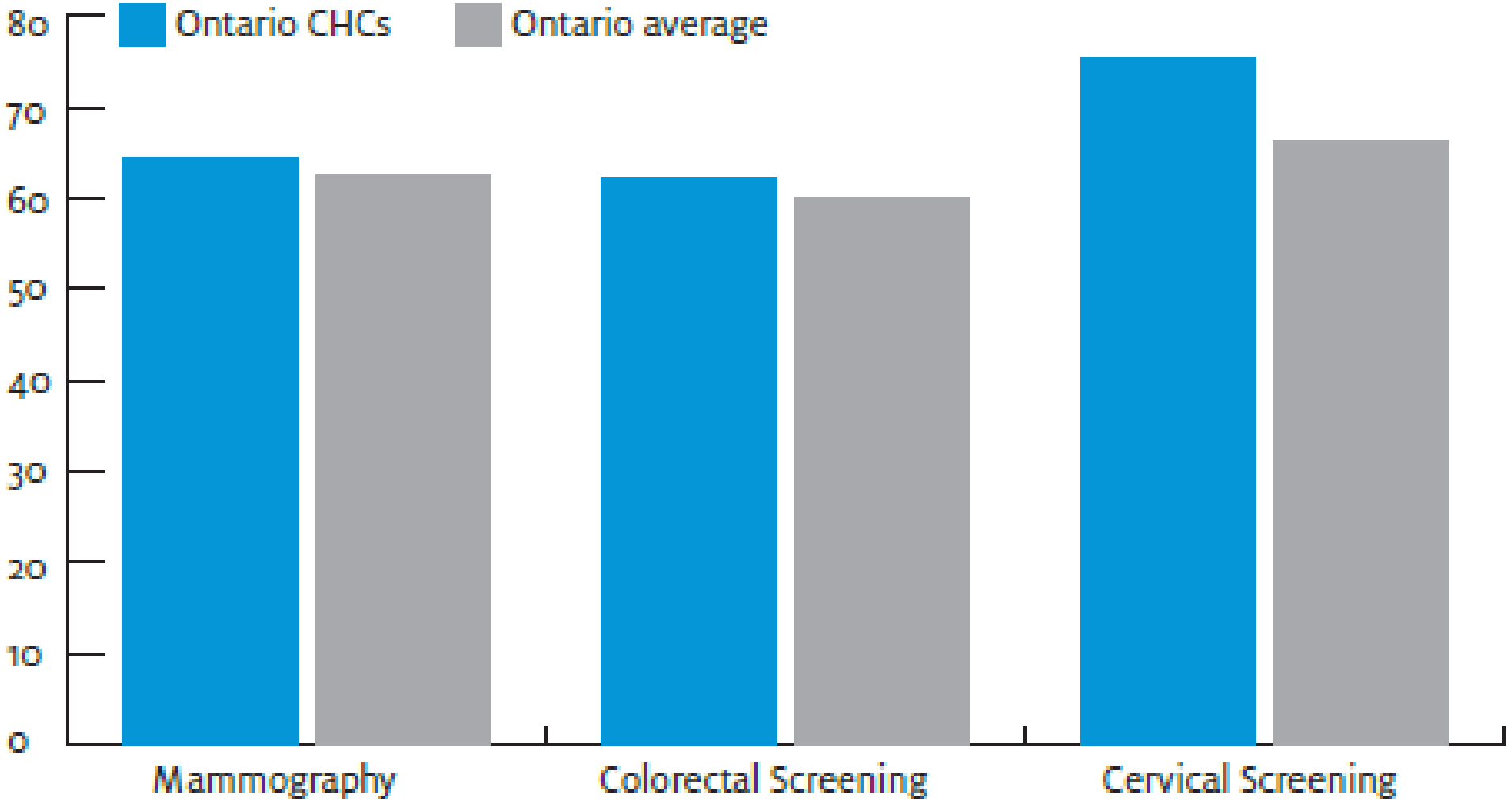
Summary of Chronic Disease Management Ontario Studies

	CHC	FFS	FHN/Blended Capitation
Foot exams in last 2 years[1]	**63%**	29%	39%
Eye exams in lasty 2 years [1]	**61%**	44%	38%
For diabetes, 2 hemoglobin A1c tests per yr[2]	**69%**	45%	62%
For hypertension, 2 BP measures per yr[2]	**81%**	78%	79%
Anti-hypertensive drug prescriptions[2]	**94%**	95%	94%

Alliance for Healthier Communities
Alliance pour des communautés en santé

1. Russell 2009, 2. Liddy 2011

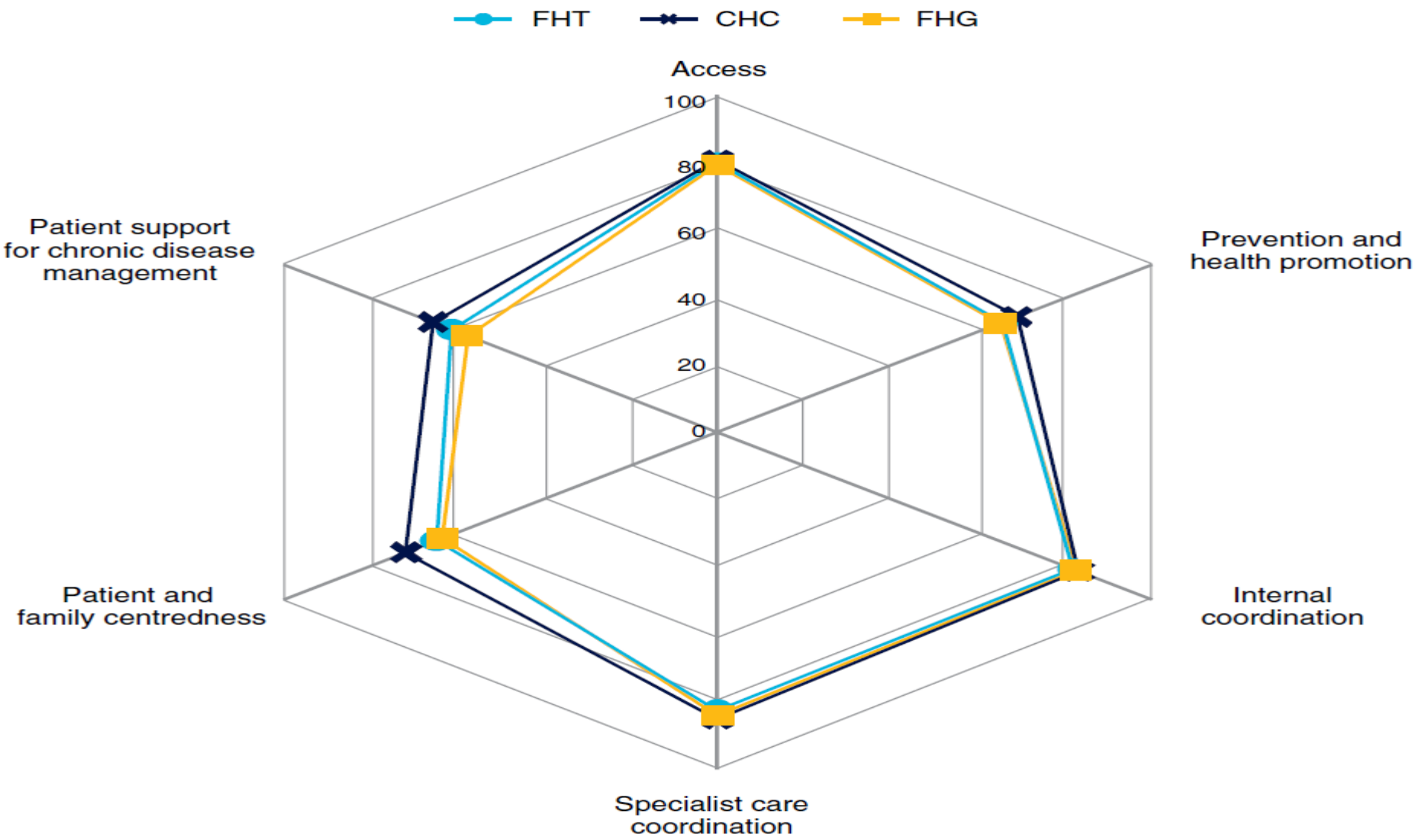
Greater Rates of Cancer Screening in Ontario



Alliance for Healthier Communities
Alliance pour des communautés en santé

AOHC 2016

Superior or equal quality and experience of care as a comparator group for FHT evaluation (2014)



Key Finding # 2.
CHC Utilization Data for Decisions Planning

- Since 2008, CHCs have reported performance & financial data quarterly (see additional information)
  - CHCs are the only primary care model in Ontario with an accountability agreement & that report financial & utilization data using MIS standards (available to the MOH & OH regions)
- Active panel size is calculated & reported quarterly to OH, along with performance targets
  - This includes only clients who have actively been seen by a physician or NP within a 3-year period.
  - The Funding Alternatives for Family Physicians AG Report, (2011) reported that 22% of people rostered to a FHO or FHG did NOT visit the practice in the fiscal year despite the physician being paid capitation payments, costing the system an additional $123 million to have these patients enrolled without receiving care

Panel Size and Service Utilization (January 2023)

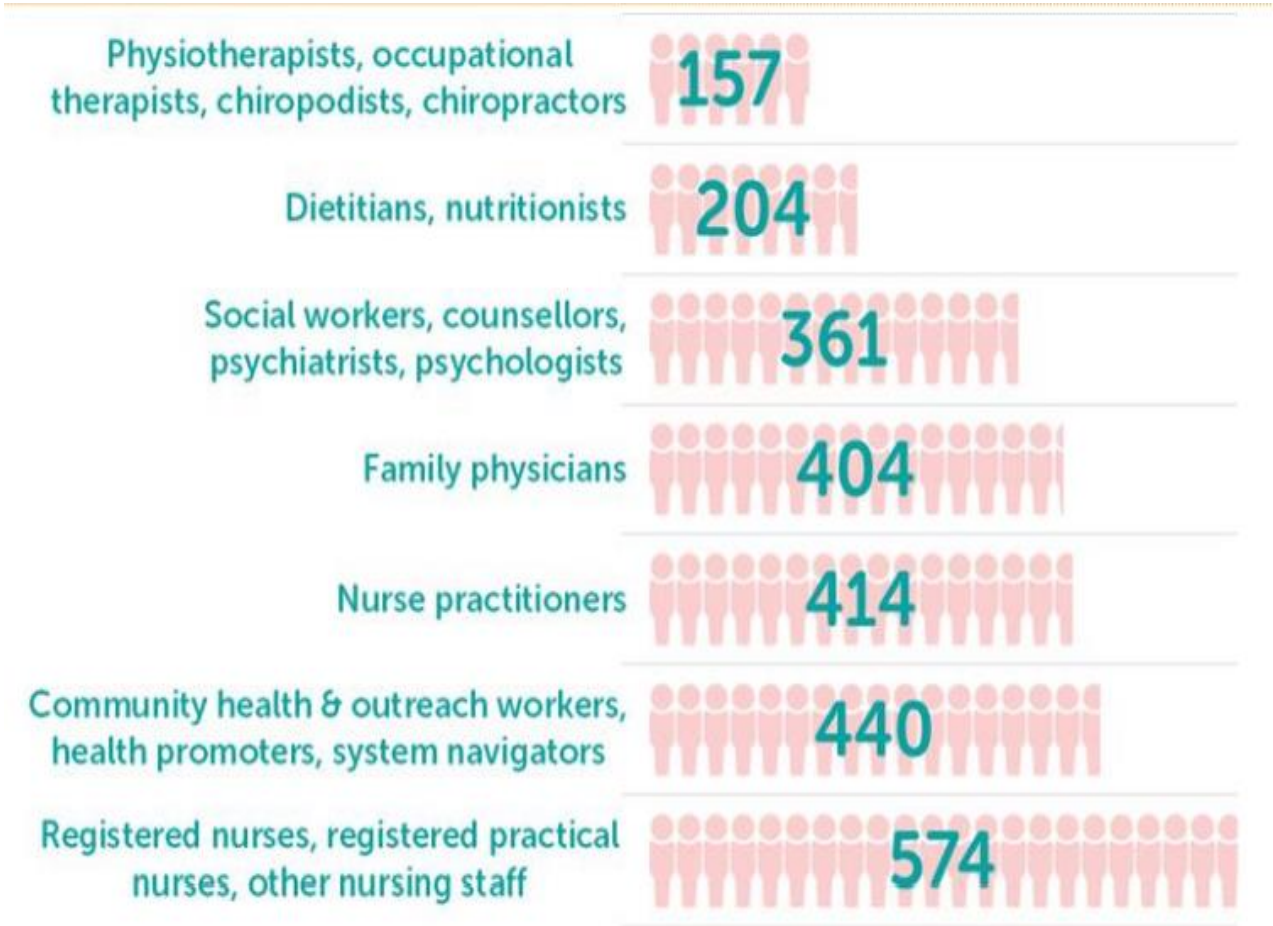
- CHCs are, on average, at 92% of target panel size
  - 33% have panel sizes exceeding 100%
  - 30% are under 80% → But the majority of these have staff vacancies and/or highly complex clients who experience homelessness, mental health and addition challenges, are uninsured, require translation, and are often served outside the centre
- CHCs pro-actively manage their panel size and continue to take on new clients
  - Since the AG report, CHCs provided primary care to an additional 180,000
  - An additional 500,000 clients actively receive team-based care and social and community supports **but are not counted in the panel size calculations**

Key Finding # 3.
MOH/OH Access to CHC data

- ✓CHCs are the only primary care model that collects standardized EMR data for clients, providers and client visits. Data extracted nightly into a data warehouse which is used for performance, reporting, planning & ongoing improvement.
- ✓A data sharing agreement, signed by all CHCs, permits sharing and use of CHC data with the MOH
- ✓A data sharing agreement is being developed to permit sharing and use of CHC data with Ontario Health. Data reports are being submitted to Ontario Health quarterly until the data sharing agreement is finalized
- ✓All financial and performance data are routinely collected & available to MOH & OH quarterly
- ✓CHC data are uploaded to ICES and CIHI to inform system planning population health research

Key Finding # 4.
MOH/LHINs definition of what providers/services should be delivered to CHC clients

- MOH can examine the range of services offered by all providers (within the CHC data)
- CHCs complete a sector survey with information about types of providers. Data are publicly reported in the Sector Snapshot
- CHCs vary by some provider types due to tailoring service delivery to client needs and to ensure health equity



Key Finding # 5. Accreditation Requirements

- ✓CHCs have endorsed & undergo accreditation every 4 years without being mandated to do so
- ✓Goal is to review the entire organization, including all services, governance, organizational planning, performance, leadership, and risk management
- ✓The majority (~80%) of CHCs are accredited with Canadian Centre for Accreditation (CCA), others with Accreditation Canada.
- ✓CCA focuses on community-based primary health care, quality, equity & collaboration
- ✓No other primary care model undergoes accreditation

AG Report: FHGs and FHOs

Family Health Groups and Organizations
Ministry **has not tracked the full cost** of the alternate funding arrangements (physicians are on-average **paid at least 25% more** than their counterparts OR if they are producing the expected benefits)
Wait times have not decreased despite more Ontarians having access to family physicians
22% of the FHO and FHG roster did NOT visit the practice in the fiscal year despite the physician being paid capitation payments ($123 Million to have these patients just enrolled but not provided care). FURTHER to this **almost half of these payments visited another physician**, and OHIP paid for those visits
Ministry paid an **additional $72 Million to FHO physicians** for provision of additional services (30% of these services were for flu shots and pap smears)
Capitation fees are based on age and sex and as a result the physician is **paid the same for a healthy patient** (who requires no medical services) as for patients with multiple medical conditions. This has resulted in **physicians de-enrolling patients** that require more medical care

AG Report: Funding Alternatives for Primary Physicians (2011)

Additional Slides and Links

Fact Sheets and Additional Information

- The Model of Health and Wellbeing Works (the evidence)
- What CHCs do and Who's on the Team
- Ministry response and progress on CHC AG recommendations