Ministry of Health and Long-Term Care

Community Health Centres

1.0 Summary

Ontario's 75 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 2016/17 fiscal year, CHCs received $401 million from the Ministry of Health and Long-Term Care (Ministry), through Ontario's 14 Local Health Integration Networks (LHINs).

CHCs stand out from other models of primary care (the routine care that a patient receives, often from a family physician) because they deliver medical services under the same roof as health promotion and community programs. CHCs can employ a team of physicians, nurse practitioners, nurses, counsellors, community workers and other professionals to offer a wide range of these 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.

While CHCs serve vulnerable populations and can contribute to reducing the strain on the health-care system and other provincial government programs, the Ministry and the LHINs lack 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.

We also found that the Ministry and the LHINs do not examine data on the utilization of CHCs—which can be either over or under capacity—to ensure funding is directed to the areas with the most needs, and to reduce the number of people who might use costlier forms of health care. Knowing the utilization rates can also inform the Ministry in its decisions on the location and number of CHCs to place across the province.

A number of primary-care models coexist in Ontario. These models include CHCs, traditional fee-for-service sole practitioners, family health teams, nurse practitioner–led clinics and Aboriginal Health Access Centres. They deliver essential primary care and sometimes other services such as community programs and interdisciplinary services (offered by professionals such as dietitians, social workers and physiotherapists) to patients. However, the Ministry has not conducted an overall review to determine the most cost-effective model

or mix of models that would best meet the needs of Ontarians, how CHCs could be better utilized, and how CHCs fit strategically within the primary-care system. This would help the Ministry and the LHINs determine whether CHCs are developing along the right path according to plan and population needs.

The following are some of our other significant observations:

- **Split responsibility between Ministry and LHINs on primary care in the last decade is not conducive to effective primary-care planning.** Planning for primary care in Ontario was shared between the Province's 14 LHINs (for CHCs) and the Ministry (for all other primary-care models) for over a decade, making it difficult for either party to have complete information to make informed decisions. This is changing under the *Patients First Act, 2016*, which came into effect in December 2016. LHINs now have the legal authority to fund and manage some elements of primary care in Ontario, including family health teams, nurse practitioner–led clinics and Aboriginal Health Access Centres (currently funded and managed by the Ministry) in addition to CHCs. LHINs also have an expanded mandate to support planning of primary-care services. Transition of the three models to the LHINs had not yet begun when we completed our audit.
- **Utilization of CHC services varies across the province.** While unmet demand exists for services at a number of CHCs, other CHCs were underutilized. We found that 16% of the CHCs were responsible for more patients than their capacity allows, some of the CHCs we visited had people waiting to access primary care and other interdisciplinary services such as mental health and physiotherapy, and some groups among the CHCs' targeted population have grown. In contrast, about half of the CHCs were serving less than 80% of their targeted number of patients. As well, 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 can be reallocated to make the best use of the investment in the CHC sector.
- **Inter-professional primary care is not available in all LHIN sub-regions in Ontario.** Four LHIN sub-regions (smaller geographic areas located within existing LHIN boundaries) do not have a CHC or any other form of primary care that offers inter-professional care. Patients in the communities without any form of inter-professional care have to visit clinicians located in multiple locations to obtain health services that are routinely provided under one roof, or travel to another sub-region to access inter-professional primary care.
- **CHC staffing model and types of services have not been defined.** 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. CHCs across Ontario employ anywhere between four and 17 types of health providers, averaging 10 types of providers. Over half of the CHCs did not have a physiotherapist, and some CHCs did not have a social worker or dietitian. Defining the staffing model and the core services that should be offered at each CHC can increase the efficiency and effectiveness of inter-professional teams and improve clients' access to their services.
- **Funding to CHCs is not tied to number of clients served.** The annual base funding that LHINs provide to CHCs is predominantly based on historical funding levels, and not tied to the number of clients the CHCs serve. Funding levels neither increase nor decrease if CHCs are serving fewer clients or are serving more than their capacity allows. As of March 31, 2017, about half of the CHCs were at less than 80% of the targeted number of clients they are

expected to serve, yet these CHCs still received the same level of base funding year after year. Similarly, the LHINs did not increase base funding to those CHCs that exceeded their targeted number of clients.

- **LHINs do not sufficiently monitor CHCs.** Two of the eight CHCs we visited did not provide 24/7 on-call services even though this is a LHIN requirement. As well, the LHINs do not require all CHCs to be accredited (that is, to undergo an external review of their operations in relation to accepted standards of good practice and risk management). We also found that most LHINs do not review accreditation results and do not monitor the accreditation status of CHCs.
- **Meaningful data is not collected to evaluate effectiveness of CHCs.** The Ministry and the LHINs have minimal information to measure whether CHCs have contributed to the improved health of their clients. The LHINs do not require CHCs to track outcomes-based indicators for their clients, such as reduced social isolation (which can be measured via client surveys) and the number of hospital days stayed by CHC clients. In addition, while all CHCs have to prepare an annual quality improvement plan, almost 100 unique performance indicators are found among all CHCs' plans combined, making comparison almost impossible. The CHCs also do not work toward common targets on these performance indicators but set the targets themselves, and not all CHCs reported data on four indicators that are common across the CHCs. Finally, the Ministry has limited access to sector information because it does not have a data-sharing agreement with the CHCs. This issue was raised in our *2000 Annual Report*, was unresolved when we followed up with the Ministry in 2002, and remains unresolved at the time of this audit.

This report contains nine recommendations, consisting of 22 actions, to address our audit findings.

Overall Conclusion

The Ministry of Health and Long-Term Care (Ministry) and the Local Health Integration Networks (LHINs) do not have effective systems and procedures to oversee and co-ordinate Community Health Centre (CHC) programs and services. They do not have sufficient information to ensure that CHCs deliver programs and services in a timely and cost-effective manner that meet community needs, including those of the priority population. At the CHC level, we found that not all CHCs had physiotherapists, dietitians and social workers on staff, as neither the Ministry nor the LHINs have required a core minimum basket of services to be provided at each CHC. As well, CHCs were not consistently providing 24/7 on-call services as required by their LHINs. Finally, while the Ministry and the LHINs measure some aspects of CHC operations, they do not measure the quality and effectiveness of services provided and publicly report on them.

OVERALL MINISTRY RESPONSE

The Ministry of Health and Long-Term Care (Ministry) appreciates the Auditor General's observations and recommendations regarding the Community Health Centres (CHC) program. The recommendations included in the report will support improvements to strengthen accountability and improve access to quality health-care services at CHCs.

The CHC model of care focuses on five service areas that support the government's overarching goal of building a patient-centred health-care system that delivers quality, value and evidence-based care in Ontario: primary care; illness prevention; health promotion; community capacity building; and service integration. In 2013, the CHCs refreshed their model and adopted the Model of Health and Wellbeing, which identified values and principles that unite CHCs: Highest Quality People and Community-Centred Health and Wellbeing; Health Equity and Social Justice; and Community Vitality and

Sense of Belonging. The eight attributes of the model define a collective understanding of what CHCs are: anti-oppressive and culturally safe; accessible; inter-professional, integrated and co-ordinated; community-governed; based on the social determinants of health; grounded in a community development approach; population and needs-based; and accountable and efficient.

CHCs and other inter-professional primary-care teams play an increasingly important role in both caring for patients and as a cornerstone of patient care by ensuring that patients have access to the services and resources they need. This sector is an essential part of the Ministry's strategic direction for Ontario's health-care system—*Patients First: Action Plan for Health Care*. This plan, and the variety of initiatives guided by it, aims to improve access to co-ordinated care that is more responsive and centred on the needs of Ontarians. In this regard, the Ministry recognizes the important contributions made by CHCs and other team-based models of primary care and, through commitments in the 2017 Ontario Budget, will be investing $145 million over the next three years to strengthen Ontario's primary-care sector, including in CHCs, by enhancing their ability to recruit and retain qualified health-care professionals and to expand access to inter-professional primary care in high-need areas of the province. This commitment is in addition to the $85 million in investments to inter-professional teams in the 2016 Ontario Budget.

While significant progress has been made to build a strong foundation of primary-care service in the province, there is more work to be done. The Ministry recognizes the important contributions CHCs make to primary health care in Ontario, and the Ministry will work together with the Local Health Integration Networks (LHINs) to make progress on better supporting and enhancing the performance of Ontario's CHCs. Our detailed responses are provided in the report's specific recommendations.

OVERALL RESPONSE FROM LHINs

Local Health Integration Networks (LHINs) appreciate the comprehensive audit conducted by the Office of the Auditor General of Ontario on the provision of Community Health Centre (CHC) services. LHINs, as health system planners, funders and integrators, will continue to support initiatives that create more timely access to patient-centred care and that promote greater consistency with respect to patient outcomes and quality. We commit to working in collaboration with the Ministry of Health and Long-Term Care (Ministry), CHCs and local clinical leaders to address the recommendations from this report.

Access to primary care, including increased primary-care attachment rates, is a priority for LHINs, as it is vital to improving the health outcomes of Ontarians. In September 2017, all LHINs, enabled by funding from the Ministry, expanded the Health Care Connect Program to further the inclusion of primary care as a foundational element of the local health-care system. Included in this program is the ongoing commitment of all LHINs to dedicate resources for the purpose of assisting Ontarians in finding a family health-care provider if they do not currently have one.

LHINs promote *Patients First: Action Plan for Health Care*, put forth by the Ministry, and welcome the expanded accountability for primary-care planning provided through the *Patients First Act, 2016* . The alignment of additional interdisciplinary primary-care models to LHINs has uniquely positioned LHINs to lead the transformation of primary care in their respective local health-care systems. LHINs look forward to partnering with the Ministry, respective CHCs and other primary-care providers to implement this exciting vision for primary care.

2.0 Background

2.1 Overview of Community Health Centres

Ontario's 75 Community Health Centres (CHCs) are community-governed, not-for-profit health-care organizations that provide primary-care and community health programs for individuals in their communities. CHCs advocate for, and provide programs and services to, individuals who otherwise face barriers to health-care services created by poverty, geographic isolation, language, culture and different abilities. In serving these individuals, CHCs work with the community and develop programs to address social issues that lead to health problems.

An example of such programs is the needle exchange program, which allows drug users to exchange used needles for clean ones, preventing the spread of HIV/AIDS and other diseases, and reducing the risk of used needles ending up in public places such as parks and children's playgrounds. The limited access to medical services in some rural areas is another barrier to primary health care that CHCs are meant to play a key role in overcoming, by serving the general population of these regions who may be lacking other health-care options in their communities. **Appendix 1** provides real-life examples of CHC clients' experiences and the positive impact that CHC services have had on their lives.

CHCs are governed by volunteer community boards. Board members are predominantly clients, community members and community leaders who provide strategic direction for CHCs to operate programs and services that are responsive to local health-care and program needs.

Clinicians such as physicians and nurse practitioners who provide primary care to patients at the CHCs are all salaried (funded by the operating budgets of the CHCs) and are not compensated under the traditional fee-for-service model through the Ontario Health Insurance Plan. CHCs are also mandated to serve clients who are not covered under the Ontario Health Insurance Plan, such as those who have no legal status to stay in Canada. (Nurse practitioners are registered nurses with advanced university education who can diagnose, order and interpret diagnostic tests, prescribe treatments including medications, and perform medical procedures.)

The goal of CHCs is to keep people in the communities where they live in good health. CHCs support the Province's health-care action plan—*Patients First: Action Plan for Health Care*—by helping to improve access to health care; providing co-ordinated and integrated care in the community; and providing the education, information and transparency patients need to help make the right decisions about their health.

All CHCs in Ontario follow the values and principles of the Model of Health and Wellbeing, as shown in **Figure 1**. This model is based on principles adapted from the World Health Organization and the 14 social determinants of health (these

Figure 1: Model of Health and Wellbeing

Source of data: Association of Ontario Health Centres and the Ministry of Health and Long-Term Care

Notes:

- The values and principles of Community Health Centres (CHCs) are presented in the outer ring.
- The model includes eight attributes (inner circle) that guide CHCs' work and approach.

are underlying conditions that help determine a person's health status, such as income, education, employment, food insecurity/security, housing, social exclusion/inclusion, gender, race and disability). The model was published in May 2013 by the CHC Executive Director Network, consisting of the chief executive officer or executive director from each CHC in Ontario.

2.2 Clients of Community Health Centres

CHCs serve about 500,000 clients each year, or about 4% of Ontarians. Ontario's CHCs are located in both rural areas and urban centres (usually at-risk neighbourhoods). In some rural areas, where access to health care is more limited, CHC clients can be the general population of the catchment area. In most other cases, however, CHC clients are those in high-risk population groups, such as the homeless, refugees, new immigrants, clients with complex mental health issues, low-income earners and those without health insurance. About 1.5% of CHC clients have no type of health insurance at all.

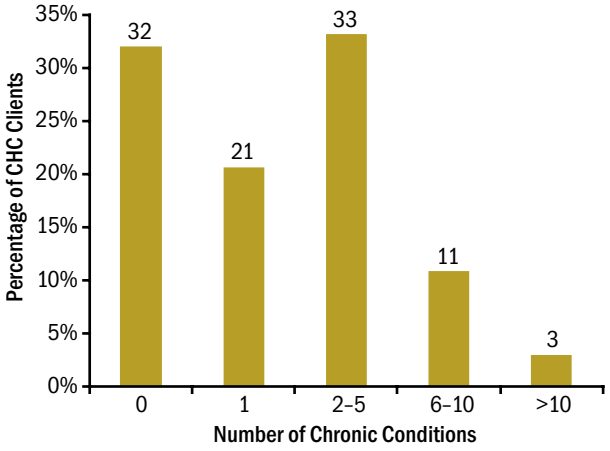
By serving vulnerable people, CHCs can contribute to reducing the strain on the health-care system and other provincial government programs. Social services agencies often have nowhere else to refer their clients, some of whom are in high-risk population groups, other than to CHCs that provide clinical and community services for these groups. The Ministry of Health and Long-Term Care (Ministry) considers these groups as priority populations, defined as those who:

- face geographic, cultural, language or other barriers to accessing an appropriate range of primary-care services, and/or
- have a higher burden or risk of ill-health due to the social determinants of health (explained in **Section 2.1**).

Many CHC clients have multiple health conditions, as shown in **Figure 2**. A study published in 2012 that compared primary-care models in Ontario noted that CHC clients are 84% more

Figure 2: Proportion of Community Health Centre (CHC) Clients with No or Multiple Chronic Conditions, March 2017

Source of data: Association of Ontario Health Centres



complex in terms of their needs than the general population in Ontario. Related to this point, 23% of CHC clients are seniors, compared to about 17% in the general population. **Figure 3** breaks out the socio-demographics of CHC clients into those in the low-income bracket, seniors and the uninsured as at March 31, 2017.

2.3 Expansion and Current Locations of Community Health Centres

Ontario's first CHC was established in the early 1970s. CHCs are not unique to Ontario—they operate in every Canadian province, including territories, sometimes under different names. Canada's first CHC was the Mount Carmel Health Centre in Winnipeg, which opened in 1926.

The Ministry, in consultation with relevant stakeholders, determines the location and number of Ontario's CHCs. The last major expansion of the CHC network in Ontario was announced in 2004 and 2005. At the time of our audit, Ontario had 75 CHCs operating in 145 locations (which includes 70 satellite sites). **Figure 4** shows their locations. **Appendix 2** shows key historical events relating to Ontario's CHCs.

Figure 3: Profile of Community Health Centre Clients, March 2017

Source of data: Association of Ontario Health Centres

Figure 3a: Breakdown of Clients by Self-Reported Individual Annual Income

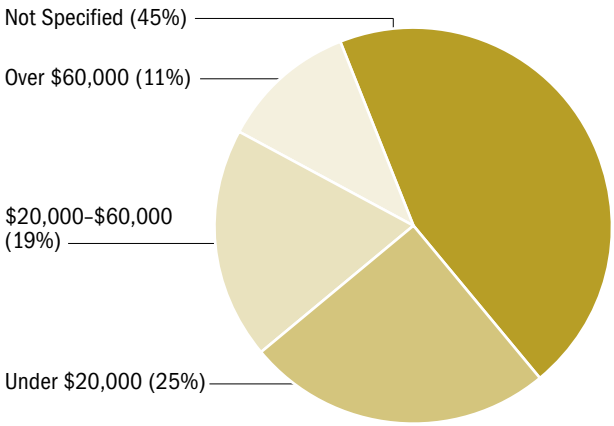


Figure 3b: Breakdown of Clients by Age

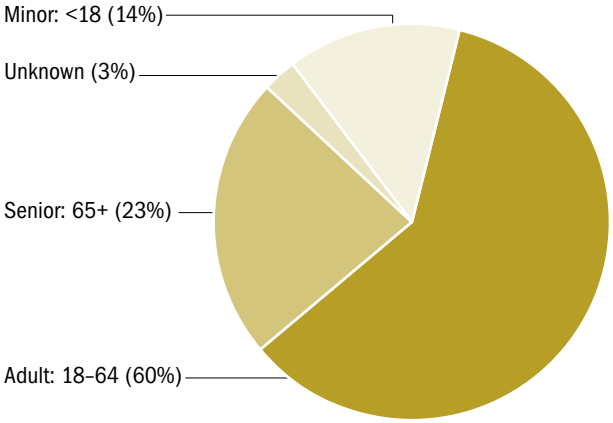
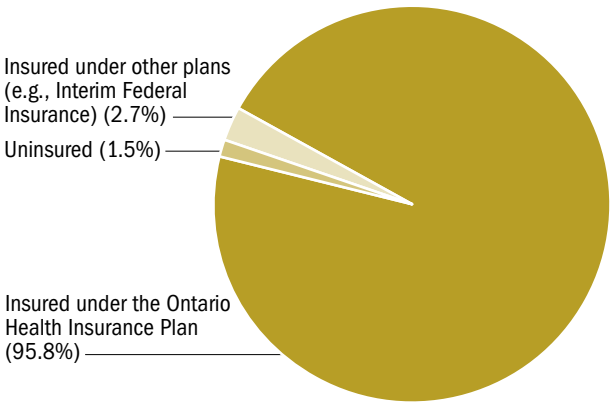


Figure 3c: Insured Status of Clients



Note: Data is only for clients rostered as primary-care patients and for interdisciplinary care at Community Health Centres (CHC). Does not include clients who only participate in CHC community programs.

2.4 Programs and Services Offered at Community Health Centres

2.4.1 Programs and Services Provided at CHCs

CHCs provide both primary-health and community health programs to clients. These programs fall into five areas that the Ministry associates with the government's overarching goal of building a patient-centred health-care system, and include:

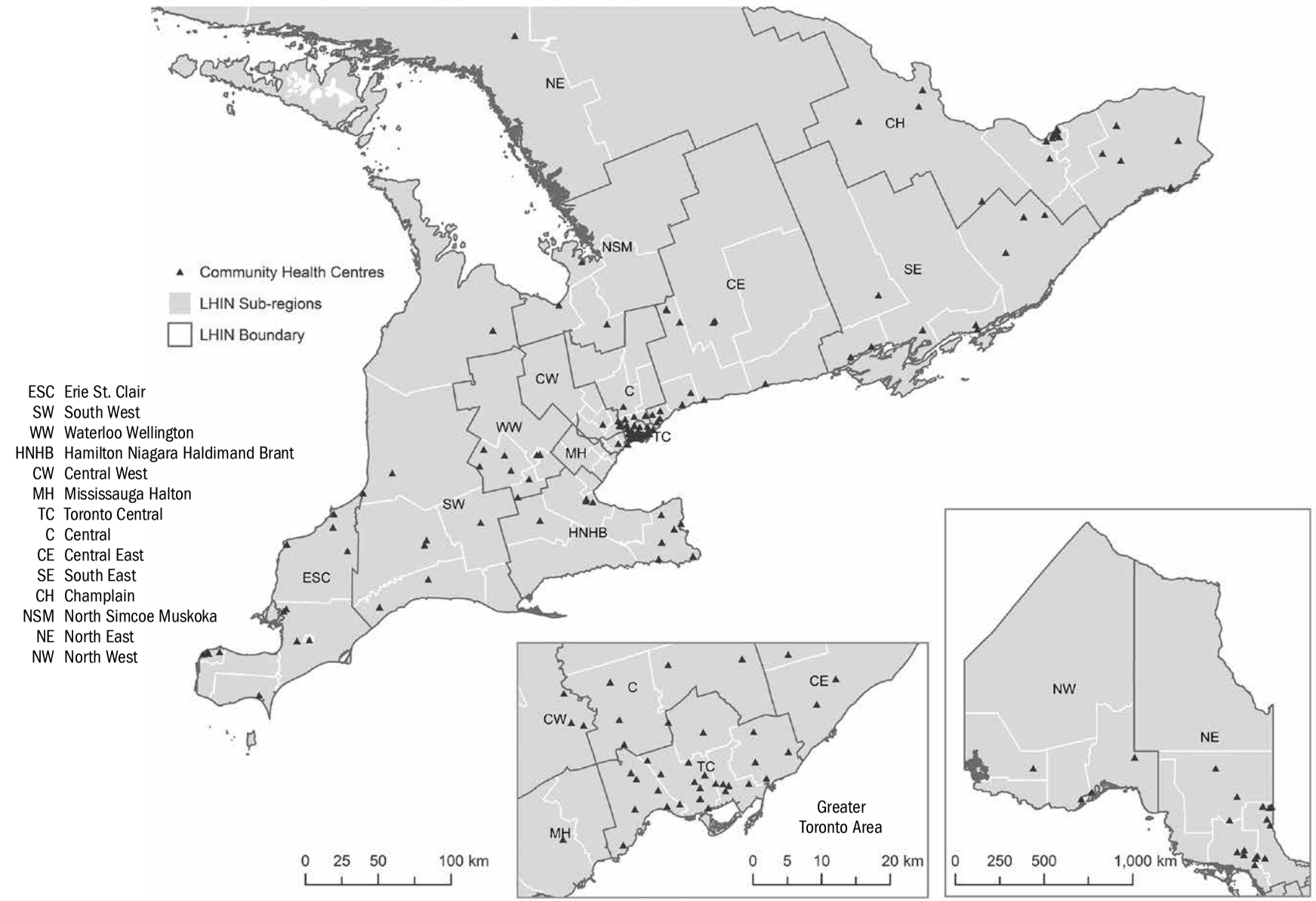
- primary care (the routine care that a patient receives—for example, visits with a physician or nurse practitioner, check-ups, immunization, ultrasounds and blood tests);
- illness prevention (for example, nutrition counselling and diabetic foot care);
- health promotion (for example, programs on stress management, smoking cessation and exercise);
- community capacity building (for example, information and education on community resources and how to access them, youth leadership training and skills development, parent and child programs, and violence prevention); and
- service integration (for example, connecting with other health-service providers).

As each CHC is governed by its own community board, each CHC can determine the type and mix of services that address these five areas and does not have to offer exactly the same services.

The inter-professional primary care (explained in **Section 2.4.2**) and community health programs that CHCs offer could be funded by the Ministry, other ministries or other levels of government. For instance, CHCs may offer diabetes education programs, smoking cessation programs and mental health support programs (funded by the Ministry), prenatal nutrition programs (funded by the federal government), legal clinics (funded by the Ministry of the Attorney General), and housing support services (funded by the municipal government). CHCs often partner with external organizations

Figure 4: Locations of Ontario's Community Health Centres

Source of data: Ministry of Health and Long-Term Care



such as immigration settlement agencies and others that focus on broader health and social issues, to ensure they target their services to those who might face barriers to health care and provide their clients with access to programs that are not available within the CHCs.

Clients may access some or all of the services that CHCs offer. About half of the CHC clients access primary care from the CHC's physicians or nurse practitioners. The other half do not access primary care at the CHC but use its interdisciplinary services and/or community health programs.

2.4.2 Professionals Who Deliver Care and Services at CHCs

The type of health care that CHCs provide is called inter-professional health care. With this model, patients can obtain a full range of health care all under one roof from a team of health-care professionals, which may include a doctor, a nurse practitioner, dietitians, chiropodists (foot specialists) and physiotherapists, and another group of professionals who support clients, such as health promoters, health-system navigators and social workers. The availability of these professionals depends on the CHC.

Other inter-professional primary-care models, some of which serve different demographics than CHCs, also exist in Ontario. **Appendix 3** provides a comparison of CHCs with these other inter-professional models, which include:

- Aboriginal Health Access Centres (10 in Ontario): centres that offer a blend of traditional Indigenous approaches to health and wellness, primary-care and health-promotion programs in culturally appropriate settings.
- Nurse Practitioner–Led Clinics (25 in Ontario): clinics that provide comprehensive and coordinated primary-care services to people of all ages. Nurse practitioners are the lead primary-care providers of these clinics. In addition to collaborating physicians, other members of the health-care team may include registered nurses, dietitians, social workers, occupational therapists and mental health workers.
- Family Health Teams (184 in Ontario): teams of family physicians, nurse practitioners, registered nurses, social workers, dietitians and other professionals who work together (but may not operate out of the same location) to provide primary health care for their community. Each family health team is set up to serve local health and community needs.

2.5 Key Players Involved in Community Health Centres

2.5.1 Ministry of Health and Long-Term Care (Ministry)

The Ministry is ultimately responsible for monitoring and reporting on the health system as a whole. The Ministry's role is to provide overall direction and leadership for the health system, focusing on developing legislation, standards and policies to support its strategic directions, and ensuring the Local Health Integration Networks (LHINs) fulfill the Ministry's expectations, as outlined in contractual documents between the LHINs and the Ministry. The Ministry funds almost all of the CHCs' program costs through Ontario's 14 LHINs, and provides capital funding directly to all CHCs.

2.5.2 Local Health Integration Networks (LHINs)

CHCs receive the majority of their funding from Ontario's 14 LHINs, which were established by the *Local Health System Integration Act, 2006*, with a mandate to create an integrated health system to improve the health of Ontarians. In addition to CHCs, LHINs also fund and oversee other health-service providers such as hospitals, long-term-care homes and community mental health and addiction services agencies. Each LHIN region has at least one CHC.

Under the *Patients First Act, 2016*, which came into effect in December 2016, LHINs now have the legal authority to fund and manage some elements of primary care in Ontario, including family health teams, nurse practitioner–led clinics, and Aboriginal Health Access Centres (currently funded and managed by the Ministry) in addition to CHCs. The LHINs also have an expanded mandate to support planning of primary-care services. Transition of the three models to the LHINs had not yet begun when we completed our audit.

The LHINs enter into an annual accountability agreement with each CHC. The agreement outlines the terms and conditions that CHCs must comply with in delivering health services to their clients.

2.5.3 Association of Ontario Health Centres

Nearly all CHCs (74 of the 75) are members of the Association of Ontario Health Centres (Association), a member-funded association based in Toronto with a staff of under 20. The Association also represents other community-governed primary-care organizations, including all 10 Aboriginal Health Access Centres, 10 of the Province's community family health teams, and about half of the Province's nurse practitioner–led clinics. In addition to receiving membership fees from its members, the Association has also received a total of about $27 million from the Ministry since 1999/2000 for various projects, most of which were related to information technology. The Association supports the CHCs through policy and stakeholder relations, information management, and research and evaluation.

2.6 Funding

In the fiscal year 2016/17, the Ministry, through the LHINs, provided $401 million of program funding to CHCs, representing under 2% of all payments to LHIN-managed health-service providers. This $401 million represents an increase of 114% from 10 years ago in 2007/08, when CHC program funding was $187 million. **Figures 5a** and **5b** show the year-over-year trend of CHC program funding as provided by the Ministry, the number of CHC locations, and the number of CHC clients. In 2016/17, the Ministry also provided just over $16 million of capital funding for CHCs.

Some CHCs also receive funding from other sources such as charities and foundations, other provincial ministries and other levels of government. In 2016/17, CHCs reported to the Ministry that they received about $96 million from these other sources.

3.0 Audit Objective and Scope

Our audit objective was to assess whether the Ministry of Health and Long-Term Care (Ministry), in partnership with the Local Health Integration Networks (LHINs) and the Community Health Centres (CHCs), had effective systems and procedures in place to:

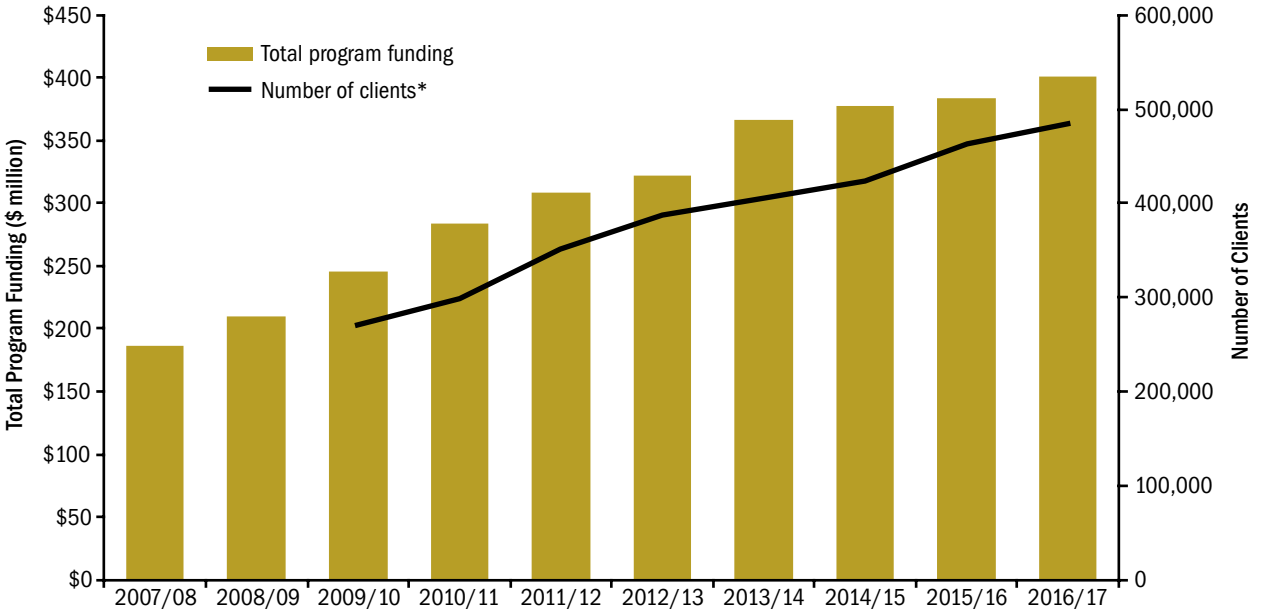
- oversee, co-ordinate and deliver programs and services through CHCs in a timely and cost-effective manner that meets community needs, including those of the priority population; and
- measure and publicly report on the quality and effectiveness of services provided.

Before starting our work, we identified the audit criteria we would use to address our audit objective. These criteria were established based on a review of applicable legislation, policies and procedures, and internal and external studies. Senior management at the Ministry and the four LHINs we visited during the audit reviewed and agreed with the suitability of our audit objective and related criteria as listed in **Appendix 4**.

We focused on activities of the CHCs in the two-year period ending March 31, 2017, and considered relevant data and events in the last 10

Figure 5a: Number of Clients and Total Community Health Centre Program Funding from the Ministry of Health and Long-Term Care, 2007/08–2016/17

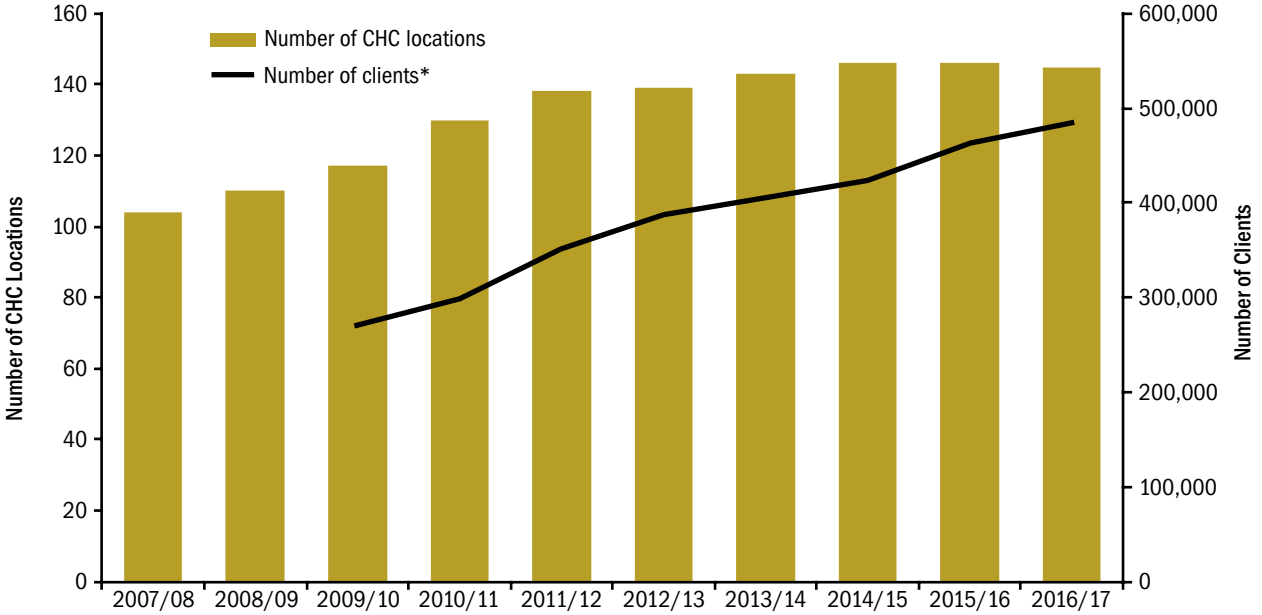
Source of data: Association of Ontario Health Centres, Treasury Board Secretariat



* Number of clients not tracked prior to 2009/10.

Figure 5b: Number of Clients and Number of Community Health Centre (CHC) Locations, 2007/08–2016/17

Source of data: Association of Ontario Health Centres, Treasury Board Secretariat



* Number of clients not tracked prior to 2009/10.

years. We conducted our audit from January to June 2017, and obtained written representation from the Ministry and the LHINs that effective November 16, 2017, they have provided us with all the information they were aware of that could significantly affect the findings or the conclusion of this report.

In conducting our work, we reviewed documents obtained from and interviewed staff at the following Ministry branches:

- Primary Health Care Branch, which provides expertise and strategic advice to CHCs to improve equitable and timely access to primary care to all CHCs;
- LHIN Liaison Branch, which develops, negotiates and manages accountability relationships with Ontario's 14 LHINs;
- Financial Management Branch, which reconciles Ministry funding with CHCs' spending at year-end; and
- Health Capital Investment Branch, which provides funding to CHCs to repair, upgrade and expand their facilities.

The Ministry provides transfer payments to Ontario's 14 LHINs, which in turn contract with CHCs to provide primary-care and community services to clients in their communities. In conducting our audit, we visited four of the 14 LHINs—Toronto Central (corporate office in Toronto), South West (corporate office in London), North Simcoe Muskoka (corporate office in Orillia) and Champlain (corporate office in Ottawa). Their combined expenditures on CHCs in the 2016/17 fiscal year were almost 50% of the overall Ministry expenditures in this area. In addition, we visited eight CHCs across these four LHINs, located in both urban and rural communities, where we toured the facilities, reviewed relevant documents, and interviewed senior management, front-line staff, board members and some CHC clients to obtain their perspectives on ways to improve program delivery. At four of the eight CHCs, we performed additional audit procedures on selected aspects of the audit.

The Association of Ontario Health Centres (Association) represents almost all CHCs in Ontario and maintains data on behalf of almost all CHCs from their electronic medical record systems. To obtain an overall perspective on the CHC sector, we met with representatives from the Association, and obtained and analyzed selected operational and aggregated anonymous client profile data.

In an effort to better understand the issues facing CHCs in Ontario, we met with representatives from the Canadian Association of Community Health Centres and the Association of Family Health Teams of Ontario. As well, we reviewed studies and reports issued by organizations such as the Primary Healthcare Planning Group (a group established in 2010 to draft and build consensus on a strategy for strengthening primary health care in Ontario, chaired by an Assistant Deputy Minister from the Ministry and including membership from the Ontario Medical Association, Registered Nurses' Association of Ontario, Ontario College of Family Physicians, and the Association), the Conference Board of Canada and the Institute for Clinical Evaluative Sciences. We also obtained statistics on complaints received by Ombudsman Ontario on CHCs and considered these in the conduct of our audit.

We engaged an expert with knowledge of the Ontario health system and in particular Community Health Centres to assist us on this audit.

4.0 Detailed Audit Observations

4.1 Lack of Evaluation on Whether CHCs Are Meeting Needs of Communities

4.1.1 No Process to Identify Whether CHCs are Over- or Underutilized

Neither the Ministry of Health and Long-Term Care (Ministry) nor the LHINs have a process to evaluate whether CHCs are meeting the demands of their

communities. We found that neither party has done any regular assessment that considers how many people the CHCs actually serve compared to the number of people they are expected to be responsible for, where wait lists exist for various CHC services, and the growing populations of targeted client groups. Such an analysis would inform how many CHCs should be funded and where they should be located across Ontario to best meet the needs of Ontarians.

As discussed in **Section 2.3**, in 2004 and 2005, the Ministry announced an expansion of a total of 49 CHCs and satellite sites. According to the Ministry, at the time of our audit, 30 of these sites 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 requested that the Ministry provide the analysis it conducted back in 2004 and 2005 to determine where these new CHCs and satellite locations should be located. The Ministry could not produce this analysis. It also informed us that the projects were submitted on a proposal basis by the sponsoring organization, which can be an existing CHC or another health-service organization. In other words, the Ministry did not assess utilization and the unmet needs of the communities involved prior to proceeding with establishing these new sites across the province.

Number of Patients CHCs Responsible for Differed from Target

The capacity of a CHC is largely driven by the actual number of primary-care clinicians who work at the centre and a patient-complexity score that differs from one CHC to the next. The Association of Ontario Health Centres (Association) calculates how many patients each CHC is expected to roster (or register) in its primary care, using a formula developed by the Institute for Clinical Evaluative Sciences that considers complexity of patient needs, which is then applied to the number of primary-care clinicians (physicians and nurse practitioners). A CHC that has more complex-needs patients would be expected to roster fewer patients than a CHC with healthier patients. This calculation is updated annually for each CHC. Overall, CHC clients are 84% more complex in terms of their needs than the general population in Ontario.

According to this patient caseload calculation formula, all CHCs are supposed to be responsible for about 405,000 patients in total. The number of patients that each CHC is supposed to be responsible for (called panel size) varies according to the complexity of patients rostered at the CHC and the number of clinicians the CHC employs. The panel size excludes clients who only use the CHC's non-primary-care services, such as community programs and interdisciplinary services offered by professionals such as social workers and dietitians.

As at March 31, 2017, CHCs across Ontario have registered about 335,300 patients, or 83% of the targeted panel size, into primary care. While 16% of CHCs were at or exceeding their expected target—with one at 172% of its expected patient caseload—about half of CHCs were at less than 80% of their targeted panel size.

We also examined how many patients CHCs actually served to better understand utilization, because even though a person is registered with a CHC, use of CHC services could vary depending on that person's ongoing health needs. For instance, a person could simply be registered as a patient at a CHC but rarely use its services, while some clients with complex needs (such as seniors) could use CHC services more frequently.

The best information we could use as a proxy of actual use was the number of patient encounters for each CHC physician or nurse practitioner. Based on Association data, on a weekly basis in 2016/17, each full-time equivalent CHC physician or nurse practitioner had 31 patient encounters (direct face-to-face interactions with patients), but some had as few as 16 encounters and some had almost 60 encounters. However, the LHINs have not

investigated the reasons why some CHCs were not seeing as many patients as others. While the differences could be attributed to the complexity of the patient population they serve, an analysis of patient encounters between CHCs that serve patients with similar complexity scores would identify opportunities where resources and funds can be reallocated among CHCs.

Wait Lists Existed for Some CHC Services

None of the four LHINs we visited required CHCs to report wait-list data, so they were unaware of which CHCs had wait lists, how many people were waiting to access CHC services, and their wait times. As a result, these LHINs could not use this information to help them determine whether some CHCs have been serving their communities better than others. Even though the Ministry had been responsible for determining the number and locations of CHCs across the province, like the LHINs it also had not collected data on CHC wait lists. Consequently, the Ministry did not have complete information to inform planning and future investment decisions. We discuss wait lists in detail in **Section 4.2.1**.

Population of Targeted CHC Clients Has Grown

Even though the Ministry made progress in increasing the number of CHCs and satellite sites with its announcements in 2004 and 2005 (see details in **Appendix 2**), the population groups that are expected to use CHC services have grown in size since then.

More than 20,000 Syrian refugees settled in Ontario between November 2015 and May 2017, and cases of social assistance (people in temporary financial need receiving assistance from the Ontario Works program) grew by 13% between 2007/08 and 2016/17. In addition, the annual immigration level is expected to increase by 29% between 2016 and 2041.

One CHC we visited during the audit indicated that in the coming years it would not be able to accommodate the needs of its community, as the population in its catchment area has grown and has aged, and their needs are complex. This CHC already had a wait list for primary care at the time of our visit and was at 119% of its capacity.

4.1.2 Overall Comparison of CHCs and Other Models Not Conducted

Separate Responsibility for Various Primary-Care Models Not Conducive to Proper Planning

A number of primary-care models exist in Ontario. Most Ontarians are familiar with the sole-practitioner physician model, but other models, notably the inter-professional primary-care models where a physician or a nurse practitioner works with other types of professional staff to provide health services to patients, also exist. We described those models in **Section 2.4.2**. In 2011, the Primary Healthcare Planning Group (described in **Section 3.0**) recommended to the Ministry that all Ontarians should be attached to inter-professional primary care—CHCs, family health teams, nurse practitioner–led clinics and Aboriginal Health Access Centres. The Planning Group further noted that "it is not recommended to develop new delivery models."

The responsibility for inter-professional primary-care models has been split between the Ministry and the LHINs in the last decade, making it difficult for either party to have complete information to make informed decisions about overall primary-care planning in Ontario. Before 2007, CHCs and other primary-care providers were under the responsibility of the Ministry. LHINs were established by the *Local Health System Integration Act, 2006*. Starting in 2007, the Ministry devolved oversight of CHCs to the LHINs, but retained responsibility for the other inter-professional primary-care models. The Ministry explained that it did so because compared to other models, CHCs were already in a mature state at that time.

With the passage of the *Patients First Act, 2016*, LHINs now have the authority to fund and manage all inter-professional primary-care models. At

the time of our audit, the Ministry had not begun transitioning funding and managing responsibilities of the three models to the LHINs, and had not established any timelines for doing so.

Lack of an Assessment of All Primary-Care Models

A comprehensive assessment of all primary-care models in Ontario would help determine how these models, including the CHCs, can best be used to effectively deliver primary care to Ontarians. Several Ontario-based studies have also called for an evaluation of all primary-care models in Ontario:

- Between 2012 and 2015, the Ministry commissioned the Institute for Clinical Evaluative Sciences and the Conference Board of Canada to conduct four studies that compared the various primary-care models to identify differences in patient demographics, utilization of health-care services and performance. Based on these studies, CHCs were not conclusively better than the other models—while CHCs outperformed other models in areas including having a higher proportion of female patients obtaining a Pap smear (a procedure to detect cervical cancer) and being better at managing their patients' chronic diseases, their patients were also found to have higher rates of hospital readmission and emergency department visits. The studies noted that these results could reflect the demographics that CHCs serve, which include a considerably larger proportion of people who are low-income, new to Canada, or have multiple health conditions. The authors of one of these studies also noted the need for further evaluation of the performance of Ontario's primary-care models in relation to costs and comparisons with models elsewhere.
- In 2011, the Primary Healthcare Planning Group recommended that the Ministry develop a clear and measurable statement of goals and objectives for which the primary-care system should be held to account, and develop a long-term strategy to continue the integration of interdisciplinary health professionals into primary-care practice.
- In 2001, the Ministry commissioned two external consultants to conduct a strategic review of CHCs. One of the objectives of this strategic review was to "situate future development of CHCs within an overall plan that is aligned with key ministry strategies and government directions, including reform of the primary-care system." That review, done 16 years ago, was the last such Ministry review of the CHCs, and it resulted in 11 recommendations to improve CHC service delivery. One of the recommendations made was that the Ministry should ensure that CHCs play a strategic role in primary-care reform.
- In our last audit of CHCs in 2000, we recommended that the Ministry evaluate the efficiency and effectiveness of CHCs in providing quality primary health care and compare the results to other primary-care models.

The Ministry informed us that the provincial plan for primary care is a component of *Patients First: Action Plan for Health Care*, which is the strategic plan for the overall health-care system in Ontario. *Patients First: Action Plan for Health Care* includes specific direction for strengthening primary care, including timely access to a primary-care provider, facilitating better access to specialists, better co-ordinated care for patients with complex conditions, allowing nurse practitioners to prescribe assistive devices, and providing more rehabilitative therapy for seniors. However, it does not specify how CHCs fit strategically within the primary-care system, in order to help the Ministry and the LHINs determine whether CHCs are developing along the right path according to plan and population needs. The plan also lacks performance metrics to measure achievement of and progress toward the stated goals of the plan.

Four LHIN Sub-Regions Lacked Inter-Professional Primary Care

In accordance with new requirements under the *Patients First Act, 2016*, in early 2017 the Ministry endorsed 76 sub-regions (smaller geographic areas located within existing LHIN boundaries) to allow LHINs to better plan, and be more responsive to, local health needs.

At our request, the Ministry asked the LHINs to identify how many of the 76 sub-regions did not have a CHC. The result of this analysis showed that 35 of the 76 sub-regions did not have a CHC, as shown in **Figure 6**. As well, four of these sub-regions do not have any other form of inter-professional primary care, such as family health teams or Aboriginal Health Access Centres.

As a result, patients in these communities do not have the benefit of receiving inter-professional primary care similar to patients in other parts of the province. Instead, they have to visit clinicians located in multiple locations to obtain health services that are routinely provided under one roof at a CHC, or travel to another sub-region to access inter-professional primary care. As well, the sole-practitioner physicians in these communities may be overwhelmed by clients with complex needs.

In the 2017 Ontario Budget, the government announced that it would invest $15 million in 2017/18 to create new or expand existing inter-professional teams so that all 76 sub-regions across Ontario will have a team.

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; and
- 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.

RESPONSE FROM LHINs

LHINs support an evidence-based approach to investing in health-care services and ensuring equitable access to care for all Ontarians. Through accountability agreements held with the LHINs, CHCs provide LHINs with regular performance updates, including information pertaining to the number of patients receiving care. These reports are monitored by the LHINs to ensure all health-service providers, including CHCs, are utilizing public funds for the intended purpose. LHINs will consider utilization and other demand information in making decisions about the CHC sector.

LHINs also support the recommendation by the Primary Healthcare Planning Group and are committed to supporting Ontarians to attach to inter-professional primary care. In 2017, all LHINs, enabled by funding from the Ministry, expanded the Health Care Connect Program to further the inclusion of primary care as a foundational element of the local health-care system.

MINISTRY RESPONSE

The Ministry is committed to ensuring that Ontarians have access to quality comprehensive and continuous primary-care services regardless of where one lives in the province. The 2017 Ontario Budget includes a commitment to support the expansion of inter-professional care teams so that all 76 sub-regions across the province have a team. To support this initiative the Ministry is also in the process of developing a methodology to assess the

Figure 6: Allocation of Community Health Centres in Local Health Integration Networks and Sub-Regions, March 2017

Source of data: Ministry of Health and Long-Term Care

LHIN	LHIN Sub-Region	Without a CHC	Without Any CHCs, FHTs, NPLCs and AHACs
Erie St. Clair	Windsor		
	Tecumseh Lakeshore Amherstburg LaSalle	X	
	Essex South Shore	X	
	Chatham City Centre		
	Rural Kent	X	
	Lambton		
South West	Grey Bruce		
	Huron Perth	X	
	London Middlesex		
	Elgin		
	Oxford		
Waterloo Wellington	Guelph-Puslinch		
	Cambridge-North Dumfries		
	Kitchener-Waterloo-Wellesley-Wilmot-Woolwich		
	Wellington	X	
Hamilton Niagara Haldimand Brant	Hamilton		
	Burlington	X	
	Niagara North West	X	
	Niagara		
	Brant		
	Haldimand Norfolk	X	
Central West	North Etobicoke Malton West Woodbridge		
	Dufferin	X	
	Bolton-Caledon	X	X
	Bramalea		
	Brampton	X	
Mississauga Halton	East Mississauga*	X	
	Halton Hills	X	
	Milton	X	
	Oakville	X	
	North West Mississauga	X	
	South West Mississauga	X	X
	South Etobicoke	X	
Toronto Central	West		
	Mid-West		
	North		
	Mid-East		
	East		

LHIN	LHIN Sub-Region	Without a CHC	Without Any CHCs, FHTs, NPLCs and AHACs
Central	North York West		
	North York Central	X	
	Western York Region		
	Eastern York Region	X	
	South Simcoe	X	
	Northern York Region	X	
Central East	Peterborough City and County	X	
	Haliburton County and City of Kawartha Lakes		
	Northumberland County		
	Durham North East		
	Durham West	X	
	Scarborough North	X	
	Scarborough South		
South East	Rural Hastings		
	Quinte		
	Rural Frontenac, Lennox & Addington	X	
	Kingston		
	Leeds, Lanark & Grenville		
Champlain	Central Ottawa		
	Western Ottawa	X	
	Eastern Champlain		
	Western Champlain		
	Eastern Ottawa	X	
North Simcoe Muskoka	Barrie and Area		
	South Georgian Bay		
	Couchiching	X	
	Muskoka	X	
	North Simcoe		
North East	Nipissing-Temiskaming		
	Sudbury-Manitoulin-Parry Sound		
	Algoma	X	
	Cochrane		
	James and Hudson Bay Coasts	X	X
North West	District of Kenora		
	District of Rainy River	X	
	District of Thunder Bay	X	
	City of Thunder Bay		
	Northern	X	X
Total		**35**	**4**

Note: LHIN: Local Health Integration Network, CHCs: Community Health Centres, FHTs: Family Health Teams, NPLCs: Nurse Practitioner–Led Clinics, AHACs: Aboriginal Health Access Centres

* East Mississauga has a satellite location for a CHC based in the Toronto Central LHIN.

need for comprehensive primary care across LHIN sub-regions and the extent to which this primary-care need is being met. The Ministry is currently in the process of fulfilling these initiatives and expects to have made final decisions on areas of investment by spring 2018. This work applies to all primary-care models.

The Ministry recognizes the importance of team-based inter-professional care to ensure that Ontarians have access to comprehensive primary care. In recognition of this, the Ministry's goal is to have a family health care provider for every Ontarian who wants one and to provide more patients with faster and more convenient access to this care. However, the Ministry also recognizes that not every Ontarian requires access to team-based inter-professional care and that primary-care provision should be aligned with the needs of a community's population.

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

MINISTRY RESPONSE

There was no established deadline to submit proposals as part of the 2004 and 2005 expansion. Currently, the Ministry would consider only funding LHIN-endorsed proposed capital projects. LHIN endorsement ensures that the proposed projects fit into current local health-planning needs. Therefore, for any of the seven outstanding health-service providers to be considered by the Ministry for a capital project for expansion or relocation, the LHIN would first need to review the request and assure the Ministry through its endorsement that the proposed project aligned with current local needs.

The Ministry welcomes the recommendation to establish timelines to transition the funding and oversight responsibilities of inter-professional primary-care models from the Ministry to the LHINs. The Ministry will work with LHINs and sector partners to prepare for transitioning responsibility for funding and oversight responsibilities of inter-professional primary-care models. The Ministry recognizes that any timeline must respect legislative obligations and operational requirements as well as the government's commitment to engage with Indigenous partners for Indigenous-governed inter-professional primary-care models.

In support of *Patients First: Action Plan for Health Care*, the Minister of Health and Long-Term Care has released Mandate Letters to LHINs to articulate provincial priorities and expectations. These Mandate Letters are publicly available and include specific sections related to primary care, including how LHINs should work with primary-care providers (such as CHCs) to deliver primary care to Ontarians in an effort to meet the goals outlined in *Patients*

First: Action Plan for Health Care. The Ministry will continue to assess LHIN progress in these areas as well as indicators specific to CHCs that exist in the Multi-Service Accountability Agreements between LHINs and CHCs.

The Ministry will also work with the LHINs in examining the feasibility of developing standard measures that would support the strategic direction for strengthening primary care as outlined in *Patients First: Action Plan for Health Care*. This work will be conducted as part of the regular cycle of renewing accountability agreements between the Ministry, LHINs and primary-care models, including CHCs.

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

Depending on their needs, CHC clients can access a variety of programs and services, including primary care, interdisciplinary care and community programs, all under one roof. As part of our audit, we reviewed complaints related to CHCs received by Ombudsman Ontario in the last three years, and found that about one in five complaints received related to delayed access to services. In our audit, we found similar issues with access to services, with clients at some CHCs unable to access care on a timely basis, and some services not being available at all.

Overall, we found that over 70% of CHCs offer telemedicine services that provide patients access to a wider range of health services, such as ophthalmology, that may not be available at the CHC.

Nevertheless, we noted that some CHCs had difficulty meeting the demand for primary care and interdisciplinary services in their communities, and not all CHCs provide 24/7 on-call services as required.

4.2.1 Ministry and LHINs Lack Information on Actual Demand for CHC Services

Neither the Ministry nor the LHINs had complete information on how many people are waiting to become CHC clients. We also found that clients at some CHCs had to wait to access interdisciplinary services and community programs.

During our audit, we found that of the eight CHCs we visited, half were not able to meet the primary-care demand in their community. Two of these CHCs maintained wait lists; the other two did not.

Of the two CHCs that had a wait list for primary care, one CHC had 60 people waiting for up to six weeks; the other had about 500 people waiting for up to 15 months to become clients of the CHC. Both were exceeding their capacity.

Of the other two that did not maintain a wait list, one was only accepting homeless people and prioritizing people who were already clients of its community programs into primary care; the other chose to refer individuals seeking primary care to Health Care Connect, a Ministry service that refers Ontarians who do not have a physician to a primary-care provider who is accepting new patients.

The CHCs indicated that individuals who are waiting to be accepted at the CHC as primary-care patients likely go to walk-in clinics or hospital emergency rooms.

We also found that clients at five of the eight CHCs we visited experienced delays in receiving care from the interdisciplinary health team, such as from a dietitian, a foot care specialist or a physiotherapist. At the time of our audit, these CHCs had between 25 and 83 clients waiting to receive interdisciplinary care, with wait times ranging from two to five months.

As well, we found that two CHCs had wait lists for some of their community programs, such as cooking classes, an anxiety support group, and exercise and falls prevention. One CHC's wait list for an exercise and falls prevention program had 90 people.

4.2.2 24/7 On-Call Services Not Consistently Available across CHCs

The CHCs' accountability agreement with the LHINs requires CHCs to provide and actively promote on-call physician services on a 24/7 basis for their ongoing primary-care clients. Similarly, the Primary Healthcare Planning Group also recommended that comprehensive primary-care providers, including CHCs, have the ability to respond to patients' health problems 24 hours a day, seven days a week.

The requirements document that the Association provides to all CHCs indicates that on-call services should be made available to ongoing primary-care clients for advice, information, self-care, scheduled appointments, and for referral to community services and to public hospitals' emergency departments, where appropriate. The document presents several options for providing 24/7 services, noting that on-call services can be pooled across two or more CHCs, shared with other primary-care agencies, or contracted out to another primary-care agency or physician(s).

When CHCs do not offer 24/7 on-call services, patients may have no other means to receive medical advice or assistance after hours than to visit the hospital emergency department, which is a costlier option and may not be warranted for the level of care they need.

During our audit, we found that two of the eight CHCs we visited do not provide 24/7 services. 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.

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; and
- identify which CHCs do not provide 24/7 on-call services and require them to do so.

RESPONSE FROM LHINs

The LHINs support the need to ensure Ontarians have timely and equitable access to quality care within available resources, including equitable access to CHC services. CHCs offer a multitude of services, only some of which may have unmet need. LHINs support collecting and reviewing wait-list information for primary care and other important CHC services.

LHINs will monitor which CHCs do not provide 24/7 on-call services and work with those CHCs to ensure they comply with program requirements.

4.3 Minimum Services and Staffing Model Not Defined

CHCs employ many different professionals—physicians, nurse practitioners, dietitians, health promoters, social workers and many more—who serve CHC clients with different health-care needs. A staffing model that supports the right numbers and best mix of providers can increase the efficiency and effectiveness of inter-professional teams and improve clients' access to their services. We found that 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 these can help CHC clients across the province to have more equitable access to CHC services, and help CHCs better direct workforce planning.

Minimum or Core Set of Services Not Defined

In Ontario, neither the LHINs nor the Ministry provide guidance on a minimum set of interdisciplinary services. Both the Strategic Review of the

Community Health Centre Program commissioned by the Ministry in May 2001 and the Primary Healthcare Planning Group in December 2011 recommended that CHCs' inter-professional teams provide a full basket of services similar to the list issued in 1996 by the Provincial Co-ordinating Committee on Community and Academic Health Services Relations (a Ministry-appointed committee). **Figure 7** outlines the services that the committee recommended.

The Ministry supported the CHC sector in developing five service components and compiled a list of the sample services within those five components, as shown in **Figure 8**. However, this list does not identify the services that all CHCs must have at a minimum.

Figure 7: Minimum Basket of Services in Comprehensive Primary Care, Recommended by the Provincial Co-ordinating Committee on Community and Academic Health Science Centre Relations, 1996

Source of data: George Southey, MD, FCFP, *Performance Measurement in Comprehensive Primary Care: Different Perspectives from Different Approaches* (May 27, 2012)

Item	Service	Description
1	Health assessment	• determination of patient's current health status and potential for health problems by collecting information on physical and psycho-social condition and lifestyle
2	Clinical evidence-based illness prevention and health promotion	• clinical prevention services for patients and families, based on evidence-based guidelines, such as periodic health exams and immunization • approach (rather than specific set of services) that focuses on broad determinants of health, underlying causes of illness, and factors that affect ability to cope, and that looks at entire population • education and support and possibly community development, advocacy and education
3	Appropriate interventions for episodic illness and injury	• in case of illness or injury, timely access to primary care services through simple telephone advice, direct patient contact, and/or referrals to secondary and tertiary care • appropriate follow-up
4	Primary reproductive care	• counselling for birth control and family planning, education, screening and treatment for sexually transmitted diseases, ante- and post-natal care, and labour and delivery • in absence of full in-house maternal care, relationship with agency that provides service
5	Early detection as well as initial and ongoing treatment of chronic illnesses	• range of services, including anticipatory care, monitoring to prevent/treat flare-ups, ongoing education for patient and family, and follow-up at appropriate intervals • knowledge about community-based services
6	Care for the majority of illnesses (with specialists as needed)	• comprehensive care to meet all primary medical-care needs, i.e., for all health problems and illnesses
7	Education and supports for self-care	• encouragement of greater self-reliance, self-care and mutual aid, through health education, counselling, links to resources in community, access to phone health information, advice and triage services
8	Support for hospital care and care provided in-home and in long-term care facilities	• in some communities, general practitioners/family physicians to deliver or co-ordinate and monitor hospital care • as minimum, involvement in planning pre- and post-hospital care, including linking patients at discharge with home care and other community services • support for care and treatment at home and in long-term care • links with home-care programs, appropriate referrals, and liaison and consultation with home-care co-ordinators and providers

Item	Service	Description
9	Arrangements for 24/7 response	• ability to respond to patients' health problems 24 hours a day, 7 days a week • direct response, not through answering machine or instruction to go to emergency
10	Service co-ordination and referral	• co-ordination of community, secondary and tertiary care
11	Maintenance of comprehensive patient health record	• management of client information in order to facilitate co-ordination and referral
12	Advocacy	• support, referral and liaison for patients aware of need but unable to organize help • supportive listening, accompaniment if necessary, writing of letters, making of telephone calls, and/or speaking on patients' behalf and organizing of case conferences
13	Primary mental health care including psycho-social counselling	• recognition of emotional and psychiatric problems, comprehensive management planning, awareness of resources in community, knowledge of when to refer patients to and/or work with other mental-health providers
14	Co-ordination and access to rehabilitation	• arrangements for appropriate rehabilitative care • referral of patients to rehabilitation therapists, participation in treatment planning and follow-up, education and advocacy, "care map" leading to return to function/school/work
15	Support for the terminally ill	• home visits and capability for 24-hour response when necessary for care and advice • co-ordination of medical care with home care and other community agencies • arranging of timely access to hospital care and proper discharge

Because the service agreement between the LHINs and the CHCs does not outline a minimum list of services, services offered by various CHCs differ widely. In particular, we found that several CHCs could not provide the required level of support within their organization for their patients who require physiotherapy and mental health care. Even though these CHCs can still refer patients to other health-care organizations, these patients are at a disadvantage compared to other CHCs' patients who can access these services all under one roof at their CHCs.

For physiotherapy, over half of the CHCs did not provide this service in 2016. In the case of mental health care, about 15% of the complaints received by the Ontario Ombudsman pertaining to CHCs in the last three years relate to inadequate support provided to CHC clients with mental illness. According to the Association, about 6% of CHC clients have serious mental illness. One sector representative noted that primary care cannot be done in isolation from mental health and addictions, and that there are many patients with mental health issues.

While we noted in our audit that all eight CHCs we visited have formed partnerships with other mental health services providers, such as hospitals and community agencies, to assist clients with mental illness, half of them indicated that they had difficulty meeting clients' mental health needs. One of these CHCs further noted that it could not find clinicians with the prerequisite knowledge to prescribe medication for mental illness. As a result, some mental health clients of these CHCs may seek care from hospitals, where care is more expensive.

Mix of Professionals Not Defined

CHCs across Ontario employ anywhere between four and 17 types of health providers, averaging 10 types of providers. **Figure 9** shows the different

Figure 8: Service Areas and Sample Services Offered by Community Health Centres

Source of data: Ministry of Health and Long-Term Care

Service Area(s)	Sample Services Included within Service Area(s)
(1) Primary Care, (2) Illness Prevention	• clinical laboratory • diagnostic imaging • non-invasive cardiology laboratories • general clinic • therapy clinic (general, foot care, naturopathy, pharmacy consultation, nutrition, physiotherapy, occupational therapy, counselling, speech and language pathology, massage therapy) • oral health clinic • chronic disease clinic (general, diabetes, asthma, hepatitis C and/or HIV/AIDS)
(3) Health Promotion, (4) Community Capacity Building	• community engagement • chronic disease education, awareness and prevention (general, diabetes, asthma/chronic obstructive pulmonary disease (COPD), hepatitis C and/or HIV/AIDS) • diabetes strategy—regional co-ordination centre • personal health and wellness—mental wellness, health promotion, personal health practices and coping skills • oral health • healthy child development (prenatal, well baby, school health, parenting advice, family planning and family well-being) • youth development (sexual health, substance use, education, employment readiness, social skills specifically targeted at youth population) • injury prevention • healthy living workshops • life skills education • sexual health • stress management • exercise • culturally specific programming • violence prevention • anger management • harm reduction • needle exchange • smoking cessation • client support services (crisis intake, prevention and management; information and referrals to external agencies; individual advocacy; case management; stable housing; homelessness; food availability; access to employment; community justice, conflict resolution and social support programs; identification clinics, food and furniture banks, and information and education about community resources and how to access them)
(5) Service Integration	• health system infrastructure policies • strategic planning • knowledge transfer with the Ministry of Health and Long-Term Care, Local Health Integration Networks and individual organizations • Health Links initiatives (to optimize co-ordination of services between health-care providers to improve quality of care for high-needs patients) • formal research (activities geared toward building scientific knowledge, generating knowledge and evidence to inform and support the community health centre's strategic plan, programs, and services and related to program evaluation, quality improvement, promoting research capacity for multiple stakeholders to build, promote and support effective mechanisms for knowledge translation and exchange for and between researchers, policy makers, service providers, service users and community members)

Figure 9: Types of Community Health Centre Personnel Who Provide Direct Care and Services to Clients, 2016

Source of data: Association of Ontario Health Centres

Position[1]	# of CHCs[2]	% of CHCs
Nurse Practitioners	74	100
Physicians	73	99
Dietitians/Nutritionists	69	93
Registered Nurses	68	92
Social workers	68	92
Other staff[3]	60	81
Health promoters	59	80
Registered Practical Nurses	49	66
Community development workers	45	61
Chiropodists[4]	35	47
Physiotherapists	32	43
Counsellors	28	38
Outreach workers	25	34
Occupational therapists	15	20
Pharmacists	12	16
Dental staff	11	15
Psychiatrists	10	14
Lab technicians	8	11
Chiropractors	6	8
Settlement workers	5	7
Physician assistants	4	5
Psychologists	4	5
Traditional healers	4	5

1. Includes positions that are funded from sources other than Local Health Integration Networks; excludes medical secretaries, administrative staff and management.
2. For all CHCs that were members of the Association of Ontario Health Centres (one CHC was not a member).
3. Other staff may include a variety of positions such as community legal workers, early childhood workers, parent support workers and other CHC workers who interact directly with clients.
4. Foot specialists.

types of health providers that work in CHCs and the percentage of CHCs that employ these professionals.

Neither the Ministry nor the LHINs define the composition of the inter-professional health teams in a CHC that would align with a core basket of services. We recognize that CHCs should have the flexibility to hire the professionals who would help meet their local community's needs, but without a defined core minimum staff complement, CHC clients in some communities may be short-changed in having access to a core group of inter-professional staff, such as physiotherapists, social workers and dietitians. In our 2000 audit of CHCs, we recommended that the Ministry develop guidelines to assist CHCs in determining cost-effective combinations of health-care staff.

The Primary Healthcare Planning Group in 2011 recommended that the Ministry develop a formal mechanism to track and analyze the activities of interdisciplinary health professionals to better understand the impact they are having in primary care. The group noted that the integration of these professionals can enable improvements in the areas of quality, access, accountability and efficiency.

We found that beyond capturing the number of interactions that CHC interdisciplinary health professionals have with their clients, the Ministry does not track or analyze the activities of these professionals as recommended by the Primary Healthcare Planning Group.

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; and
- 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.

RESPONSE FROM LHINs

The LHINs recognize that the communities and the needs of those communities served by CHCs are unique, which may mean that equitable community services do not translate to the same service offering. LHINs will work with the Ministry to assess the appropriateness of defining a set of core CHC services, including interdisciplinary health professionals. LHINs support the planning of health-care services at the sub-region level and will continue to support CHC programs that are tailored to the unique needs of their respective patients.

MINISTRY RESPONSE

The Ministry understands that the needs of patients and communities vary considerably across Ontario and that CHCs have an important role in designing and delivering services and programs that meet these diverse needs through the five service areas. Careful review is required to determine whether or not further standardizing a core set of services provincially beyond these five areas for inclusion into LHIN-CHC accountability agreements supports or detracts from the roles that CHCs perform in tailoring their services based on patient, community and population need. The Ministry will work with LHINs and sector partners to assess the relative benefits of this approach.

The Ministry acknowledges data gaps on the range of services offered by CHCs and is working to improve in this area. The type of inter-professional health providers delivering services in CHCs reflects the diverse needs of the patients and communities they serve. Similar to the above, the Ministry will work with LHINs and sector partners to assess the relative benefits of determining whether a CHC should employ a core component of inter-professional staff as part of the regular cycle of renewing accountability agreements between the Ministry, LHINs and CHCs.

4.4 Ministry and LHINs Lack Useful Information on CHCs

The Association collects information from each CHC's electronic medical record system and analyzes this data to provide information reports. But the Ministry does not have access to this information because it does not have a data-sharing agreement with the CHCs. This issue was raised in our *2000 Annual Report*, was unresolved when we followed up with the Ministry in 2002, and remains unresolved at the time of this audit.

CHCs and primary-care services in general lack data to measure their impact on the health of the clients they serve. Health Quality Ontario, the Province's adviser on health-care quality, was tasked in 2011 with an initiative to develop better performance measures for primary care. This work was still under way at the time of our audit.

We also found that the Ministry and the LHINs do not collect meaningful information from CHCs to measure whether they have contributed to improved health of their clients. As a result, the Ministry and the LHINs cannot determine whether patients receive quality services and at a lower cost, and whether the Ministry should make additional investments in CHCs.

We look at these issues in detail in the following subsections.

4.4.1 CHCs Use Different Electronic Medical Record Systems

At the time of our audit, the 75 CHCs across the province did not use the same electronic medical record system to record details and data about their interactions with patients. Altogether, five systems were in use, with the majority of CHCs using one common system. In our 2016 audit "Electronic Health Records' Implementation Status," we noted that the Ministry did not require all community-based physicians to use standardized electronic medical record software, and individual community-based physicians who want to manage

their patients' health information electronically can select the software of their choice. As a result, even though the Association aggregates client and provider data from CHCs to generate sector-wide information on socio-demographic characteristics (such as income level, age and insured status) and on health-care providers employed by CHCs (such as the number of physicians, dietitians or social workers, and the number of clients they saw), it could not do so for three CHCs, as two of them do not use an electronic medical record system that is compatible with the Association's system. The remaining CHC is not a member of the Association.

The most common system used was sold to another vendor in September 2016, and the old system that was in use was being transitioned to a new system under the new vendor during our audit. The Association felt that it would be beneficial to have all CHCs use this new system—for instance, having a common system would allow for reporting in a consistent manner—but cannot compel all CHCs to use it because each CHC is governed by its own board and not accountable to the Association. At the time of our audit, the Association did not know how many CHCs will adopt the new system. One of the eight CHCs we visited was undecided at the time of our audit, but was leaning toward the use of another system used by other local physicians; another CHC had decided that it would not switch to the new system. Neither the Ministry nor the LHINs have promoted the use of systems that are compatible with the mainstream system to facilitate the collection and analysis of sector data.

4.4.2 Ministry and LHINs Continue to Have Limited Insight into CHC Sector Data and Analysis

The Ministry provided about $24 million to the Association between 2011/12 and 2016/17 to acquire and implement electronic medical record systems at CHCs. With this funding, the Association could collect and analyze clinical information from those CHCs that use a compatible system, and provide summary anonymized clinical information to CHCs. CHCs in turn could review their own and each other's information to compare statistics on areas such as the number of client interactions, client demographics and diagnoses.

Despite having made this investment, the Ministry cannot routinely access CHC client and service data maintained by the Association, and must specifically request this data. Having this information is important because the Ministry does not otherwise have information about the services that are provided by CHCs. Unlike other primary-care models, physicians and other clinicians at CHCs do not bill the Ontario Health Insurance Plan, which provides data on each health-care service rendered.

In our previous audit of CHCs in 2000, we recommended that the Ministry expedite the resolution of any access-to-information issues. The Ministry advised us in our 2002 follow-up report that a data-sharing agreement between the Ministry and CHCs would be finalized in June 2002. The Ministry indicated that it established such an agreement with the Association in 2002 to use the Association's management information system, but that system has since been decommissioned. At the time of this audit, the Ministry has yet to resolve data access issues. The Ministry informed us that it was awaiting the development of a common database that contains sector data before finalizing the data-sharing agreement. However, we noted that this common database has already been in place since 2008 and almost all CHCs have been using it. At the time of our 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, limiting their ability to effectively oversee CHCs, as we discuss in **Section 4.5**.

4.4.3 Effectiveness of CHCs Not Known

CHCs Do Not Collect Data to Measure Program Outcomes

Information that the Ministry or the LHINs collect from CHCs is not meaningful in evaluating whether

CHCs have contributed to the improved health of their clients. As a result, the Ministry and the LHINs cannot determine whether patients receive quality services, and at a lower cost, and whether the Ministry should make additional investments in CHCs.

While the CHCs report certain information to the LHINs as required in the accountability agreement, such as the number of patients screened for cancer, number of full-time equivalents of staff, number of individuals served, and number of service provider interactions, these indicators for the most part measure CHC outputs. The LHINs do not require CHCs to track outcomes-based indicators, such as reduced social isolation (which can be measured via client surveys) and number of hospital days stayed by CHC clients. Such indicators would allow the LHINs to measure the impact that team-based care has on a client's health. Even though Health Quality Ontario collects some outcome information from CHCs, not all CHCs report on this information (we discuss this issue in **Section 4.5.2**). (Health Quality Ontario is the Province's adviser on health-care quality and is entrusted with monitoring and reporting on how the health-care system is performing, and with providing guidance on important quality issues and assessing evidence to determine what constitutes optimal care.) 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.

Primary-Care Performance Measurement Framework Not Yet Implemented

To respond to a recommendation made by the Primary Healthcare Planning Group, Health Quality Ontario in 2014 developed the Primary-Care Performance Measurement Framework. The framework identifies nine domains, 112 practice-level and 179 system-level measures (at the community, regional and provincial levels) to assess performance in primary care. For example, one measure used in the effectiveness domain is the number of patients with asthma whose symptoms have been under control during the past four weeks. **Appendix 5** sets out the framework and the nine domains that align with Health Quality Ontario's attributes of a high-performing health-care system (access, patient-centredness, integration, effectiveness, focus on population health, efficiency, safety, appropriate resources and equity). (These nine domains have since evolved to six domains that capture similar areas.)

In its report, Health Quality Ontario notes that data is available for only 15 (13%) of the recommended practice-level measures and 73 (41%) of the system-level measures. It also noted the need to develop additional infrastructure to support the data collection, analysis and reporting to address the data gap.

The Ministry informed us that this framework serves as the foundational component of provincial efforts to collect data and measure performance from primary-care providers, including the CHCs, and that it has prioritized the measures and adopted a subset of the recommended measures—18 of the 112 practice-level measures and 12 of the 179 system-level measures. However, data was still not available for all of these measures and the Ministry has not established the timelines for implementation of all the prioritized measures.

Limited Information on Community Programs

CHCs offer community programs such as Pathways to Education (a national program to improve high-school graduation rates in low-income communities), smoking cessation, senior recreation programs and healthy eating programs to their clients. These programs are important, as many are tied to the underlying factors that influence people's health (called social determinants of health, which were explained in **Section 2.1**). To assess whether community programs have made a positive impact on participants, most CHCs conduct surveys. Beyond that, CHCs find measuring

effectiveness of community programs challenging. Some CHCs told us that they cannot easily attribute improvement in a client's health to their community programs. Other challenges reported include:

- CHCs do not consistently maintain data on clients participating in community programs—many community program clients access the community programs only but not primary care from the CHC. As a result, their data is not collected in the CHC's electronic medical record system, which is typically used only for primary-care services. Some CHCs are starting to obtain data from clients participating in community programs, and some are working on adding community program client data to their electronic medical record system, but for the most part, data on community programs is not electronically tracked.
- CHCs do not consistently track community program information in the community initiatives reporting tool—the reporting tool, developed by the Association at a cost of about $100,000, is designed to track community initiatives for CHCs to facilitate knowledge and best practices sharing, and evaluation of the initiatives. Three of the eight CHCs we visited do not use this tool, with one opting for its own in-house tracking tool, citing the reasons that the inputs are time-consuming to complete and the value of the tool is not evident. We examined how many CHCs across the province actively used this tool and found that one-quarter of CHCs do not enter any information in it.

At the time of our audit, the Association was working on new indicators or measurements that will help evaluate the impact of community programs/initiatives.

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;
- finalize the data-sharing agreement with CHCs and assess the feasibility of sharing the data with LHINs;
- establish timelines for collecting information for the remaining measures the Ministry has prioritized according to the Primary-Care Performance Measurement Framework; and
- develop performance indicators that measure outcomes of CHC clients for all types of services provided, collect this information and analyze the results.

MINISTRY RESPONSE

The Ministry agrees that improved access to data would enable a more comprehensive measurement of the effectiveness of CHCs. The Ministry has initiated activities to address data gaps and is working with the CHC sector to find ways of collecting data from CHCs, including data housed in their Electronic Medical Records, for this purpose.

The mechanism through which data can be shared, such as data-sharing agreements, requires a review of requirements and legislation governing the collection, use and disclosure of personal health information prior to implementation. The Ministry will work toward finalizing a data-sharing agreement with CHCs. The Ministry expects this review and preliminary implementation steps to be undertaken by the fall of 2018. In addition, the Ministry will research if access issues to CHC data for LHINs can be addressed; work will begin in the upcoming year to examine the feasibility of this initiative.

As part of the *Patients First: Action Plan for Health Care*, the Ministry has worked with Health Quality Ontario (HQO) to improve reporting on the primary-care sector through HQO's annual Measuring Up report, in which the Primary-Care Performance Measurement Framework informed this work. The Ministry will work to build on this progress by working with partners to establish timelines to evaluate the benefit of additional priority indicators and measures. The Ministry recognizes that any timeline must respect legislative obligations and operational requirements, such as any pending Multi-Service Accountability Agreements, Ministry-LHIN Accountability Agreements, and Physician Service Agreements.

CHCs are required to include a variety of performance data and supporting documentation as part of their Multi-Service Accountability Agreements with their respective LHINs, including the number of active clients registered, volume of services delivered by type of health-care provider, major health issues and priority populations addressed, major achievements, strategic plans and organizational goals. The Ministry will work with the LHINs to develop business practices that allow for these activities to be tied to outcome measures to facilitate improved performance management in the CHC sector. The Ministry will work together with the LHINs and CHCs within existing accountability structures to review existing performance measures and consider different or additional measures, if necessary. Further, it will establish timelines for collecting this information against these measures if different or additional measures are necessary.

RESPONSE FROM LHINs

The LHINs support this recommendation and encourage the Association of Ontario Health Centres to continue the development and implementation of its Business Intelligence Reporting Tool. LHINs will continue to work with CHCs to strengthen client outcome measurement and continue to evolve accountability instruments to achieve optimal performance.

4.5 Limited Oversight of Community Health Centres

In lieu of conducting formal site inspections of CHCs, the Ministry and LHINs instead rely on the accreditation process (an evaluation by an independent and qualified accreditor) and the quality improvement plans (CHC-prepared documents that include results of patient surveys) to monitor CHCs' effectiveness and quality of services.

We found that the LHINs do not require all CHCs to be accredited. We also found that most LHINs do not review accreditation results and do not monitor the accreditation status of CHCs.

As well, while all CHCs have to prepare an annual quality improvement plan for purposes of quality assurance, they choose their own performance indicators, and as a result almost 100 unique performance indicators are found among all CHCs' plans combined, making comparison almost impossible. In addition, the CHCs do not work toward common targets but set the targets themselves. We also found that not all CHCs reported data on four indicators that are common across the CHCs (CHCs are required to report three of these four indicators as part of their accountability agreement with the LHINs).

We look at these issues in detail in the following subsections.

4.5.1 Accreditation Encouraged but Not Tracked and Issues Not Reported to LHINs

The LHINs do not require CHCs to be accredited. According to the Community Health Centre Guidelines issued by the Association in November 2013, "it is expected that all CHCs commit to participate in an accreditation process."

Accreditation provides an external review of an organization's operations in relation to accepted standards of good practice and risk management. During an accreditation process at a CHC, accreditors from an external accreditation organization (there are several such organizations commonly used by health-care organizations in Ontario) perform a site audit to ensure the CHC is compliant with standards. These standards relate to areas such as governance, organizational planning and performance, risk and safety, and programs and services. CHCs that obtain accreditation pay for this from their operating budget. The accreditation status is typically renewed every four years.

Obtaining accreditation can provide assurance to the LHINs that funding provided to CHCs has gone toward services that meet standards to ensure patients are safe and receiving quality care. We noted the following concerns with CHCs' accreditation:

- Only one of the four LHINs we visited requires CHCs to report their accreditation status. The other LHINs did not have information on which CHCs in their region are accredited.
- Two of the eight CHCs we visited are not accredited, but expect to be accredited within the next few years.
- The LHINs do not require CHCs to submit the accreditation review report, or report any issues noted by the accreditors during the accreditation process. As a result, the LHINs cannot use this opportunity to identify systemic issues and encourage CHCs to rectify them.
- 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. Two of the four LHINs we visited offer governance training to health-service providers in their regions, including CHCs, but the other two do not.

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;
- identify areas that accreditation reviewers suggested should be improved through a review of CHCs' accreditation reports and work with CHCs to rectify the issues; and
- make available governance training and promote it to CHCs.

RESPONSE FROM LHINs

The LHINs continue to support a focus on quality improvement of health services and recognize that accreditation, which is a voluntary process, is one of the many tools available to benchmark performance and support improved quality. LHINs are committed to developing a local health system that is rooted in high-quality, patient-centred care and will continue to work with all health-service providers, including CHCs, to ensure quality assurance mechanisms are in place.

LHINs will work toward making available governance training to CHCs, leveraging existing efforts that are already in place at some LHINs.

4.5.2 Quality Improvement Process Results Not Assessed for Systemic Concerns

CHCs Began Submitting Quality Improvement Plans in 2013/14

Quality improvement plans are documents that include performance indicator results, comments on these results, and quality commitments made by a health-care organization. Under the *Excellent Care for All Act*, Health Quality Ontario receives

quality improvement plans for the purpose of quality assurance from hospitals. Health Quality Ontario also receives quality improvement plans from certain health-service providers who are obligated to submit them as part of their contract with either the Ministry or the LHIN. The requirement for CHCs to submit quality improvement plans to Health Quality Ontario began in 2013/14 as outlined in the accountability agreement between CHCs and the LHINs.

CHCs report performance indicators related to such issues as access, patient experience and cancer screening rates, the percentage of clients who are able to see a doctor or nurse practitioner on the same day or next day, and the percentage of eligible clients who are up to date in screening for breast cancer.

Annually, upon receiving the quality improvement plans, Health Quality Ontario compiles the results and submits a summary report to the Ministry.

Ministry and LHINs Do Not Review Quality Improvement Plan Results to Determine CHCs' Quality of Care

In our last audit of the CHCs in 2000, we recommended that the Ministry conduct regular reviews of CHCs to ensure that CHCs review their quality of care. In this audit, the Ministry indicated to us that it has reviewed CHCs' quality of care, and that it accomplished this by reviewing a summary report that Health Quality Ontario prepares based on CHCs' submitted quality improvement plans. The Ministry told us that it would use the report to determine where CHCs can improve performance and where further investments could be made.

However, we found that this publicly available summary report aggregates information on all primary-care organizations that submit quality improvement plans, including family health teams, Aboriginal Health Access Centres, nurse practitioner–led clinics and CHCs, so the Ministry cannot possibly use the summary report to measure the CHCs' own performance. In other words, the Ministry does not publicly report on CHCs' performance.

We also found that the Ministry does 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 underperformance is corrected. This review and follow-up was inconsistent among the LHINs we visited.

We reviewed all CHCs' quality improvement plans from 2016/17 and noted the following:

- CHCs report on almost 100 unique indicators, only four of which are common across CHCs. While the variety could be attributed to differences among CHCs and may promote the development of new common indicators, this lack of commonality makes comparisons or benchmarking of CHCs challenging.
- We reviewed the 2016/17 results of the four common indicators. We found that not all CHCs reported complete information, and CHCs that did report the information needed to improve on their performance. **Figure 10** shows the 2016/17 results for these indicators.
- Of the almost 100 indicators, only four reported indicators measured patient outcomes. For two of these indicators, only about half of the CHCs reported data in these areas, and few met their performance targets. For the other two indicators, only one CHC reported on each of them. Health Quality Ontario informed us that these indicators are either optional or reported on by only select CHCs. **Figure 11** shows the 2016/17 results for these indicators.
- Performance targets are set by the CHCs themselves, unless the indicators are specified in their accountability agreement with the LHIN, in which case the LHIN-developed target is used. Some CHCs may set a high standard for their performance, while others set a much lower standard. For example, in the case of the indicator that measures the percentage of patients who saw their primary-care provider within seven days after discharge from

Figure 10: Results on 4 Common Indicators Reported by Community Health Centres (CHCs) in Quality Improvement Plans, 2016/17

Source of data: Health Quality Ontario

			% of CHCs			Performance Level (%)	
Indicator	# of CHCs Reporting on the Indicator[1]	Range of Performance Targets (%)[2]	Met Target	Did Not Meet Target	Excluded Due to Incomplete Information	Highest Performance Achieved	Lowest Performance Achieved
% patients who stated that when they see the doctor or nurse practitioner, that person or someone else in the office always/often spends enough time with them	73	70–100	45	45	10	100	76
% patients/clients who saw their primary-care provider within 7 days after discharge from hospital for selected conditions (based on CMGs[3]).	74	5–95	30	31	39	100	5
% respondents who responded positively to the question: "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?"	74	70–100	42	50	8	100	62
% patients and clients able to see a doctor or nurse practitioner on the same day or next day, when needed	73	37–97	25	61	14	95	23

1. There are 75 CHCs in total.
2. Performance targets are set by either the CHCs themselves or their Local Health Integration Networks. They are stated as a percentage that differs ("range") according to the indicator and by individual CHC.
3. CMG: Case Mix Groups—acute-care in-patients with similar clinical and resource-utilization characteristics, including the following seven conditions: stroke, chronic obstructive pulmonary disease, pneumonia, congestive heart failure, diabetes, cardiac and gastro-intestinal disorders.

Figure 11: Results on 4 Outcome Indicators Reported by Selected Community Health Centres (CHCs) in Quality Improvement Plans, 2016/17

Source of data: Health Quality Ontario

Indicator	# of CHCs Reporting on the Indicator[1]	Range of Performance Targets (%)[2]	% of CHCs			Performance Level (%)	
			Met Target	Did Not Meet Target	Excluded Due to Incomplete Information	Highest Performance Achieved	Lowest Performance Achieved
% of patients/clients who visited the emergency department for conditions best managed elsewhere	41	0–55	32	44	24	3	55
% of acute hospital in-patients discharged with selected CMGs[3] that are readmitted to any acute in-patient hospital for non-elective patient care within 30 days	33	0–55	15	33	52	0	55
% of hospital in-patients discharged readmitted for non-elective care within 30 days	1	20[4]	100	0	0	3	3
% of clients with diabetes meeting LDL cholesterol target of <2.0, or 50% reduction from baseline	1	90[4]	0	100	0	43	43

1. There are 75 CHCs in total.
2. Performance targets are set by either the CHCs themselves or their Local Health Integration Networks. They are stated as a percentage that differs ("range") according to the indicator and by individual CHC.
3. CMG: Case Mix Groups—acute-care in-patients with similar clinical and resource-utilization characteristics, including the following seven conditions: stroke, chronic obstructive pulmonary disease, pneumonia, congestive heart failure, diabetes, cardiac and gastro-intestinal disorders.
4. Target is for the sole CHC that reported on this indicator.

hospital for selected conditions, one CHC set a target of 95% while another CHC set a target of 5%. Similarly, in the case of the indicator that measures the percentage of patients who visited the emergency department for conditions best managed elsewhere, one CHC set a high target of 0% while another CHC set a target of 55%.

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;
- streamline the number of performance indicators that CHCs need to report in their quality improvement plans; and
- establish common performance targets across all CHCs.

MINISTRY RESPONSE

In partnership with Health Quality Ontario (HQO) and the LHINs, the Ministry introduced the requirement for team-based primary-care models, including CHCs, to submit an annual Quality Improvement Plan (QIP) to HQO as a means of embedding quality improvement into the culture of primary-care organizations. The QIP Program is managed by HQO, an agency with the statutory authority to advise the Ministry on health quality and to promote continuous quality improvement aimed at substantial and sustainable positive change in health care. The Ministry will work with HQO to improve feedback to inter-professional primary-care organizations, including CHCs, regarding systemic issues.

While the Ministry acknowledges that there are over 100 performance indicators that CHCs may choose to include in their QIP, three are priority indicators for CHCs. This approach aims to strike a balance between ensuring common quality improvement standards across all CHCs, while providing organizations the option to integrate custom or local indicators that fit the improvement priorities they want to communicate to the public. The Ministry will work with HQO and LHINs to determine if this approach requires further streamlining.

Recognizing that CHCs need to be responsive to the primary-health-care needs of their respective communities, the Ministry agrees that it is important to establish common performance targets across all CHCs. At present, CHCs are required to have panel size targets—meaning targets that identify the number of primary-care clients to be served—based on the risk profile of the population served and their complement of primary-care providers (that is, physicians and nurse practitioners). The Ministry will continue to work with LHINs and the sector to identify additional common performance targets across all CHCs as part of the regular cycle of renewing accountability agreements between the Ministry, LHINs and CHCs.

HEALTH QUALITY ONTARIO RESPONSE

Health Quality Ontario (HQO) provides information back to the CHCs through education, including through HQO's webinar series where analysis is shared from the Primary Care Sector Quality Improvement Plans (QIPs) from the last year as well as areas of focus for the following year's QIPs. HQO also has targeted webinars where issues, such as equity or patient relations, and content relevant to all sectors, including CHCs, are looked at. Lastly, the QIPs and content contained therein are publicly accessible and searchable such that anyone—a CHC, Ministry staff or member of the public—can search

for relevant information on quality in any given sector by organization, sector or LHIN.

As described in the QIP guidance documents, a QIP should reflect an organization's commitment to a balance of local and provincial priorities. While HQO recommends priority indicators, organizations are encouraged to select indicators based on their current performance, provincial priorities, regional initiatives, and the feedback of their patients and providers. Similarly, organizations are encouraged to set targets based on their current performance, giving consideration to whether current benchmarks are available and their capacity for improvement. HQO is committed to continuing to work with CHCs as part of our annual review of QIP indicators to identify opportunities to streamline and better align reporting requirements.

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

The annual base funding that LHINs provide to CHCs is predominantly historical. Funding increases in the last few years have primarily been related to retention and recruitment of health professionals who work at CHCs. None of the LHINs we visited adjusted CHCs' funding levels when CHCs did not meet or exceeded the targeted panel size (the number of patients that the CHC is expected to serve, considering the number of physicians and nurse practitioners and the complexity of patients rostered at the CHC). As of March 31, 2017, about half of CHCs were at less than 80% of their targeted panel size, yet these CHCs still received the same level of base funding year after year. Similarly, the LHINs did not increase base funding to those CHCs that exceeded their targeted panel size.

The addition of newcomers to Ontario communities can increase CHCs' caseloads. A number of CHCs we visited indicated that they had seen an influx of newcomers, especially Syrian refugees, to their centres in recent years. Both the Ministry and the LHINs expect CHCs to provide primary-care and community services to these newcomers; however, the CHCs received no additional base funding to provide services.

One CHC we visited told us that it met the surge in demand by contracting a physician using surplus funds it had from not being able to hire a physician full-time, but could only accept Syrian refugees with complex issues as it was already providing care to patients close to its targeted capacity. Additionally, two other CHCs we visited informed us that they received one-time funding only from their respective LHIN, and that continued services to Syrian refugees are absorbed by their base funding. Two other CHCs received no additional funding for Syrian refugee clients and instead used existing funding to support these clients.

The accountability agreement between the LHIN and the CHC does not explicitly require each CHC to report the number of patients registered against the targeted panel size to its LHIN. As a result, three of the four LHINs we visited do not collect data from their CHCs on the actual number of patients served. The one LHIN that does collect this information did not adjust funding to the CHCs in the region if they did not meet their targeted panel size. Instead, it expects CHCs not achieving the target to improve in the following reporting period.

As also noted in **Section 4.4.3**, the LHINs do not track the number of clients who access community programs only, limiting the LHINs' ability to evaluate whether funding for these programs should be adjusted, if necessary.

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.

RESPONSE FROM LHINs

The LHINs will continue to monitor and assess funding to support CHCs to meet the needs of Ontarians. LHINs formally review CHC funding annually to assess the appropriateness of funding and service to patients. This process takes into account the unique characteristics of the patients within the CHC community and comparison to provincial benchmarks. Nevertheless, the LHINs will evaluate if other factors, such as the number of people served and geographic location, should be included in their assessment of funding.

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

Dissemination of best practices can help the sector innovate, reduce inefficiencies, and provide more effective and higher quality services. Consultants who conducted the Ministry-commissioned strategic review of the CHC program in 2001 recommended that the Ministry support the dissemination of best practices. The Ministry indicated that dissemination of information on best practices is mainly the responsibility of health-care providers' associations and Health Quality Ontario.

We looked at the Association of Ontario Health Centres, which represents 74 of the 75 CHCs, and we found that the Association has shared best practices among CHCs, particularly through its annual conference materials and sessions. We noted that conference topics in 2017 and 2015 covered areas such as supporting Syrian refugees, incorporating telemedicine in CHC practice, integrating a physiotherapist with clinical staff, and engaging and serving francophone populations.

With respect to Health Quality Ontario, the Ministry noted that the *Patients First Act, 2016* includes measures to provide statutory authority for Health Quality Ontario to recommend evidence-based quality standards for health-service providers (including CHCs) and the LHINs to appoint local clinical leads whose responsibilities include the promotion of clinical standards. At the time of our audit, not all LHINs had appointed clinical leads. Health Quality Ontario has recommended some quality standards that would be relevant to CHCs, which focus on patient conditions where there are large variations in how care is delivered.

We found, however, that given the Ministry has had direct oversight responsibilities for most of Ontario's inter-professional primary-care models for many years, it 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.

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*; and
- develop and implement a mechanism to compile and share best practices from all inter-professional primary-care models, including CHCs.

MINISTRY RESPONSE

The Ministry acknowledges the importance of ensuring that primary-care best practices at a local level are disseminated across the province. The dissemination of best practices is not only an opportunity for CHCs, but for the health-care system as a whole.

Health Quality Ontario (HQO) has a mandate to support continuous quality improvement within Ontario's health system and to make

recommendations to health-care organizations and other entities on evidence-based clinical care standards. Under the *Patients First Act, 2016*, the role of Health Quality Ontario has been expanded to include making recommendations to the Minister concerning clinical care standards and performance measures. Through the recently established Quality Standards Council, experts from a variety of fields, including primary care, review best practices and associated evidence for the purpose of broad dissemination to primary care and other parts of the health-care system as a means of reducing variation and improving the overall quality of health services. The Ministry plans to continue supporting HQO in this endeavour and leveraging the benefits to the sector that will come with improved dissemination of best practices.

In addition to the clinical care standards currently in place, over the next year HQO plans to release additional standards for conditions such as opioid use disorder and chronic obstructive pulmonary disease.

The *Patients First Act, 2016* has significantly enhanced the role of the LHINs to be the single point of accountability for local and regional health-service planning, delivery and performance management. This will require engagement with the health system at all levels, including primary-care providers. A central component of the Patients First strategy was the establishment of an integrated clinical leadership structure for LHINs. The Ministry will work with the LHINs to establish processes and/or a platform to enable effective clinical engagement across the health-care system to improve the sharing of best practices and innovation.

To support these initiatives, the Ministry also funds the Health Links program to improve local connections and communication between primary health care and the rest of the health-care system to ensure more equitable access and a smoother patient experience. HQO is a key partner in ensuring the success of the Health Links program, including the delivery of the Best Practices Framework, deployment of quality improvement specialists across Ontario to help Health Links achieve its quality improvement goals, and capturing Health Link indicators on a quarterly basis.

RESPONSE FROM LHINs

The LHINs will continue to identify and share best practices from across the health system. For example, LHINs have partnered with Health Quality Ontario to facilitate the local implementation of Clinical Quality Standards. This is a key function of the clinical leads in each LHIN subregion, who work with all health-service providers, including CHCs, to ensure that patients have access to high-quality, patient-centred health care.

Appendix 1: Examples of Community Health Centre Client Experiences

Source of data: Selected Community Health Centres

Note: The names, locations and identifying details have been changed to protect privacy.

Kevin's Story

Kevin is a 70-year-old man who came to Canada, where his extended family was living, in 1989. He was without status in Ontario after his visitor's visa expired. In 2006, he began to experience medical symptoms that required clinical services, which he was unable to pay for. By 2007, he was introduced by his niece to a health promoter at a Community Health Centre (Centre) who worked with seniors. The health promoter introduced Kevin to the case co-ordinator for intake for primary care. By this time, Kevin's health, food security and finances had deteriorated. He was sent for tests and diagnosed with Parkinson's disease for which he would require lifelong medications. Case co-ordination continued to assist him with social, immigration, food security and financial support. He was able to access medications through a combination of samples and pharmaceutical company compassionate medication programs offered through the Centre. He was also able to access foot care through a referral to a chiropodist. Being without status for more than 20 years meant he was unable to access any government services. With the help of his case co-ordinator, he applied for status on humanitarian and compassionate grounds. In 2009, he was able to secure legal status and was referred to an immigration lawyer. Kevin could not have imagined success without his perseverance and that of the staff at the Centre. He described that he had never come across such an organization that worked so hard on behalf of its clients and really goes above and beyond the call of duty. Kevin felt that he is alive today because of his religious faith and the Centre's impact on his life medically, socially, mentally and emotionally.

Denise's Story

Denise has been affiliated with a Community Health Centre (Centre) for the last 15 years. She was introduced to the Centre by her mother and her two brothers. Denise's family had been volunteers for various programs offered at the Centre. In 2003, Denise went to her doctor at the Centre to get results of a biopsy and was diagnosed with breast cancer. The doctor arranged for her to see the surgeon. During the next year and a half, she was under constant care from both the doctors at the Centre as well as the nurse practitioners, who were always available when the doctors were busy with other patients. When Denise had a heart attack, she was referred to a dietitian and other interdisciplinary care at the Centre, such as a physiotherapist. She was referred to the Fitness for Health program by her doctor, a joint program run by the Centre and the YMCA, which allowed her to use YMCA facilities to exercise. Denise also joined the Centre's walking group for six weeks. She cannot express enough gratitude for what the Centre has done for her and for what it has done for the community. She exclaims that she is eager to experience all the other programs at the Centre. Denise feels that the Centre is doing its utmost to provide assistance wherever it can to people who need it.

Appendix 2: Key Events Relating to Ontario's Community Health Centres, 1970s–2017

Prepared by the Office of the Auditor General of Ontario based on information provided by the Ministry of Health and Long-Term Care

Year	Event
1970s	Ontario's CHC program had pilot status within the Ministry of Health and Long-Term Care (Ministry). At that time, Ontario had a total of 9 urban health centres in Ottawa and Toronto.
1984	The Ministry established the CHC program, recognizing CHCs as a part of Ontario's primary health-care system.
2000	The Office of the Auditor General of Ontario (formerly the Office of the Provincial Auditor of Ontario) conducted a value-for-money audit on the CHC program.
2001	The Ministry commissioned two external consultants to conduct a strategic review of the CHC program.
2004	The Ministry announced an expansion of CHCs by 10 satellite sites to extend the services of existing CHCs to areas where these services are needed.
2005	The Ministry announced an expansion of CHCs by 22 additional CHCs and 17 satellite sites.
2006	Ontario's 14 Local Health Integration Networks (LHINs) were established under the *Corporations Act* and continued under the *Local Health System Integration Act, 2006*.
2011	Accountability and base operating funding for CHCs were devolved from the Ministry to the LHINs.
2017	Current network of CHCs in Ontario includes 75 CHC corporations with a total of 145 locations.

Appendix 3: Comparison of Inter-Professional Primary Care Models in Ontario

Prepared by the Office of the Auditor General of Ontario

Model	Community Health Centres (CHCs)	Family Health Teams (FHTs)	Nurse Practitioner–Led Clinics (NPLCs)	Aboriginal Health Access Centres (AHACs)
Description	• Provide services in five key areas: primary care, illness prevention, health promotion, community capacity building and service integration. • The professional team of a CHC is composed of a physician, nurse practitioners and other health professionals, which may include a dietitian, social workers, nursing staff, physiotherapists, etc. • Designed to address social determinants of health and provide services to uninsured clients.	• Team of family physicians, nurse practitioners, registered nurses, social workers, dietitians and other professionals who work together to provide primary health care for their community. • Each FHT is set up to serve local health and community needs. For example, an FHT in Northern Ontario may provide primary care as well as other services catered to the needs of First Nations groups.	• Provide comprehensive primary-care services in underserved areas where it is difficult to employ or attract physicians. • Work to improve the quality of care through enhanced health promotion, disease prevention, mental health care and chronic disease management. • Nurse practitioners, along with collaborating physicians, are the lead primary-care providers. Other professionals may include registered nurses, dietitians, social workers, health promoters, mental health workers, physiotherapists and other health-care providers.	• Similar to CHCs but target Indigenous populations. • Offer a blend of traditional Indigenous approaches to health and wellness and contemporary primary health care in a culturally appropriate setting. • Teams are made up of physicians, nurse practitioners and traditional healers, and include other professional staff such as dietitians and social workers.
Governance model	Community-based board of directors	Three possible governance models: community-based, provider-based, or mixed (a combination of community- and provider-based governance)	Community-based board of directors	Community-based board of directors representing Indigenous communities
Year(s) established	1970s Expansion 2004 to 2013	Formally established in 2005. Original Family Health Networks (predecessor model) were created in the late 1990s and underwent changes over the years	2007	1995
Number as of March 2017	75	184	25	10

Model	Community Health Centres (CHCs)	Family Health Teams (FHTs)	Nurse Practitioner–Led Clinics (NPLCs)	Aboriginal Health Access Centres (AHACs)
Primary population/ demographics served	Priority populations include individuals who are: • homeless or low-income • new immigrants • uninsured • considered to have complex mental health issues • facing barriers to access primary care as a result of socio-demographics including age, race, sexual orientation, language, etc. Some CHCs have an Indigenous and/or francophone focus.	All population	All population	Indigenous population
# of clients as of March 2017	About 500,000	About 3.4 million	About 56,000	About 93,000
Accountable to	Local Health Integration Networks	Ministry of Health and Long-Term Care	Ministry of Health and Long-Term Care	Ministry of Health and Long-Term Care

Appendix 4: Audit Criteria

Prepared by the Office of the Auditor General of Ontario

1.	Roles and responsibilities are clearly defined and accountability requirements are established to facilitate the delivery of care and services to program users in a collaborative manner in accordance with legislative, contractual and program requirements.
2.	Programs and services are developed to meet client needs and are accessible. Unmet service needs are monitored and resources allocated or planned for accordingly.
3.	Funding allocations are applied to programs based on established needs, commensurate with the value of services to be provided, and evaluated on a timely basis.
4.	Performance measures and targets are established, monitored and compared against actual results to ensure that the intended outcomes are achieved and that corrective actions are taken on a timely basis when issues are identified.
5.	Accurate, timely and complete financial and operational information is regularly collected from the Community Health Centres to assess their performance, effectiveness and efficiency, and results are publicly reported.

Appendix 5: Primary-Care Performance Measurement Framework

Source of data: Health Quality Ontario