

Who Doesn't Deserve Excellent Care?

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Abstract

Discussion on implementation of the Excellent Care for all Act, 2010 (ECFA Act), Bill 46, has focused on the hospital sector in Ontario, but it also has relevance outside the hospital setting. As primary healthcare, long-term care and home care all receive public funding, these sectors should be expected to be compliant with Bill 46. But does the act also govern government-funded (i.e., by other than the Ministry of Health and Long-Term Care) community-based programs such as adult day programs, meals-on-wheels, nutrition programs for children, and more? We propose that we cannot exclude any of these essential programs. We also consider the non-hospital sector and health organizations that do not receive public funding.

The healthcare system will be well served if we consider whether the ECFA Act's key elements should be implemented across the system both vertically and horizontally. Vertical implementation in the hospital sector could be followed by primary care, home and community care, long-term care, and the rest of the vertical silos within the healthcare system. But by taking the horizontal approach, all sectors within and outside of what we traditionally think of health would be integrated using an evidence-informed and outcome-based approach and methodology.

Bill 46, the Excellent Care for All Act, 2010 (ECFA Act), was passed in Ontario to govern and strengthen healthcare organizations, including hospitals and other organizations that are provided for in the regulations and that receive public funding (Legislative Assembly of Ontario 2010).

To date, the discussion has focused on implementation of the ECFA Act in the hospital sector in Ontario, but it is essential to also examine its relevance outside the hospital setting. The obvious questions deal with what is expected from primary healthcare, long-term care and home care settings. After all, they receive public funding and are an essential part of the healthcare continuum. Based on the language of the act, all of these sectors should be expected to be compliant with Bill 46. Going one step further, however, the question needs to be asked, "Does the act also govern government-funded (i.e., by other than the Ministry of Health and Long-Term Care) community-based programs such as adult day programs, meals-on-wheels, nutrition programs for children, and more?" These types of community-based programs are an essential part of our healthcare programs or, maybe more correctly, illness programs. If the act is about excellent care for all, we propose including these essential programs, as they are important contributors to good care.

The hospital component of patient/person/client-centred "excellent care" constitutes only a minor part of the care experience of most Canadians. For example, providing an excellent care-centered approach with patients with type II diabetes would include evidence-informed, team interdisciplinary care (dietitians, social workers and more), as well as preventive care for the patient and the family. A patient receiving such a comprehensive level of care would be less likely to subsequently require dialysis, amputation or other acute care hospitalizations. By including the family in preventive care measures, we might be able to stop or delay the onset of type II diabetes in other individuals.

The EFCA Act and Considerations for the Non-hospital Sector

The elements of Bill 46 provide a solid foundation for making Ontario “the healthiest place in North America” as stated in *Ontario's Action Plan for Health Care* (Government of Ontario 2012). To achieve this goal, the EFCA Act has seven key elements that lay out the actions to be undertaken by publicly funded healthcare organizations. These are (1) establish quality committees that report on quality-related issues; (2) put annual quality improvement plans in place and make these available to the public; (3) link executive compensation to the achievement of targets set out in the quality improvement plan; (4) put patient/care provider satisfaction surveys in place; (5) conduct staff surveys; (6) develop a declaration of values, following public consultation; and (7) establish a patient relations process to address and improve the patient experience (Legislative Assembly of Ontario 2010).

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Keeping these key elements in mind, and considering how the non-hospital sector might comply with the act, we need to think about the following questions:

- What is quality, and who is responsible for achieving it? What does evidence-based or evidence-informed mean outside of hospital walls?
- What are the structural adjustments needed to build and achieve the spirit of the EFCA Act, coupled with *Ontario's Action Plan for Health Care*?
- How will the EFCA Act ensure that quality is improving beyond individual organizations and/or sectors to the system level?

In the following sections, we consider each of these important issues.

1. What is quality, and who is responsible for achieving it?

The concept of quality is different in the hospital sector from the home and community care, long-term care or primary care sectors. According to Goodwin and Lange (2011: 49):

Quality and safety are not just parallel imperatives; rather, they are inextricably linked concepts that rely on each other to function effectively. Safety for clients or patients is complex when multiple organizations, regulated and unregulated paid providers and unpaid family caregivers make up the team providing care in an uncontrolled home environment.

In the hospital sector, we can develop a best practice guideline for wound care or fall prevention, and the system and environment can be structured to monitor compliance of regulated and unregulated professionals who are largely employees of the hospital or have hospital privileges. The reality in the home is very different. In the home setting while the professionals providing care follow best practice guidelines, the home environment is managed by the family and the other factors related to care are not managed and monitored by the healthcare team. Organizations that provide care in the home are held accountable to organize their care in accordance with evidence-based, evidence-informed guidelines. Furthermore, similar to the hospital sector, organizations are expected to assess the practices of their staff in accordance with organizational care standards.

At this point, similarities between hospital and home end. If a nurse goes into a home and makes an assessment on a client's level of risk of falls, the nurse can recommend how to reduce the risk of falling. For example, he or she can suggest putting away the area rug, as it poses a risk for tripping. The decision about whether to accept the nurse's recommendation is in the hands of the client and family. If the family chooses not to accept the evidence-based recommendations and the patient falls, breaks a hip or worse, where does the accountability lie?

How will we uphold the client's right to live in an environment that he or she chooses? How will quality be measured in this patient-centred paradigm? Analysis of the situation would demonstrate that the nurse provides the best possible advice, but the decision to take that advice rests with the client. Providing care in the home limits the elements of professional control over the environment and decisions that are made.

2. What are the structural adjustments needed to build and achieve the spirit of the EFCA Act coupled with *Ontario's Action Plan for Health Care*?

In addition to the previous issue, we also have to examine several structural issues that contribute to the implementation of the EFCA Act. Bill 46 identifies the Local Health Integration Networks (LHINs) as the responsible agency to receive and approve plans. While the accountability model is correct and might work if you have ten or more hospitals in your LHIN, how will it work in community settings, primary care offices and other settings, of which there are hundreds in any LHIN. Furthermore, many of these organizations are small or medium-sized, with limited or no resources. Let's not forget that the main economic engine in Ontario (and, in fact, Canada) is small and medium-sized organizations, which employ the majority of the workforce. Many of these organizations will not have the resources needed to build plans, submit reports and stay on top of best practice guidelines.

We need to put in place structures and/or financial supports that guarantee achievement of the EFCA Act's expected outcomes without breaking the backs of these organizations.

3. How will the EFCA Act ensure that quality is improving beyond individual organizations and/or sectors to system level improvement?

The elements of the EFCA Act are solid and will enhance the quality of care as it is applied across the various sectors, as planned. Ontarians who access healthcare, however, will not fully realize the benefit until measurements of "excellent care" are extracted at the system level. Success will come only when we measure the "in-between," which includes transitions between sectors and the impact that decisions made within one sector affect client outcomes in another.

The overall healthcare system will be well served if we consider whether the EFCA Act's seven key elements should be implemented across the system both horizontally and vertically. Vertical implementation will follow the current pattern. The act is currently implemented in the hospital sector, and this could be followed by primary care, home and community care, long-term care, and the rest of the vertical silos within the healthcare system. Another approach, and one that will lead to better care and better clinical and fiscal value, is a horizontal implementation of the act. Under this approach, for example, diabetes, one of the leading chronic diseases, can be targeted and managed in the context of population health. In the horizontal implementation, organizations or agencies involved in impacting the individual or community would be required to comply with the element of the act. By taking the horizontal approach, all sectors within and outside of what we traditionally think of health would be integrated using an evidence-informed and outcome-based approach and methodology. Communities could target areas of concern in their population, be they a chronic disease and/or a social determinant of health. By doing so, we will advance both the global and local approach, leading to the achievement of better care, better value and better health.

To implement the EFCA Act in an integrated manner, LHINs must play an active role. LHINs are established to advance the planning of an integrated system. This can be achieved by ensuring comprehensive planning, monitoring and compliance evaluation systems. Having one global framework that takes into account the elements of the act, coupled with the remaining integration agenda, will lead to a better system than the one we have today.

We aim for patient-centred excellent care; we also need to aim for collaborative integrated system partnership where government, funders, LHINs, regulators and others work smarter so that Ontario becomes the healthiest place in North America by 2020. **HQ**





About the Authors

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