CITY OF HAMILTON

PUBLIC HEALTH SERVICES

Office of the Medical Officer of Health

TO:	Mayor and Members Board of Health
COMMITTEE DATE:	February 18, 2016
SUBJECT/REPORT NO:	Patients First Discussion Paper – Board of Health Response (BOH16005) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Dr. Julie Emili 905-546-2424 Ext. 2169
SUBMITTED BY & SIGNATURES:	Jessica Hopkins, MD, MHSC, CCFP, FRCPC Acting Medical Officer of Health Public Health Services

RECOMMENDATION

(a) That staff be directed to prepare a letter to the Minister of Health and Long-Term Care for submission by the Mayor on behalf of the Board of Health as an official response to the "Patients First: a proposal to strengthen patient-centred health care in Ontario" discussion paper, and that the letter include the following:

(i) That the Board of Health supports the recommendations of the Patients First discussion paper in principle, but that the Minister of Health and Long-Term Care engage in a consultative process with local public health units and municipalities with respect to implementation of the Patients First objectives,

(ii) That Local Health Integration Network (LHIN) governance include a mechanism for municipal involvement in health system decision-making with the specific mechanism to be determined in consultation with local municipalities,

(iii) That LHIN decision-making, including health system planning and allocation of funding to public health units and health care organizations, be done through a transparent process,

(iv) That to maintain a strong local public health system responsive to the needs of the local community, the Medical Officer of Health retain decision-making authority independent of the LHIN and that the role of the Board of Health in local public health governance be maintained,

(v) That funding directed to local public health units cannot be reallocated by the LHIN to other health services,

(vi) That the summary of themes raised through consultation with Board of Health members be included in the letter to the Minister of Health and Long- Term Care; and,

(vii) That copies of the letter be forwarded to the Hamilton Niagara Haldimand Brant (HNHB) LHIN, the Association of Local Public Health Agencies (alPHa), other Boards of Health of Ontario, the Association of Municipalities of Ontario (AMO), and the Council of Ontario Medical Officers of Health (COMOH).

(b) That the Board of Health endorse the Medical Officer of Health's letter to the Minister of Health and Long-Term Care providing feedback on the Patients First discussion paper.

EXECUTIVE SUMMARY

The Ministry of Health and Long-Term Care (MOHLTC) released *Patients First:* a *proposal to strengthen patient-centred health care in Ontario* on December 17, 2015 (see Board of Health Meeting January 11, 2016 items 7.1 and 11.4). The discussion paper proposes to expand the role of the Local Health Integration Networks (LHINs) with the goal of reducing gaps and strengthening patient centred care. This expanded role will include funding and accountability for public health. The proposal contains four components:

1) More effective integration of services and greater equity;
2) Timely access to primary care, and seamless links between primary care and other services;
3) More consistent and accessible home and community care; and,
4) Stronger links between population and public health and other services.

The MOHLTC has requested input on the proposal by February 29, 2016 and put forward questions for discussion. A process was developed to collect feedback from Board of Health members through a survey and focus groups. This report summarizes the results of the survey and focus groups completed with members of the Board of Health (attached as Appendix B) and the response from the Medical Officer of Health (attached as Appendix C).

Key themes from this consultation included:

- General support for the principles included in the paper, but need for consultation about how the proposal is implemented;
- Support for the focus on improving patient care and patient experience as the path towards improving the health system in Ontario;
- LHIN boundaries should follow health unit boundaries or Hamilton should be a sub-region of the LHIN;
- The LHIN board should include elected representation that will reflect the community perspective;
- Need for transparency in how LHINs operate, the new governance structure and funding model;
- Measurement and accountability mechanisms need to be created and implemented within the new system;
- Importance for the Board of Health to retain decision-making for local issues;
- The Medical Officer of Health should continue to have authority over public health decision and influence over decisions in health care that may affect population health; and,
- Concern that funding will be re-allocated from public health to the larger health system.

FINANCIAL - STAFFING - LEGAL IMPLICATIONS

Financial: None

Staffing: None

Legal: None

HISTORICAL BACKGROUND

The MOHLTC released *Patients First:* a *proposal to strengthen patient-centred health care in Ontario* on December 17, 2015 (attached as Appendix A).

The Medical Officer of Health provided an overview of the discussion paper at the January 11, 2016 Board of Health meeting and outlined a process for receiving feedback from Board of Health members (http://hamilton.siretechnologies.com/sirepub/mtgviewer.aspx?meetid=871 &doctype=AGENOA item 7.1).

POLICY IMPLICATIONS AND LEGISLATED REQUIREMENTS

The Patients First discussion paper proposes to expand the role of the Local Health Integration Networks (LHINs) with the goal of reducing gaps and strengthening patient centred care. The proposal contains 4 components:

1) More effective integration of services and greater equity;
2) Timely access to primary care, and seamless links between primary care and other services;
3) More consistent and accessible home and community care; and
4) Stronger links between population and public health and other services.

To better integrate local population and public health planning with other health services, the report proposed to formalize linkages between LHINs and public health units:

- Create a formal relationship between the Medical Officers of Health and each LHIN for the planning of population health services.
- Transfer dedicated provincial funding for public health units to the LHINs for allocation to public health units.
- LHINs assume responsibility for accountability agreements with public health units.
- Local boards of health would continue to set budgets.
- Boards of health would continue to be managed at municipal level.
- Expert panel to be appointed to advise on opportunities to deepen partnership between LHINs and public health units.

RELEVANT CONSULTATION

A survey that included all of the questions for discussion from the proposal was sent to the Board of Health for completion and 3 focus groups were held with Board of Health members. The results of this report are based on 7 responses.

Community and Emergency Services staff reviewed the Patients First discussion paper and provided the following comments which are aligned with themes identified by Board of Health members:

- The Ministry of Health and Long-Term Care is to be commended on the intention to strengthen the health care system to reduce the fragmentation that creates health inequity;
- There is concern that it would be a loss to community services if public health units focus more on issues surrounding the health care system and the treatment of patients rather than the prevention of illness and disease;
- The accountability lines between public health units and the LHINs are unclear and clarity is necessary to ensure effective health planning that addresses population health and health inequities; and,

- The discussion paper may have implications for access to information and the ability to conduct community-wide service planning. Changes to legislation, such as the Personal Health Information Protection Act, may be needed to ensure access to "health" information for non-MOHLTC-funded public services that would collaborate in local planning (e.g., Best Start Network)

ANALYSIS AND RATIONAL FOR RECOMMENDATION

The detailed results of the survey and focus group are outlined in Appendix B of this report. There was general support for the principles included in the paper, but the need for consultation about how the proposal is implemented was identified. BOH Members were supportive of the focus on improving patient care and patient experience as the path towards improving the health system in Ontario.
The importance of ensuring the Board of Health retained its authority for local decision making and that the Medical Officer of Health continue to have authority over decisions impacting public health and influence over decisions in health care that may impact public health were identified. BOH Members also expressed concerns that funding could be re-allocated from public health to the larger health system.

A number of suggestions were made that would help ensure clarity and transparency with the proposed new governance model including:

- LHIN boundaries should follow health unit boundaries or Hamilton should be a sub-region of the LHIN
  - The LHIN board should include elected representation that will reflect the community perspective
  - Need for transparency in how LHINs operate, the new governance structure and funding model
  - Measurement and accountability mechanisms need to be created and implemented within the new system

ALTERNATIVES FOR CONSIDERATION

The Board of Health could choose not to submit a formal response, but this alternative is not recommended.

ALIGNMENT TO THE 2012 - 2015 STRATEGIC PLAN

Strategic Priority #1 - A Prosperous and Healthy Community

1.5 Support the development and implementation of neighbourhood and City wide strategies that will improve the health and well-being of residents.

Strategic Priority #2 - Valued and Sustainable Service

2.2 Improve the City's approach to engaging and informing citizens and stakeholders

Strategic Priority #3 - Leadership and Governance

3.1 Engage in a range of inter-governmental relations (IGR) work that will advance partnerships and projects that benefit the City of Hamilton.

APPENDICES AND SCHEDULES ATTACHED

Appendix A to Report BOH16005 - Patients First discussion paper

Appendix B to Report BOH16005 – Summary of themes identified through the consultation process with Board of Health Members

Appendix C to Report BOH16005 – Letter to the Minister of Health and Long-Term Care from the Medical Officer of Health

PATIENTS FIRST

A PROPOSAL TO STRENGTHEN PATIENT-CENTRED HEALTH CARE IN ONTARIO

DISCUSSION PAPER
December 17, 2015

Ontario

PATIENTS FIRST

Message from the Minister of Health and Long-Term Care

Over the past decade, Ontario's health care system has improved significantly. Together, we have reduced wait times for surgery, increased the number of Ontarians who have a primary health care provider and expanded services for Ontarians at home and in their communities. There are, however, a number of areas where we need to do more.

Too often, health care services can be fragmented, uncoordinated and unevenly distributed across the province. For patients, that means they may have difficulty navigating the system or that not all Ontarians have equitable access to services. Too often our system is not delivering the right kind of care to patients who need it most.

The next phase of our plan to put patients first is to address structural issues that create inequities. We propose to truly integrate the health care system so that it provides the care patients need no matter where they live. Our proposal is focused on population health and integration at the local level. It would improve access to primary care, standardize and strengthen home and community care, and strengthen population and public health. It would also ensure that services are distributed equitably across the province and are appropriate for patients.

With this paper, we are seeking your input on our proposal, and your advice about how to integrate other improvements including, for example, community mental health and addictions services. Through this engagement process, we want to hear from providers, patients and caregivers around the province, in cities and rural communities, in our diverse cultural communities and in our French-language communities. We want to engage with First Nations, Métis and Inuit partners about how this process can complement our ongoing work to strengthen health outcomes in Indigenous communities.

As Ontario's Minister of Health and Long-Term Care, I am excited that we have the opportunity to work together to continue developing one of the best health care systems in the world—a system that truly puts patients first. I hope you will join us, and contribute your expertise. We can't succeed without it.

Dr. Eric Hoskins
Minister of Health and Long-Term Care

EXECUTIVE SUMMARY

PUTTING PATIENTS FIRST

Ontario is committed to developing a health care system that puts patients first. Over the past 10 years, the province has improved access to primary care, provided more care for people at home, reduced hospital wait times, invested in health promotion programs, and taken steps to make the system more transparent and more accountable. But there are still gaps in care.

GAPS IN CARE

Ontarians, including patients, care providers and system experts have identified challenges in our health care system.

- Some Ontarians – particularly Indigenous peoples, Franco-Ontarians, members of cultural groups (especially newcomers), and people with mental health and addiction challenges – are not always well-served by the health care system.
- Although most Ontarians now have a primary care provider, many report having difficulty seeing their provider when they need to, especially in evenings, nights or weekends — so they go to emergency departments and walk-in clinics instead.
- Some families find home and community care services inconsistent and hard to navigate, and many family caregivers are experiencing high levels of stress.
- Public health services are disconnected from the rest of the health care system, and population health is not a consistent part of health system planning.
- Health services are fragmented in the way they are planned and delivered. This fragmentation can affect the patient experience. It can also result in inefficient use of patient and provider time and resources, and can result in poor health outcomes.

Many of these challenges arise from the disparate way different health services are planned and managed. While local hospital, long-term care, community services, and mental health and addiction services are all planned by the province's 14 Local Health Integration Networks (LHINs), primary care, home and community care services and public health services are planned by separate entities in different ways. Because of these different structures, the LHINs are not able to align and integrate all health services in their communities.

A PROPOSAL TO STRENGTHEN PATIENT-CENTRED CARE

To reduce gaps and strengthen patient-centred care, the Ministry of Health and Long-Term Care is proposing to expand the role of the Local Health Integration Networks. In *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*, the ministry provides more detail about the four components:

1. **More effective integration of services and greater equity.**
   To make care more integrated and responsive to local needs, make LHINs responsible and accountable for all health service planning and performance.

   Identify smaller sub-regions as part of each LHIN to be the focal point for local planning and service management and delivery.

In their expanded role, LHINs would be responsible for working with providers across the care continuum to improve access to high-quality and consistent care, and to make the system easier to navigate – for all Ontarians. The LHIN sub-regions would take the lead in integrating primary care with home and community care.

2. **Timely access to primary care, and seamless links between primary care and other services.**
   Bring the planning and monitoring of primary care closer to the communities where services are delivered. LHINs, in partnership with local clinical leaders, would take responsibility for primary care planning and performance management.

The LHINs would work closely with primary care providers to plan services, undertake health human resources planning, improve access to inter-professional teams for those who need it most and link patients with primary care services. The ministry would continue to negotiate physician compensation and primary care contracts.

3. **More consistent and accessible home and community care.**
   Strengthen accountability and integration of home and community care. Transfer direct responsibility for service management and delivery from the Community Care Access Centres (CCACs) to the LHINs.

With this change, LHINs would govern and manage the delivery of home and community care, and the CCAC boards would cease to exist. CCAC employees providing support to clients would be employed by the LHINs, and home care services would be provided by current service providers. This shift would create an opportunity to integrate home and community care into other services. For example, home care coordinators may be deployed into community settings, such as community health centres, Family Health Teams and hospitals.

4. **Stronger links between population and public health and other health services.**
   Integrate local population and public health planning with other health services. Formalize linkages between LHINs and public health units.

The Medical Officer of Health for each public health unit would work closely with the LHINs to plan population health services. LHINs would be responsible for accountability agreements with public health units, and ministry funding for public health units would be transferred to the LHINs for allocation to public health units. Local boards of health would continue to set budgets, and public health services would be managed at the municipal level.

With the above four changes the ministry would continue to play a strong role in setting standards and performance targets, which would help ensure consistency across the province. The LHINs would be responsible for performance management, and for preparing reports on quality and performance that would be shared with the public and providers.

A PATH FORWARD

With *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*, the ministry will engage the public and providers to discuss the proposal. The ministry has many questions concerning how to plan for and implement the proposed approach successfully. The full paper includes a series of discussion questions. The ministry is committed to listening. You are invited to review the full paper at www.health.gov.on.ca/en/news/bulletin and submit feedback or pose questions to health.feedback@ontario.ca.

The ministry looks forward to continuing the conversation...and to taking the next steps towards building a high-performing, better connected, more integrated, patient-centred health system.

OUR PROMISE

Put Patients First

In the *Patients First: Action Plan for Health Care* (February 2015), the Ontario Ministry of Health and Long-Term Care set clear and ambitious goals for Ontario's health care system:

Access

Improve access - providing faster access to the right care.

Connect

Connect services - delivering better coordinated and integrated care in the community closer to home.

Inform

Support people and patients - providing the education, information and transparency Ontarians need to make the right decisions about their health.

Protect

Protect our universal public health care system - making decisions based on value and quality, to sustain the system for generations to come.

To achieve these goals, the ministry must put patients, clients and caregivers first. We must create a responsive health system where:

- care providers work together to provide integrated care,
- patients and their caregivers are heard and play a key role in decision making and in their care plans,
- people can move easily from one part of the system to another,
- someone is accountable for ensuring that care is coordinated at the local level.

OUR PROGRESS

Over the past 10 years, Ontario's health care system has made great progress in improving the patient experience:

- **More access to primary care.** Family physicians, nurse practitioners and other health care providers — often working in team-based practices — have improved access to primary care. Nearly four million Ontarians receive care through these new teams.
- **More care closer to home.** Home and community care providers are providing care for more clients — many with complex conditions — at home, for longer periods of time.
- **Shorter hospital wait times.** Hospitals have reduced wait times for most surgical procedures and improved emergency department wait times, despite the fact that the number of people needing these services continues to increase. Hospitals are actively using evidence, data and information on the patient experience to improve quality.
- **More support for people to stay healthy.** There is a greater focus on disease prevention and health promotion.
- **More protection for our health system.** The *Excellent Care for All Act, 2010* has put in place tools and processes that have increased transparency, enhanced the system's focus on quality, and engaged Ontarians in improving health system performance.

These accomplishments are the result of a great deal of planning and hard work by all parts of the health system: hospitals, primary care and specialized offices and clinics, home and community care, long-term care homes, LHINs, CCACs and other health service organizations that provide care to Ontarians.

TODAY, 94%
of Ontarians report having a regular primary health care provider.

Compared to 2003,
OVER 24,000
more nurses and
6,600
more physicians are providing patient care.

Physicians representing more than
10 MILLION ONTARIANS
now have electronic medical records.

OVER 80%
of primary care physicians use electronic medical records in their practice.

Flu shots are available in
2,500
pharmacies.

Vaccines and newborn screening programs have been expanded.

1,076
health care organizations submit annual Quality Improvement Programs.

A PROPOSAL
to Strengthen Patient-Centred Care

Despite the progress, there is still more to do. Listening to patients, clients, caregivers and providers, we know that some people can struggle to get the primary care and home and community care services they need, and they still find the system fragmented and hard to navigate. We also know services are not as consistent as they should be across the province.

What we have heard from Ontarians has been confirmed in a series of expert reports, including those developed by Health Quality Ontario, the Auditor General of Ontario, the Primary Health Care Expert Advisory Committee, the Expert Group on Home and Community Care, the Commission on the Reform of Ontario's Public Service (the Drummond Report), and the Registered Nurses' Association of Ontario.

To ensure Ontarians receive seamless, consistent, high quality care — regardless of where they live, how much they earn or their ethnicity — we must address the challenges that affect the system's ability to provide integrated patient-centred care.

Many of these challenges arise from the disparate way these different health services are planned and managed. Some — such as hospitals, long-term care, community services and mental health and addiction services — are planned and managed by the province's Local Health Integration Networks (LHINs). Others — such as primary care, home and community care services, and population and public health services — are currently planned and managed in different ways.

We propose expanding the LHINs' mandate to include primary care planning and performance management; home and community care management and service delivery; and developing formal linkages with public health to improve population and public health planning. Under this proposal, LHINs would assume responsibility for planning, managing and improving the performance of all health services within a region, while still maintaining clinician and patient choice.

In this paper, we describe in more detail the challenges facing the health care system as well as the structural changes being proposed. We also pose a series of questions for discussion.

IMPROVING HEALTH EQUITY AND REDUCING HEALTH DISPARITIES

Our proposed plan focuses specifically on ways to improve access to consistent, accountable and integrated primary care, home and community care, population health and public health services. Informing this proposal are the needs of diverse Ontarians who rely on our health care system, including seniors and people with disabilities, as well as health equity and the importance of the social determinants of health, such as income level and geography.

The ministry also recognizes that some Ontarians struggle to access health and social services.

- The health outcomes of **Indigenous Peoples in Ontario** — particularly those living in remote and isolated communities — are significantly poorer than those of the general population. Improving health care and health outcomes for First Nations, Métis and Inuit peoples is a ministry priority. This means the health care system must provide better supports and services for patients, families and caregivers, and these services must respect traditional methods and be culturally appropriate. To develop these services, we will build and maintain productive and respectful working relationships at both the provincial and local levels. We will meaningfully engage Indigenous partners through parallel bilateral processes. Through collaboration, we will identify the changes needed to ensure health care services address the unique needs of First Nations, Métis and Inuit peoples no matter where they live across the province.
- **Franco-Ontarians** face challenges obtaining health services in French. To meet their needs, and improve their patient experience and health outcomes, we must ensure that the health care system is culturally sensitive and readily accessible in French.
- Members of **other cultural groups, particularly newcomers**, may struggle to get the health care they need. As part of our commitment to health equity, the system must be able to recognize the challenges that newcomers face and provide culturally appropriate care and timely access.

- **People who experience mental health and addiction challenges** also face barriers to getting the care they need when they need it. The ministry is committed to strengthening mental health and addictions services. We will look to the work of the Mental Health and Addictions Leadership Advisory Council to ensure that changes in mental health and addiction services enhance access and improve overall system performance.

Over the next few years, as we continue to transform and restructure the health care system — making it more integrated, accessible, transparent and accountable — we will work to improve health equity and reduce health disparities. In their expanded role, LHINs would be responsible for understanding the unique needs of Indigenous peoples, Franco-Ontarians, newcomers, and people with mental health and addiction issues in their regions, and providing accessible, culturally appropriate services. At the same time, the ministry would pursue discussions with these partners to determine how best to adapt system structures to provide effective person-centred care.

THE PROPOSAL

1. More Effective Integration of Services and Greater Equity

THE ISSUE

The Ontario health care system offers excellent services, but they are fragmented in the way they are planned and delivered. This fragmentation can affect the patient experience. It can also result in inefficient use of patient and provider time and resources, and have a negative impact on health outcomes.

THE SITUATION NOW

Under the *Local Health System Integration Act, 2006*, the 14 LHINs are responsible for managing their local health systems. LHINs plan and manage performance in the acute care, long-term care, community services, and mental health and addictions sectors. Other services are managed differently. For example, CCACs are responsible for planning and contracting home care services and administering the placement process for long-term care. Although CCACs are accountable to the LHINs for their performance and receive funding from the LHINs, they have their own boards and operate rather independently. Other than the ministry, there is no organization accountable for planning primary care or specialist care services, and very little focus on managing or improving primary care performance. The province's public health services also have their own system for planning and delivering services.

Since their creation a decade ago, the LHINs have improved regional planning for and integration of some services. Across the LHINs, we've seen the impact of some successful efforts to integrate providers and services.

However, as the Auditor General recently noted, the LHINs lack the mandate and tools to align and integrate all health services. Under their current mandate, they cannot hold some parts of their local systems accountable or manage improvement in many service areas.

Through Health Quality Ontario, we also learned that there is variation across LHINs in terms of health outcomes. We have also heard that some LHIN boundaries may no longer fit patient care patterns in their communities.

EXAMPLES OF SUCCESSFUL INTEGRATION

- Collaborative care models, such as Family Health Teams, Community Health Centres, Aboriginal Health Access Centres and Nurse Practitioner-Led Clinics, allow health care providers to work together as an integrated team to deliver comprehensive care and coordinate services with a range of partners, including home and community care.
- Integrated service models, such as Health Links, bring together health care and other providers in a community to better and more quickly coordinate care for patients with complex needs.

To reduce gaps and ensure that services meet local needs, it is time to enhance the LHINs' authority. In a health care system focused on performance management and continuous quality improvement, it is also important for the ministry to hold the LHINs accountable for their performance. As part of any transformation, we must ensure their activities result in better access as well as greater consistency of services across the province.

PROPOSAL #1

To provide care that is more integrated and responsive to local needs, make LHINs responsible and accountable for all health service planning and performance.

Identify smaller regions as part of each LHIN to be the focal point for local planning and service management and delivery.

In their expanded role, LHINs would:

- Assess local priorities and current performance, and identify areas for improvement.
- Work with providers across the care continuum to improve patients' access to services, and make it easier for both patients and providers to navigate the system.
- Integrate and improve primary care, home and community care, acute care, mental health and addiction services and public health across the entire health care system.
- Drive the adoption of technology to enhance care delivery through, for example, integrated systems or virtual access to care providers through telemedicine.
- Prepare public reports about the patient experience with different health services and other reported outcomes to help drive improvements.

Although the LHINs have demonstrated that they are the right structure to enhance service integration, accountability and quality, they themselves would need some adjustments and additional tools to take on an expanded role. For example, their governance structures would need to be revisited (see Appendix) and their boundaries would need to be reviewed and possibly refined. In addition, LHINs would be asked to identify smaller geographic areas within their regions — or LHIN sub-regions — that reflect community geography, such as the current Health Links regions. Such LHIN sub-regions would be the focus for strengthening, coordinating and integrating primary health care, as well as more fully integrating primary care with home and community care, and ultimately fulfilling the clinical coordination responsibilities currently provided by the CCACs.

ACROSS ONTARIO'S 14 LHINs

- Life expectancy ranges between 78.6 and 83.6 years old.
- Smoking, obesity, and physical activity rates vary.
- The percentage of people who report that their health status is excellent or very good ranges from 6.8 per cent to 11.7 per cent.

In the transformed system, the ministry would retain its role in health workforce planning, in collaboration with LHINs and other partners.

QUESTIONS FOR DISCUSSION:

- How do we support care providers in a more integrated care environment?
- What do LHINs need to succeed in their expanded role?
- How do we strengthen consistency and standardization of services while being responsive to local differences?
- What other local organizations can be engaged to ensure patients are receiving the care they need when they need it? What role should they play?
- What other opportunities for bundling or integrating funding between hospitals, community care, primary care and possibly other sectors should be explored?
- What areas of performance should be highlighted through public reporting to drive improvement in the system?
- Should LHINs be renamed? If so, what should they be called? Should their boundaries be redrawn?

ANTICIPATED PERFORMANCE IMPROVEMENTS

- ✓ Care delivered based on community needs
- ✓ Appropriate care options enhanced within communities
- ✓ Easier access to a range of care services
- ✓ Better connections between care providers in offices, clinics, home and hospital

2. Timely Access to Primary Care, and Seamless Links Between Primary Care and Other Services

THE ISSUE

Despite a significant increase in the number of primary care providers, in some cases, Ontarians still find it difficult to get care when they need it. As a result, many patients use costly emergency departments for primary care problems. At the same time, primary care providers report that, because of the way the system is organized, they find it difficult to connect their patients to the other health services they need.

THE SITUATION NOW

All high-performing health care systems are based on strong primary care services delivered through a variety of models, including family doctors and primary care nurse practitioners working as part of inter-professional teams. Effective primary care is essential to improving health outcomes.

To understand how well Ontario's primary care services perform, Health Quality Ontario compared Ontario data with international data from the Commonwealth Fund. Compared to other developed countries, it found that Ontario performs poorly on access measures, such as same- or next-day appointments when people are sick or weekend after-hours appointments. It also found that, in Ontario, access to primary care is influenced by where people live and factors such as immigration status or the language spoken most often at home

57%
of Ontarians cannot see their primary care provider the same day or next day when they are sick.

52%
find it difficult to access care in the evenings or on weekends.

Low-acuity patients account for
34%
of emergency department visits.

The 2015 report *Patient Care Groups: A new model of population based primary health care for Ontario*, prepared by the Primary Health Care Expert Advisory Committee led by Dr. David Price and Elizabeth Baker, highlighted the challenges that primary care providers face when trying to connect their patients with other health services and suggested ways to address many of these challenges.

PROPOSAL #2

Bring the planning and monitoring of primary care closer to the communities where services are delivered. LHINs, in partnership with local clinical leaders, would take responsibility for primary care planning and performance management.

Set out clearly the principles for successful clinical change, including engagement of local clinical leaders.

Every Ontarian who wants a primary care provider should have one. Primary care should act as a patient's "Medical Home", offering comprehensive, coordinated, and continuous services and working with other providers across the system to ensure that patient needs are met. Making the LHIN and LHIN sub-regions the focal points for primary care planning and performance measurement would be a crucial step towards achieving these goals.

With the proposed approach:

- LHINs would work closely with primary care leaders, patients and providers to plan and monitor performance within each LHIN sub-region.

- Planning would include improving access to inter-professional teams for those who need it most, facilitating care plans and supporting an integrated, coordinated patient-centred experience.
- LHINs, in partnership with local clinician leaders, would be responsible for recruitment planning, linking new patients with doctors and nurse practitioners, and improving access and performance in primary care.
- To make it easier for patients to connect with primary care, each LHIN sub-region would have a process to match unattached patients to primary care providers.
- Existing relationships between patients and their care providers would continue. Patients will always have the right to choose their primary care provider, and the sub-regions would help patients change physicians or nurse practitioners to get care closer to home. Similarly, clinicians would retain choice for what patients they care for within their sub-regions.
- While LHINs would play a greater role in primary care health human resources planning, physician compensation and primary care contracts would continue to be negotiated by the government and administered centrally. Ontario Medical Association (OMA) representation rights would continue to be respected.
- To help drive continuous quality improvement in primary care, the ministry would more methodically measure patient outcomes in primary care to help understand the patient experience accessing primary care, including same-day and after-hours care, and satisfaction with service.
- LHINs would collect, assess and publish performance indicators at a sub-region level and share that information with health care providers and managers to support performance improvement, as well as to help inform the organization of primary care in each LHIN sub-region.

With the proposed emphasis on local care coordination and performance improvement, the primary care sector would be better positioned to meet the needs of communities across the province. These changes will enable the approach to Patient-Centered Medical Homes as recommended by the Ontario College of Family Physicians and others.

There are more than
12,000
primary care physicians in Ontario, and about
450
enter practice each year.

ANTICIPATED PERFORMANCE IMPROVEMENTS

- ✓ All patients who want a primary care provider have one
- ✓ More same-day, next-day, after-hours and weekend care
- ✓ Lower rates of hospital readmissions
- ✓ Lower emergency department use
- ✓ Higher patient satisfaction

QUESTIONS FOR DISCUSSION

- How can we effectively identify, engage and support primary care clinician leaders?
- What is most important for Ontarians when it comes to primary care?
- How can we support primary care providers in navigating and linking with other parts of the system?
- How should data collected from patients about their primary care experience be used? What data and information should be collected and publicly reported?

3. More Consistent and Accessible Home and Community Care

THE ISSUE

Home and community care services are inconsistent across the province and can be difficult to navigate. Many family caregivers who look after people at home are experiencing high levels of stress – due in part to the lack of clear information about the home care services available and how to access them. Primary care providers report problems connecting with home care services, and home care providers say the same thing about their links to primary care.

THE SITUATION NOW

The last major reform of home and community care was in 1996 with the creation of 43 CCACs responsible for planning, coordinating, delivering and contracting services designed to help people leave hospital earlier and stay independent in their homes for as long as possible. In 2007, the 43 CCACs were amalgamated to align geographically with the LHINs.

Timing of first nursing and personal support visits varies by Community Care Access Centre.

One-third of informal caregivers are distressed, twice as many as four years ago.

Bringing Care Home, the 2015 report of the Expert Group on Home and Community Care led by Dr. Gail Donner, highlighted the ongoing service challenges in the home and community care sector. According to that report, the current model is cumbersome. It lacks standardization across the province and is not consistently delivering the services that people need, including our growing population of seniors. However, the Expert Group encouraged the government to focus first on functional change before addressing any structural changes.

The ministry responded with the *Roadmap to Strengthen Home and Community Care*, which outlined a plan to improve care delivery. This work is well underway and includes bundled care initiatives, self-directed care and more nursing services at home for those who need them, among other initiatives.

The Auditor General recommended that the ministry revisit the model of home care delivery in Ontario — echoing recommendations in the 2012 report from the Commission on the Reform of Ontario's Public Service (the Drummond Report). In its 2012 report, *Enhancing Community Care for Ontarians*, the Registered Nurses' Association of Ontario also encouraged the ministry to review the duplication within the current home and community care system, and to improve linkages with primary care.

PROPOSAL #3

Strengthen accountability and integration of home and community care. Transfer direct responsibility for service management and delivery from the CCACs to the LHINs.

The ministry proposes to move all CCAC functions into the LHINs to help integrate home and community care with other parts of the health care system, and to improve quality and accountability. The proposed shift will create opportunities to embed home and community coordinators in other parts of the system.

Under this proposal:

- The LHIN board would govern the delivery of home and community care, and the CCAC boards would be dissolved.
- CCAC employees providing support to clients would be transitioned to and employed by the LHINs.
- Home care coordinators would be focused on LHIN sub-regions, and may be deployed into community settings (such as family health teams, community health centres or hospitals).
- Home care services would continue to be provided by current service providers. Over time, contracts with these service providers would be better coordinated and more consistent within the geographic model of the LHIN sub-regions.
- LHINs would be responsible for the long-term care placement process currently administered by CCACs.
- The ministry's ten-point plan for improving home and community care would continue under LHIN leadership.

While care planning and delivery would be done at the local level, the function of establishing clinical standards and outcomes-based performance targets for home and community care would be centralized. Having common standards and targets for the whole province will ensure more consistent and higher-quality care.

ANTICIPATED PERFORMANCE IMPROVEMENTS

- ✓ Easier transitions from acute, primary and home and community care and long-term care
- ✓ Clear standards for home and community care
- ✓ Greater consistency and transparency around the province
- ✓ Better patient and caregiver experience

QUESTIONS FOR DISCUSSION

- How can home care delivery be more effective and consistent?
- How can home care be better integrated with primary care and acute care while not creating an additional layer of bureaucracy?
- How can we bring the focus on quality into clients' homes?

4. Stronger Links Between Public Health and Other Health Services

THE ISSUE

Public health has historically been relatively disconnected from the rest of the health care system. Public health services vary considerably in different parts of the province and best practices are not always shared effectively. While local initiatives and partnerships have been successful, public health experts are not consistently part of LHIN planning efforts to improve population health. Many aspects of the health care system are not able to properly benefit from public health expertise, including issues related to health equity, population health and the social determinants of health.

THE SITUATION NOW

Public health services in Ontario are managed by 36 local public health units, whose mandate is to assess population health (e.g. the health status of their community) and implement programs to improve health. Because the public health system is municipally based, public health unit areas do not align with LHIN boundaries.

Improving population health is an important goal for both local public health units and the health care system as a whole. However, many of the complex social, economic and environmental factors that affect health — such as income, education, adequate housing and access to healthy foods — lie outside the health system. In their efforts to improve health, public health units look at how these complex determinants collectively affect the health of individuals and communities.

According to the 2015 Health Quality Ontario report, population health outcomes vary across our communities. To close these gaps, the health system needs more consistent and meaningful collaboration and coordination between public health, the rest of the health care system and LHINs.

While many important public health functions — such as restaurant inspections — do not overlap with health care planning or delivery, others — such as surveillance of reportable infectious diseases, documentation of immunizations, smoking cessation programs and other health promotion initiatives — do. Where the system's and public health's interests overlap, public health would benefit from more in-depth knowledge of the population's health status available through LHINs as well as the LHINs' ability to distribute health resources to address health inequities. LHINs would also benefit from greater access to public health expertise when planning health services.

PROPOSAL #4

Integrate local population and public health planning with other health services. Formalize linkages between LHINs and public health units.

To better integrate population health within our health system, we propose that LHINs and public health units build on the collaborations already underway, and work more closely together to align their work and ensure that population and public health priorities inform health planning, funding and delivery.

To support this new formal relationship:

- The ministry would create a formal relationship between the Medical Officers of Health and each LHIN, empowering the Medical Officers of Health to work with LHIN leadership to plan population health services.
- The ministry would transfer the dedicated provincial funding for public health units to the LHINs for allocation to public health units. The LHINs would ensure that all transferred funds would be used for public health purposes.
- The LHINs would assume responsibility for the accountability agreements with public health units.
- Local boards of health would continue to set budgets.
- The respective boards of health, as well as land ambulance services, would continue to be managed at the municipal level.

As part of a separate initiative to support more consistent public health services across the province, the ministry is modernizing the Ontario Public Health Standards and Organizational Standards to identify gaps and duplication in service delivery; determine capacity and resource needs; and develop options for greater effectiveness.

The ministry would also appoint an Expert Panel to advise on opportunities to deepen the partnership between LHINs and public health units, and how to further improve public health capacity and delivery.

ANTICIPATED PERFORMANCE IMPROVEMENTS

- ✓ Health service delivery better reflects population needs
- ✓ Public health and health service delivery better integrated to address the health needs of populations and individuals
- ✓ Social determinants of health and health equity incorporated into health care planning
- ✓ Stronger linkages between disease prevention, health promotion and care

QUESTIONS FOR DISCUSSION

- How can public health be better integrated with the rest of the health system?
- What connections does public health in your community already have?
- What additional connections would be valuable?
- What should the role of the Medical Officers of Health be in informing or influencing decisions across the health care system?

WHAT WOULD THE PROPOSED CHANGES MEAN FOR ONTARIANS?

Patients, clients and family caregivers would have one point of contact in each LHIN sub-region responsible for connecting them with a primary care provider, as well as other health services and resources. All Ontarians should have better access to inter-professional providers including specialists when they need them, including better access to same-day, next-day, and after-hours and weekend care.

Ontarians — including patients recovering from a stay in hospital and people who are frail or who have chronic conditions — would find it easier to understand, access and navigate the home and community care services available to them.

Patient choice will be respected. People who have pre-existing relationships with primary care providers outside their LHIN sub-region will not have to change providers. One of the guiding principles of home care during and after the transition will be ensuring continuity of care providers.

Physicians, nurses and other care providers would work in a system and structure that supports integration, helps them do their jobs, maintains their clinical autonomy, makes the most of their time and expertise, and sets clear accountabilities. Clinicians would benefit from improved access to personal health information that makes it easier to coordinate care and track the care patients receive in different parts of the system. Health care providers would also retain choice for deciding what patients they would care for.

Specialist physicians would benefit from local planning that enhances access to their services and promotes the use of technology (e.g. e-consult and e-referral) and shared care using telemedicine to provide services for complex patients who live far from specialty care.

Hospitals would benefit because changes in the primary care and home and community care sectors would enable them to provide more continuous care, and help address intractable problems such as high rates of hospital readmissions, alternate level of care and inappropriate use of emergency services.

PATIENT CHOICE WILL BE PROTECTED

- No one will have to change primary care providers.
- Care decisions will take into account where people live, work and go to school.
- There will be no new restrictions on long-term care home choices.
- There will be no new layer of bureaucracy between Ontarians and the health services they need.

CCAC employees perform essential work that will continue under this proposal. CCAC employees who support clients would be integrated into the LHINs and their collective agreements will be respected. Some CCAC coordinators may end up working in hospitals or primary care settings, but they will still be employed by the LHINs. The CCAC management structure would be reviewed in conjunction with the management structure of expanded LHINs in order to support service planning and delivery in a way that maximizes care for patients and clients while improving efficiency.

Public health staff would see no change in the critical work they do every day in their communities. However, they would have stronger links with other parts of the health system.

Long-term care leaders and employees would have better support in managing transitions for clients between acute home and community care, and long-term care. They should benefit from better service planning and delivery in the home and community sector.

The health system itself would be more efficient. There would be less duplication of services, better sharing of information and more effective use of technology to ensure quick access to health information, including lab results and diagnostic imaging. Connections across the full continuum of care would mean, for example, that family physicians receive hospital discharge summaries and providers in the acute sector receive community care assessments. Patients would also have access to publicly available information about health system performance that is specific and relevant to them.

A PATH FORWARD

The proposed structural changes to Ontario's health care system are designed to strengthen patient-centred care and deliver high-quality, consistent and integrated health services to all Ontarians. Implementing these changes while ensuring the continuity and improvement of high-quality services will require a well-thought-out and carefully implemented plan.

The ministry has questions about how to successfully plan for and implement this proposed approach. With the release of this discussion paper, the ministry will begin an engagement process to discuss the proposal and its refinement. The ministry is committed to listening to staff and clinicians, patients, clients and caregivers, other health care partners, Indigenous peoples, and municipal and other community and government partners.

We hope to receive feedback on the questions in this proposal, including:

- How can clinicians and health care providers be supported in leadership roles in continued system evolution?
- How do we ensure changes are supportive of and responsive to future service changes that are still being worked on, such as home and community care?
- How do we create a platform for further service integration, such as enhanced community mental health and addictions services?
- What accountability measures need to be put in place to ensure progress is being made in integrating health care services and making them more responsive to the needs of the local population?
- How do we support improved integration through enhanced information systems, data collection and data sharing?
- What can be done to ensure a smooth transition from the current system to the one proposed in this proposal?
- How would we know whether the plan is working?

If there are other questions, please submit them for consideration. Feedback and questions can be sent to health.feedback@ontario.ca or submitted at www.health.gov.on.ca/en/news/bulletin.

The ministry looks forward to continuing the conversation about this proposal in a variety of forums. We hope this discussion will result in a plan that can successfully build a high-performing, better connected, more integrated, patient-centred health system — one that responds to local needs and is committed to continuous quality improvement.

The proposed model would require changes to legislation including but not limited to the *Local Health System Integration Act, 2006*, the *Community Care Access Corporations Act, 2001*, the *Home Care and Community Services Act, 1994*, the *Health Protection and Promotion Act*, among others. The ministry is reviewing relevant acts and intends to propose draft legislation for consideration by the Legislative Assembly in the spring of 2016.

APPENDIX

System Governance

The success of the proposal outlined in this paper is based on the ministry, LHINs and health care providers having the tools they need for effective governance and management. Clear and meaningful accountability relationships will be developed, and transparent performance measurement must be strengthened.

To fulfill their new responsibilities, the LHINs would require expanded boards and leadership with the necessary skills, expertise and local knowledge.

At the same time, LHINs need to be aligned with the ministry's objectives to ensure accountability to Ontarians and consistently equitable services. LHIN activities would need to be carefully defined and performance plans supported and enforced by the ministry. A variety of measures would be put in place to enhance LHIN accountability to the ministry and to Ontarians, including transparency, the identification of standards, funding and enhanced ministry authority.

As the 2008 report *High Performing Healthcare Systems: Delivering Quality by Design* demonstrated, it is possible to develop a culture of quality when objectives and structures are aligned.

QUESTIONS FOR DISCUSSION

- What other tools are needed for effective governance?
- What would be the most effective structure for LHIN boards and their executive?
- How can LHINs promote leadership at the local level?

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Summary of themes identified through the consultation process with Board of Health Members

Overall impressions

- General support for the recommendations in the Patients First paper in principal, but would like further information on how the recommendations will be put into action.
- Regionalization could be a very positive change as long as it is well organized, with roles, accountabilities and funding clearly articulated.
- Would like to have a decision-making role within the new system
- Hopes the Ministry of Health and Long-Term Care (MOHLTC) listens to comments & ideas and incorporates them into their plan

Thoughts around LHINs

- Wonders if the Local Health Integration Network (LHIN) has the capacity and/or capability to lead this given the current mandate and structure? If not, what would the LHIN need to build this?
- Would recommend rebranding by changing the name from LHIN to something new that better represents their new role
- Suggest that LHINs be realigned so that boundaries better correspond with existing health unit boundaries.
- Suggest that there may be a need for more LHINs to allow for more local focus within LHINs [desire to retain the structure and authority of the LHIN level in a smaller geographic area as opposed to sub-LHINs]
- LHIN board should include elected representation, local input and represent the composition of the communities it serves – with more representation from larger areas (which would align with our current democratic system).
- LHIN boards should also include representation from a variety of groups who work in the system (e.g. Public Health Services (PHS), hospitals, Long-term Care, housing, community services, community members)
- Recommends that the Medical Officer of Health (MOH) has more authority on public health matters and that MOH should be able to influence decisions [in the health care system] that would be detrimental to the public's health.

Arms' length decision-making

- Concerned that the needs of Hamilton will be unmet if decisions are made by an arms' length organization.
- Concerned about a potential loss of control over how municipal dollars are spent
- Concerned that public health will be subsumed by primary care, so that the large scale impact of public health's population-level preventive measures will be greatly reduced while more resource intensive person-level health care will be increased

Transparency

- Noted the need for transparency in how LHINs operate, their goals and governance structure.
- The funding model needs to be clearly articulated and communicated
- Recommends granting the elected Board of Health (BOH) decision-making ability as a LHIN sub-region as a way to achieve the goals of transparency and accountability
- The roles of the LHIN, MOH, BOH and other stakeholders need to be clearly defined
    - Wants more clarity around the reporting structure for the MOH. Will there be three reporting relationships? (i.e. MOH+BOH, MOH+LHIN, MOH+MOHLTC)
    - Wants to ensure that any new reporting relationships for the MOH are in the best interest of residents
- Uncomfortable with the concept of appointments for LHIN Board and would like a more transparent process about how LHIN board is chosen.
- If some LHIN boards members are not elected, suggested that a vetting process may be helpful so that communities involved could recommend some potential members to represent their needs.

Measurement & Accountability

- New system needs measurement and accountability embedded within it
- Accountabilities of all parties involved need be clearly articulated and communicated
- Wants to know who solves the problem of differing expectations (e.g. expectations around provision of service)

- Suggest that there is a system to measure service and register and respond to complaints (e.g. report cards from patients, healthcare workers, long-term care organizations)
- New system needs to be focused on people and less focused on bureaucratic systems & processes that may impede programs and services

Impact on BOH structure & governance

- Recommends that the BOH be on the same level as/or a part of the LHIN board. This would ensure that the BOH has decision-making authority for changes that will affect Hamilton.
- Recognizes there is a risk that the BOH could be collapsed within the LHIN and that this may result in a loss of service for Hamilton.
- Wonders if more authority to LHINs would diminish a public health unit's accountability to the BOH
- Recommends that the City of Hamilton be a sub-region of the LHIN and that in general, sub-regions should align with existing structures [like municipalities] in order to maintain high levels of service to residents

Impact on funding

- Concerned over how these changes will impact funding for services and programming within Hamilton.
- Would like the BOH and public health units to have decision-making input around how both provincial and municipal dollars are spent.
- Wonder if there will be extra steps around approving discretionary funding (i.e. BOH currently has autonomy over discretionary funding decisions)
- Concerned that the wording in the Patients First paper could lead to LHINs re-allocating funding away from public health units to other groups who claim to be doing public health-related work. This is related to the concern that public health units will be subsumed within the larger primary care system

Impressions on the dissolution of Community Care Access Centre (CCAC) [home care] into the LHIN

- Agreed that a new structure that better integrates various levels of care would better serve the needs of the community
- Noted that for home-based care to work, sufficient funding is essential
- Recommends that front-line home care workers be employed by the LHIN

Health Care services

- Likes the focus on improving patient care and patient experience as the path towards improving the health system in Ontario
- Likes the concept of physicians travelling to patients' homes to provide care
- Would prefer to see generalized hospitals rather than specialty hospitals, so that people can easily access care in their area and to minimize transfers between hospitals which may impact Emergency Medical Services (land ambulance) costs and be disruptive for patients
- Identified that an urgent care facility on the south mountain is needed

Hon. Dr. Eric Hoskins, M.P.P
Ministry of Health and Long-Term Care
80 Grosvenor Street
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M7A 2C4

Dear Minister Hoskins,

Thank you for the opportunity to provide feedback on behalf of City of Hamilton Public Health Services in response to the proposals outlined in Patients *First: A proposal to strengthen patient-centred health care in Ontario.* Hamilton has chosen to provide both a staff perspective through the Medical Officer of Health, as well as the Board of Health perspective through a consultation process with our Board. We hope that you find the breadth and depth of the input provided to be of assistance as you consider next steps.

We support the goals and intentions behind the proposals in Patient's First, and are encouraged by the Ministry of Health and Long-Term Care's renewed focus on population health, commitment to addressing structural issues in the health care system that create inequities and taking action on next steps in health system transformation.

As it relates to public health, the Patients First discussion paper identifies the need to integrate local population and public health planning with other health services, and formalize links between LHINs and the Medical Officer of Health in order to improve linkages between Public Health and other health services[i]. Public Health welcomes integration of local population and public health planning with health systems planning. Through engagement with the LHINs and the health system at both a strategic and operational level, *Public Health can contribute significant expertise and perspectives during strategic planning and decision making, priority setting, policy development, and service coordination.* Public Health's population health and health equity lens can assist the health system in being responsive to local population needs, and ensuring integrated, comprehensive approaches are taken across the spectrum from health promotion through treatment, and focusing on root causes and the determinants of health to shift health outcomes.

A thoughtful, deliberative approach to proceeding with this change is essential to ensure that system integration does not come at the cost of a strong public health system. In some jurisdictions, integration of Public Health into regionalized health systems has led to erosion of Public Health services, and both Public Health priorities and funding have been usurped by acute care pressures. A thorough understanding of the proposed changes and their potential consequences is critical. In-depth consultation with the sector and a review of experience with public health integration into regional health

systems in other jurisdictions is necessary in order to gain the most benefit for the health of the province, and avoid any unintended negative consequences.

Toronto Public Health identified many important challenges and opportunities, and made a number of recommendations in the report - Healthy *People First: Opportunities and Risks in Health System Transformation in Ontario.* We support the issues raised and recommendations that Toronto has made, and dd belowh further feedback that highlights important issues and offers additional perspectives. Attached as well are specific input related to the questions raised in the discussion paper regarding Public Health as well as LHIN governance.

Focus on keeping people healthy

In order to have a meaningful population health approach and to address health equity as a system, the focus of the proposed formalized relationship between the Medical Officer of Health, Public Health Unit, local Boards of Health and the LHIN needs to be on keeping people healthy, understanding what keeps them from being as healthy as they can be, and determining the health systems role in supporting people's health in collaboration with other sectors including municipalities, education, etc.

Public Health works to keep people healthy through advocacy, targeted interventions, and broad collaboration and partnership with other sectors and community partners to promote health, prevent disease and injury, and protect people from harm. It is critical that in the midst of transformation that the health of the overall population does not lose priority or meaning and that upstream population health approaches do not get usurped by the downstream demands on acute care. Historically, Ontario's health system is typically focused on patients and clinical outputs. *It is important to highlight that the traditional health system's overall contribution to population health is minor.* For the health of our population, it is critical that Public Health continue to have a population health mandate, independence, and continue to be empowered to work with all sectors and partners that influence health to enable cross-sector collaboration to promote, prevent, and protect health. As the health system enhances its efforts to improve population health and health equity, system accountability measures should follow suit.[ii]

Develop Clear Integration Framework and Governance Model

Learn from other jurisdictions

The Patients First proposal has the potential to capitalize on opportunities for better integration of public health and a population approach to health system planning.

To achieve this we recommend the province, through the proposed Expert Panel, develop a clear framework for how public health and population health outcomes can be achieved in a regionalized health systemodel and study and learn from areas where regional models have succeeded and failed at integrating public health. As a necessary

support, an integration framework for the full system would include clear definition of all of the sectors and their roles, and a clear framework for implementation. A clear system framework, with learnings from integration and regionalization experiences in other jurisdictions, will ensure public health is not eroded, fragmented, or transitioned to a more clinical orientation in order to fill gaps in acute or primary care.

Geo-politically Significant Boundaries

Although this is not a major concern in Hamilton, for much of the province there will need to be an adjustment of LHIN boundaries to be along geo-political population boundaries to better align with populations and other sectors that influence health such as social services, municipalities, school boards etc. so populations that are being planned for have significance. It is important that sub-LHIN boundaries also take these factors into consideration.

Local Governance of Public Health with the LHIN

Local governance of Public Health achieves better population health outcomes. Local Boards of Health act as an independent voice and advocate for their represented populations. In a new model, to avoid duplication, local Boards of Health could be augmented or adapted to serve as sub-LHIN governing councils. Boards of Health should continue to be accountable for implementing OPHS/OPHOS standards and setting budgets through a transparent and clear budget process.

Maintain Medical Officer of Health Independence

An essential component of the public health system is the independence of Medical Officers of Health from local environmental pressures, to make difficult decisions, and advocate for healthy public policy on behalf of the people they serve.

Independence is critical for accountability and health protection. It also is important for innovation and to promote healthy public policy broadly. For example, municipal smoking by-laws began at the local level led by Medical Officers of Health and Boards of Health. As well, Public Health has a role in regulating other parts of health system and as such independence is important to maintain.

Ontario Public Health Standards and Ontario Public Health Organizational Standards review

There is good work underway with the modernization of the OPHS/OPHOS. We recommend that the review process is evidence based, ensures that the new standards can make the intended full impacts, and that local health units receive full funding to achieve the standards. Strong OPHS/OPHOS are essential to ensure both effectiveness and consistency across Ontario's Public Health System, especially if accountability agreements for public health move to being set by the LHINs.

However, we are concerned that there will be a fiscal, rather than a system effectiveness focus to these reviews. Any changes made to these standards should be evidence based rather than a "slimming down". It is recommended that the ministry's review of the OPHS and OPHOS strengthen standards for effective and accountable local Public Health services, focusing upstream (e.g., disease prevention and health promotion) rather than downstream (e.g., acute, primary and long-term care). Continued flexibility for local Boards of Health to meet additional local needs will remain an important component of local Public Health.

Strengthen Community Collaboration

Public Health must continue to work with all of the sectors that influence health. To effectively address population health, which is rooted in social determinants, it is important that the LHIN also partner with other sectors that influence health. Bringing these partners to the LHIN table as well would only further strengthen such partnerships, deepen collective understanding, and improve the potential for meaningful, aligned action and healthy public policy.

Financial Investments in Population and Public Health

Maintain financial investments in public health for public health purposes. All current and future public health funding provided to the LHINs for allocation for public health purposes must be protected so that it cannot be reallocated to meet gaps in other health services.

Additional investments in Public Health should continue to be made to both achieve good OPHS standards and to support the addition of population planning and integration work and taking on the additional roles in the health system as proposed in the discussion paper.

It is also important that budget allocation and financial processes at the LHINs are transparent.

Patients First Discussion Questions

1. How can public health be better integrated with the rest of the health system?

Public Health can be better integrated with the rest of the health system at both strategic and operational levels. Conversely, the health system also needs to adjust and understand the role of Public Health, and also understand population health strategies as separate from population based needs planning.

Public Health can bring a deep understanding of local population health and population health methods and strategies, as well as the social determinants of health lens to help

with broader system planning to help achieve better health outcomes and improve health inequities. With population health expertise, Public Health could support and work with the broader health system in reviewing and acting on system goals and health outcomes across health service delivery organizations, including primary care. Further, health impacts would benefit from alignment of strategies and effort across health promotion, disease prevention, health protection and treatment.

2. What connections does public health in your community already have?

City of Hamilton Public Health Services, along with public health units across the province, have a rich history of community collaboration, working together with a larger system of healthcare, social services, education, and NGO's/not for profits in our City on initiatives to improve health outcomes and health equity. Hamilton Public Health has longstanding connections with FHT, Primary Care, Acute Care Hospitals, Post-secondary institutions, McMaster Department of Family Medicine, school boards, early years sector, municipality, social services, business community.

3. What additional connections would be valuable?

It would be valuable for Public Health to have a formal relationship with LHIN executive level, and health service provider leadership, as well as continue to strengthen connections and take joint action with other non-health community partners as listed above.

In order to support the work of public health, it is important to maintain a clear mandate from the province to work with broad community partners from Health, Education, Social Services, Not-for-profits / NGO's, Post-secondary institutions as part of the Ontario Public Health Standards.

If the health system becomes accountable for influencing population health and health equity which is grounded in social determinants of health outside of the health care system, the LHIN must also establish formal relationships with school boards, municipality, earl years services, child care, social services and affordable housing, and the non-for profit sector – all of which influence health.

4. What should the role of the Medical Officers of Health be in informing or influencing decisions across the health care system?

Population Health Lens and Health System Planning

The Medical Officer of Health (MOH), and the Public Health Unit (PHU) is well equipped to contribute to health system planning, working together with LHIN leadership and health service provider leadership at a strategic planning level to influence local health decisions, health system planning, and advise on issues and strategies to address overall population health. The MOH can bring a health equity lens that is much broader

than health care delivery. The MOH can bring a population health approach to health system planning and to support program and service alignment with population health and social needs.

It is important to note that population health and needs based health system planning are two very different concepts. In the proposed model the MOH should be involved in both. This new responsibility for the MOH and public health will need to consider the potential for "participation burden" as public health engages more deeply with the health system in all its breadth. Resources must be in place to support these activities so that MOHs and PHUs continue to have capacity for core public health purposes and functions as well.

Medical Officer of Health Independence

An essential component of the public health system is that the MOH retains independence from local pressures to make difficult decisions that may not be popular, on behalf of the population served. Independence is critical for accountability and health protection and also in order to have innovation and to promote healthy public policy broadly. As well, Public Health has a role in regulating other parts of health system and as such independence is important to maintain.

5. What can be done to ensure a smooth transition from the current system to the one proposed in this proposal?

It is recommended that prior to passing legislation to formalize linkages between LHINs and PHUs, the ministry establish the proposed Expert Panel, with strong representation from MOHs, Boards of Health and Public Health units, as well as the LHIN and other health system partners, to evaluate the need for a formal relationship as described in the Discussion Paper and further develop joint expectations for collaborative work between Public Health, the LHIN and the rest of the health system whether based in a formal relationship or not.

Importantly, we need broad system alignment in achieving specific population health outcomes – not just sick care – investing in capacity building of the population for better health. It is critical that a transition to a future state augments Public Health, and health system capacities, and does not erode public health.

6. What other tools are needed for effective governance?

As regards Public Health governance, in order to ensure an effective transition from the current system to the one proposed in Patients First a clear, detailed framework with defined goals, outcomes, roles and responsibilities for Public Health and a clear governance structure is critical. This detailed framework would consider where

accountability between the MOHLTC, the LHIN, and the Board of Health lies ensuring the model does not create a participation burden.

As regards LHIN governance, ultimately, the proposed changes will generate a large amount of work for the LHINs which may detract from oversight, planning and accountability. The governance challenges of being both an oversight body and a service provider need to be considered and worked through. In their current state, LHINs do not have the capacity or capability to take on additional systems oversight and service delivery roles.

Further, a clear governance model and standards for LHIN governance that includes the required resources and skills would be important to ensure effective and consistent governance across the province. The Ontario Public Health Organization Standards, which outline expectations for various aspects of both the boards and management in order to ensure effective governance and accountability may be of assistance in creating similar expectations for the LHINs.

Elizabeth Richardson, MD, MHSc, FRCPC
Medical Officer of Health
Public Health Services

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