

“Patients First”: A proposal to strengthen patient-centred health care in Ontario

A response by Quest Community Health Centre

About This Response

How this Document was Developed

This document was developed in response to “Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario” issued as a discussion paper by the Ministry of Health and Long-term Care in December 2015.

The response is the result of discussions by the Board of Directors and senior staff of Quest Community Health Centre and has benefitted from their participation in sessions held by the Association of Ontario Health Centres and the Hamilton Niagara Haldimand Brant Local Health Integration Network (LHIN).

How Our Response is Organized

We have organized our response in two sections. In the first section, we have presented general comments regarding Quest and areas where we clearly support the Ministry’s proposal.

We have also identified areas where we have issues or questions that are not fully resolved in the paper and that could affect our organization’s support as the various components of the proposal are further debated and rolled out. Our leading comments are in bold face with more detailed comments underneath.

In the second section, we have addressed the four components of the Ministry’s proposal and the detailed questions raised under each.

About Quest and Our Overall Support for Putting “Patients First”

Quest Community Health Centre (CHC) provides an integrated approach to health care delivery by offering a range of primary health care, health promotion and community development programs. As a community health centre that currently puts our clients first and is funded, designed and developed to address gaps for specific priority populations struggling to access primary care and related services in our region, we are fully supportive of the overall goal espoused by the Ministry in “Patients First” of strengthening patient-centred care. This goal is laudable and we believe it is aligned with our own Mission, Vision and Values along with those of CHCs generally

We are encouraged to see the emphasis on health equity and equality of access to services given our

own endeavours to build an understanding of the determinants of health and develop skills to improve and maintain our clients' health and well-being. This includes addressing and raising awareness about issues such as employment, housing, social support, education, environment, isolation and poverty and their impact on health.

Quest CHC supports the recognition of Ontarians who are not always served well by the health care system including Indigenous peoples, Franco-Ontarians, members of cultural groups (especially newcomers), and people with mental health and addiction challenges.

We would welcome a broader statement from the Ministry that acknowledges all communities that are marginalized, the continued role of CHCs in addressing their needs, and the need for additional resources to do so.

Our own clients include individuals and groups who are some of the most marginalized in our community, groups that other health care providers are too often reluctant to serve: people facing complex issues such as mental health, addictions, and concurrent disorders, people who are homeless/under-housed and those living in poverty, at risk children, youth and families, isolated seniors and members of Niagara's LGBTTIQQ2S communities who are often excluded from or rejected by more traditional, mainstream services.

We support the Ministry's acknowledgement of how difficult it is for some groups to access services and how better integration of services will improve this situation.

We strive to achieve more equitable access to services for our clients though we recognize there is still much to be achieved. Collaboration is one way that we work to ensure equitable access through a holistic approach – an approach that clearly puts patients first. This involves working within our own interdisciplinary team (physicians, nurse practitioners, nurses, social workers, health promoters, community outreach workers, dentists, chiropractors, and other allied health professionals) and our many partners who include education, housing, employment, social services, as well as other health providers. Quest operates out of our main site as well as several points of service such as schools and the hospital, also contributing to ease of access. The Ministry may want to consider this in its model.

We are also concerned that the importance of locally based community governed organizations is not acknowledged or mentioned; we believe this feature of our current primary health care system is fundamental to ensuring that programs and services are relevant to clients and ultimately accountable to the people and the communities served. This type of locally governed model of service delivery is particularly important to those individuals who are not well positioned to represent their needs, including those who receive services from not-for-profit organizations such as CHCs.

Further to the local governance issue, the current LHIN structure does not embrace the community either directly in the governance process or through readily accessible and transparent mechanisms that support and maximize quality community input. We have found that having community members involved in the governance process who can speak directly about the barriers that disadvantaged populations face is critical to developing meaningful plans and ultimately promoting quality delivery.

“Patients First” focuses only on some players in the system (LHINs, CCACs and public health) and not on others.

CHCs, FHTs, lone primary care operators including family doctors, and addiction and mental health services receive scant mention. Hospitals, walk-in clinics (which are proliferating in our area), long-term care facilities, palliative care and end of life services, and allied health professionals operating on their own or in self-structured teams in the community are not mentioned at all.

We need to develop a better understanding of exactly who the future players should be and how these players will work together to achieve an integrated system of services.

Prior to enhancing their role, The MOHLTC has a responsibility to ensure that all LHINs are equally capable of planning toward and coordinating an integrated health care system. Initially and also over the longer term, the Ministry needs to hold LHINs accountable for keeping “Patients First” as well as for the providers that report to LHINs.

This should include:

- expectations regarding regular, direct community consultation and engagement
- promoting and supporting the development of greater consistency among all 14 LHINs to achieve high quality planning and management of the system
- the development of patient-centred indicators that gauge performance at all levels in the system
- the capacity to collect patient outcomes information as well as information about patient experiences to provide a picture that helps identify what is working and not working in the system
- an approach to problem-solving issues that draws on the network of providers as well as patients themselves
- a single electronic medical record for each patient that is accessible in both official languages
- mechanisms for feedback from communities, health care professionals and primary service providers directly to the province regarding the work of the LHINs – in other words, 360 degree accountability.

Though we are generally supportive of the direction that the Ministry is taking, we are concerned that so much of “Patients First” is about implementation with a number of decisions appearing to be taken already regarding how the system should work.

The “Patients First” proposal supports clinicians retaining choice for what patients they care for within their sub-regions.

Clinicians, specifically Family Physicians, need support when working with clients with complex needs. They need to be able to work as part of an interdisciplinary team in order to achieve client-focused planning and service delivery. CHCs were designed to support complex, marginalized individuals who are challenged in accessing the primary care system. They have been doing so in Ontario since 1974. The Ministry should use this as an opportunity to require stronger dialogue between CHCs and solo Family Physicians working independently of interdisciplinary teams, so that the CHCs can support these Family Physicians in addressing the needs of their complex clients within a model of health and wellness that addresses the social determinants of health. The Ministry will also need to address financial considerations to support this type of collaborative practice and interdisciplinary service delivery. We would also suggest that once independent practitioners retire, these specific clients be transferred to CHCs.

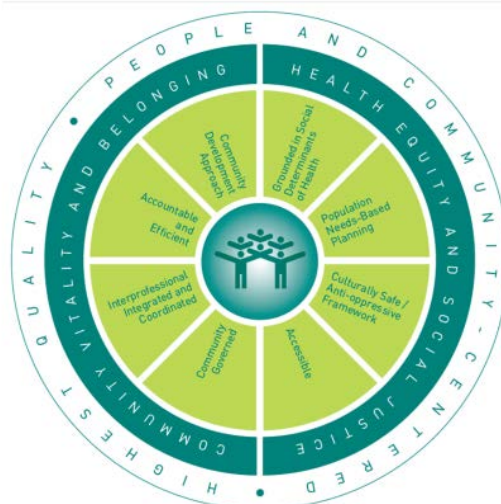
We believe that it is important to pay attention to the language we use to signal our underlying philosophy and what we want to achieve. We also advocate taking as broad a perspective as needed in mapping out the potential scope of change in order to ensure a holistic response.

Even though we have used the term “patient” in our response to “Patients First”, the term speaks to a different time and a way of working where patients are seen as passive recipients of medical treatment who present with a specific illness or issue and have little insight into their own health and health care.

Quest, along with other CHCs and health care providers, uses the term “client” in our everyday practice. We continually strive to move outside old paradigms and see our clients in a holistic way. With that in mind, a shift in language across all health care providers will shift perspective and help to give the client a voice in the process.

The scope of our discussion, at the provincial level, needs to be inclusive of people and communities just as our work with individuals needs to bring them into the process. No single health care provider or type of practitioner should be privileged over others and the discussion needs to move away from terms such as “patient,” “health care” and “primary care” alone. Instead, we believe a province wide initiative that truly puts people first needs to focus on health and well-being, properly acknowledging the importance of the broad social determinants of health and the service providers who address them.

CHCs have developed a model of health and well-being that is a useful point of departure in this type of dialogue. The model can be found on page five. We believe our model can help us better discuss



concepts such as population-based health and health equity and ultimately lead to an integrated approach which has the capacity of working with individuals in a holistic way.

Response to the Proposal's Components

The remainder of the paper addresses the questions posed within the proposal's separate components. There is some overlap with the preceding comments.

1. More effective integration of services and greater equity

How do we support care providers in a more integrated care environment?

In order to achieve a more integrated care environment, work with individual patients needs to be grounded in a determinants-of-health approach that gives clients a say and encourages client ownership of their own individualized integrated care plan. All providers of service need to be schooled in this approach. This requires individual practitioners learning about the determinants of health and learning where other service providers in the community can offer support.

Planning, coordination and delivery of services at a community level, needs to be designed in a similar fashion. It needs to promote community ownership of the local plan and be accountable to the patients and the communities served as well as the network of stakeholder groups that make up the community. Ultimately, the plan needs to be judged based on whether it focuses on and actually achieves improved community access to services and improved patient outcomes. Only this type of plan is indicative of an integrated care environment that has the capacity to deal with patients in a holistic way within a broad definition of health.

More specifically, the Ministry needs to engage in a patient-centred planning process that puts patients first, recognizes a holistic approach to meeting their needs and keeps patients as the focus above the interests of other stakeholder groups and the distractions these pose. This is the only way that local plans will emerge that can respond to the diversity of patients in our community and others.

What do LHINs need to succeed in their expanded role?

Our first concern is whether the Ministry should expand the role of LHINs. We are not optimistic that merging planning and delivery (i.e., LHINs taking on the CCAC function) will work. It is difficult to deal objectively and fairly with issues across the system in a situation where some services are managed in-house and others are not.

The CCAC function aside, the Ministry needs to ensure that individual LHINS have the capacity to assume the roles described in "Patients First."

In order to succeed, LHIN Boards as well as staff need to be open to listen and give serious consideration to feedback, questions and suggestions from patients, communities, service providers and health care professionals. This may sometimes be difficult, but a fresh approach is clearly needed. All of these communities should be considered partners in supporting positive change.

LHIN Boards need to be truly community-based – that is diverse and inclusive, where members have different backgrounds, experience, expertise and perspective and where the community is involved in the appointment process. At the same time, LHIN Boards should demonstrate openness to community/stakeholder engagement through regular consultations and mechanisms such as working groups, advisory committees, etc., and articulated strategies that ensure comprehensive community access and participation, along with effective Board and senior management outreach, reporting and evaluation.

Individual LHINs may need some time to take stock of their capacity as they move forward, what has worked/not worked in the past and what additional supports and time may be needed for the LHIN to assume its new role in supporting an integrated health care system.

There needs to be clear acknowledgement at the Ministry level that it is asking a lot of the LHINs as well as service providers and that roles are changing and will change even more before a more patient-centred health care system emerges.

How do we strengthen consistency and standardization of services while being responsive to local differences?

In addition to identifying the goal of local planning and delivery, the Ministry should identify the beliefs and principles or values that should guide planning and delivery. These values should include transparency, inclusiveness, equity and being patient-centred.

The Ministry should also:

- clearly delineate the roles and responsibilities of LHINs and the service planning and delivery partners that form an integrated health care environment at the local level.
- identify what local plans should address – in other words, basic parameters regarding what the plans need to address and common high-level milestones or deliverables.
- set expectations that those in charge of the process locally will create a level playing field that values and supports input from all stakeholders/stakeholder groups. This should include community members and patients themselves. Decisions can no longer be made in isolation based on assumptions about what is best for patients.

Stakeholder engagement will allow those who must ultimately implement changes to have ownership of what emerges. It will allow organizations like Quest to bring our expertise in integration and community-based primary health care to the table, learn from the process and strengthen our relationships with our community partners. It will promote a better understanding of the unique skills and expertise of our partners.

Ultimately it will reinforce accountability back to patients, the local community and the local network. In addition, there should be mechanisms for regular dialogue with and feedback from patients, communities, health care professionals and service providers on how planning, implementation and delivery are doing, thereby allowing for suggestions for improvement. These mechanisms should be in place within the local network and between local stakeholders and the Province. They should

include informal and formal feedback and evaluation – 360 degree accountability for the LHIN and for service providers.

What exactly should be standardized and what should be determined locally? Beyond the suggestions in this response, the term “standardization” requires careful definition and critical thinking. System management and delivery still need to be flexible and responsive to individual and community needs.

Should these considerations be given weight as implementation proceeds, it will make it easier to hand over responsibilities to sub-regional units. As it stands, dividing the LHINs into sub-regions creates the potential for making oversight of the system more difficult and creating another layer of bureaucracy without having addressed the inconsistencies between the present LHINs.

There are, nevertheless, advantages to creating smaller units for planning purpose. We are not sure that Niagara should be a sub-region given its considerable diversity and geography. Whatever the path, these decisions should not be taken without a more considered process that includes stakeholder input.

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?

Local primary care providers should be meeting and working together in an open and inclusive way to resolve and correct local service gaps. For example CHCs and FHTs, as well as other primary care providers could meet to discuss and share best practices in an effort to move us toward stronger partnerships and improved service delivery for those requiring complex care. In areas where family health practitioners need access to healthcare teams, a model or models should be developed locally through support, sharing of expertise and identification of best practices.

CHCs that are currently functioning successfully in an integrated service delivery model should be leaders in this type of dialogue. The goal should not be to have CHCs provide services outside their mandate, but rather to work with other service providers in helping them cultivate, establish and maintain a model of partnerships and working agreements that support an interdisciplinary, holistic approach with respect to serving complex, marginalized clients.

What other opportunities for bundling or integrating funding between hospitals, community care, primary care and possibly other sectors should be explored?

The Province’s goal is stronger patient-centred health care. Bundling or integrating funding between hospitals, community care, primary care and other sectors is not an automatic means to achieving this end.

CHCs, based in local communities and locally governed, are particularly well suited to meet the needs of complex clients. More specifically, the CHC Model was established and funded as a client centred model to address the social determinants of health and the variety of needs of individuals who belong to marginalized groups. CHCs do this well and effectively, but they are often outstripped by demand for service. Integrated planning and increased dialogue and working relationships are important and the various parts of the system need to be encouraged and supported in working together.

What areas of performance should be highlighted through public reporting to drive improvement in the system?

The focus needs to be on Health Equity – equal access and quality health care for all. Right now individuals within our communities who are experiencing multiple or complex needs (e.g. concurrent disorders and poverty) often find it difficult to access services. CHCs have been developed and designed with Ministry support to meet the needs of marginalized populations. Regular reporting on the percentage of these individuals served by CHCs, FHTs and primary care physicians, would help drive system improvement and ensure access and service equity.

Should LHINs be renamed? If so, what should they be called? Should their boundaries be redrawn?

The name is not that important except perhaps to signal that the LHINs will have a new role in a reorganized health care system that puts patients first.

2. Timely access to primary care, and seamless links between primary care and other services

How can we effectively identify, engage and support primary care clinician leaders?

As noted above, it is important to engage all stakeholders in providing timely access to primary care and links between primary care and other services. This includes CHCs, FHTs and private practitioners.

The Ministry is particularly interested in how best to engage local clinical leaders. However, we are not clear what the term “local clinical leaders” is intended to mean. CHCs, FHTs and private practitioners are all involved in primary care delivery and this is the pool from which those who represent primary care providers at various planning and coordination tables should be drawn along with other stakeholders.

In order to support better integration of service, all of these groups need to be at the table together, along with other allied health professionals and service providers that can support the development of interdisciplinary, holistic, patient-centred health care.

Health Care providers who work in CHCs can provide valuable insights and expertise based on their perspectives in working as part of interdisciplinary teams and with clients with complex needs.

What it means to support clients in navigating the system or coordinating services needs to be clearly defined. Once again CHCs as a result of the role of each member of their interdisciplinary team in system navigation, and the role of Community Outreach Workers specifically, can help to inform processes and outcomes related to system navigation.

It is not just the LHIN that will be assuming a new role in this re-visioned, patient-centred health care system. Many players will take on new responsibilities including private practitioners. The Ministry needs to ensure the involvement of all parties including private practitioners in the planning process. All key stakeholders must be at the table to bring this vision to life. At the same time, the Ministry needs to set expectations for all clinicians that include best practices for service delivery in an integrated health care system.

What is most important for Ontarians when it comes to primary care?

A holistic approach to identifying and meeting needs and everyone having timely access to the services they require (health equity) are what is important to Ontarians when it comes to primary care.

CHCs incorporate this holistic approach, having been designed and funded to provide interdisciplinary services that address the social determinants of health to those Ontarians who are experiencing complex needs and/or are challenged in accessing the primary health care system. While Quest's response to this question focuses primarily on these individuals, many features of it are applicable to all Ontarians.

Those most in need should be able to access services through a CHC. Their care should be coordinated by primary health care providers and grounded in an approach that is based on a deep understanding of the social determinants of health.

Care that is responsive to patients needs to be timely and high quality. This includes access to healthcare within a reasonable timeframe, integrated and quality care that includes follow up and meaningful dialogue between service providers. Service providers, whether pharmacists, doctors, and/or other primary health care providers need to be quickly "on the same page" in terms of their overall perspective regarding services to patients in general and the particular patient they are working with. They should support a broad understanding of health and wellness rooted in the determinants of health, have a clear understanding of their roles and the roles of others in the service delivery network, as well as what is needed to provide the best service to the patient within their scope of practice. Education and prevention should be key components in supporting this vision.

Complex care requires oversight and coordination. Continuity of care is very important in complex cases. There should be a required "warm hand off" between practitioners.

At a more general level, the current system needs to be more coherent and organized to eliminate treatment errors and clarify the issues that need to be addressed.

In addition, providers should be using one shared electronic information system that builds a comprehensive patient history and record of care. This would reduce duplication of medications, as well as appropriate follow up on issues pertinent to surgeons and other specialists, etc.

How can we support primary care providers in navigating and linking with other parts of the system?

We do need to support primary care providers in navigating and linking with other parts of the system.

We should consider health care teams as an approach. CHCs are leaders in this field and can provide best practice examples for others. The focus should be "shared care" as opposed to a hierarchical model where physicians direct other health care players. We should move to a true team approach where every player at the table has something to contribute and is allowed to do so in a meaningful way. There needs to be honest and open dialogue that considers the input of everyone involved in that individual's care.

As mentioned earlier, an integrated electronic medical record that allows appropriate restricted access to all healthcare providers (pharmacists and dental professionals, etc.) to share information more quickly and easily can help support system navigation.

Also, there needs to be some formal professional development of primary care providers that builds

in various approaches to communication, cultural and lifestyle tolerance and understanding. Diversity training to build understanding and awareness should be included in formal professional development.

This may be a role that LHINs can assume moving forward.

How should data collected from patients about their primary care experience be used? What data and information should be collected and publicly reported?

Data collected from patients should be consolidated and used to assess how well the system is working. This along with demographic information about the community can be used to produce a regular report card at the LHIN or sub-LHIN level that reinforces accountability and supports future planning and priority-setting.

Important principles underpinning this discussion are that:

- patient information belongs to the individual patient
- we need to be cautious and ensure that the only data collected and/or reported is data that will actually be used.

We noted the importance of a common EMR earlier in our response. Aggregating patient data related to key indicators on a regular basis can provide a better understanding of what patients within a particular region or sub-region need and the types of services that they are accessing.

Aggregate patient information can be compared to public health and Census-based demographic information about the community in order to better understand whether there is equity of access and equity of service delivery across the community. Ultimately, this data can feed into an annual or biennial report card at the LHIN or sub-region level. It can also be taken up by public health to establish priorities for health promotion at a community level.

3. More consistent and accessible home and community care.

How can home care delivery be more effective and consistent?

Home care delivery will be more effective and consistent if:

- resources allocated meet the demand for service
- there are clear and transparent policies and procedures that are understandable to those who need to access the service as well as the larger community
- there is consistent training and evaluation of staff who deliver service, and
- mechanisms are in place for patient voices to be heard along with those of families and substitute decision makers.

Hallmarks of a home care system that puts patients first are equitable access, manageable wait times, and quality of services based on best practice research. We cannot address the situation in any given community without the Ministry setting overall expectations regarding standards of service and standards of care. Accurate data and regular monitoring within individual communities are critical to determining whether the system and services are functioning according to expectations. Feedback from service users, related service providers and other stakeholders is critical to appraising the home care system and constantly improving it.

We question whether LHINs are the best choice for home care delivery and whether they can juggle their role as systems managers with their role in service delivery (this is discussed further below). However, if they are the place where accountability ultimately resides for home care planning, funding and delivery, then there needs to be an objective, independent evaluation of how home care is working and follow-up by the Ministry to ensure that LHINs take appropriate corrective measures where warranted. In addition to having standards in place, it would make sense for the Province to require all home care to be accredited by a recognized accrediting body that uses independent surveyors to assess whether or not services are provided according to standards and best practices.

How can home care be better integrated with primary care and acute care while not creating an additional layer of bureaucracy?

CHCs currently outreach service to and provide system navigation for a variety of client groups and provide an example of a logical place for home care coordinators to be employed going forward.

While this is only one of many possible service delivery models, we need to consider fresh and innovative approaches to home care. This includes improved service delivery models, as well as new approaches to compensation. Service providers who function differently should be consulted and compensated in a model that allows them to receive appropriate compensation comparable to those functioning in a fee for service model. If we are truly focused on the patient, we should be finding ways to provide high quality service in a timely way that works for their situation.

How can we bring the focus on quality into clients' homes?

A focus on quality home care is important.

Quality home care starts with recognition of the patient – who they are, their strengths, the areas where they need support and the development of a plan in which the patient has a clear say. Patients should be empowered to be partners in making informed choices within the system. How and when home care providers and patients will communicate needs to be clear from the initial meeting and this understanding needs to be part of the service plan agreement.

Home care is currently not regulated or accredited. As noted earlier, standards are needed along with accreditation by a recognized accrediting body whether this service rests with the LHIN or elsewhere. Accreditation could provide LHINs and the community served with reasonable periodic assurances of quality, efficiency and effectiveness.

At the same time, there will need to be mechanisms in place that support maintaining quality on an everyday basis. These could include a well-informed public; transparency of decision making; a case management process that is aligned with best practice standards and gives the patient a say; a process that keeps patients and their families as well as primary care providers and others involved with the patient (e.g., pharmacist, social worker, etc.) informed as appropriate; and an accessible complaints procedure that is fair to the patient and that results in quick communication/action where concerns are raised.

Home care providers must be expected to link with primary care providers and others involved with the patient. The link with primary care providers is essential because this is the service provider who likely has the longest and most intimate association with the person. Decisions need to be based on a holistic approach that recognizes all of the factors including those rooted in the social determinants of

health that affect the person in need of home care.

Wherever home care resides, there need to be mechanisms for supporting individual workers in providing consistent decision making and service delivery including ongoing training and development.

Should home care providers be assigned to work in and with host agencies (vs. becoming employees), enhanced coordination will be essential to successful implementation. Partnership agreements must ensure that roles and responsibilities for case coordination, delivery, monitoring and individual worker appraisal and service evaluation are clearly defined. Workers in these situations will need to be supported and monitored based on formal expectations between the LHIN, the worker and the host agency. There will also be a need for special mechanisms that are built into partnership agreements that provide for holding individual workers accountable for the work they perform. Host agencies will need to be reimbursed for taking on these roles and be briefed and/or trained in the expectations that they can and should have of home care providers.

4. Stronger links between public health and other health services

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

In order for public health to be better integrated with the health system, their role needs to be more clearly defined and public health departments or units need to operate consistent with that role.

While public health can and does assume a number of roles outside of services delivery in some regions (e.g., dealing with emergency preparedness, public health inspections, etc.), for purposes of the Ministry's "Patients First" proposals public health's most important role is facilitating the collection, analysis and sharing of population-based information and playing a valid role in terms of prevention and health promotion. The information they gather and provide should be responsive and helpful to the communities they serve, as well as all health care providers within that community.

Where gaps or unfulfilled needs are identified the LHIN should be advised, as well as any partner agencies or service providers so that the LHIN and the care providers may work toward appropriate corrective measures.

LHIN funding for primary care should not be directed to public health. Timely and accurate information to the community, the LHIN and other stakeholders should be a key responsibility of public health and an activity for which they are held accountable through agreements with the Province.

As part of an integrated health network public health departments need to coordinate with one another to maximize productivity and responsivity. They also need to engage in regular dialogue with community members and other stakeholders that can support providing information that is timely and relevant for planning and service delivery. These could include chronic disease prevalence, reproductive, maternal and infant health data, or dental insurance coverage, for example. Public health should provide information to inform planning and serve as a knowledge resource but should not be directly responsible for the planning of health care for communities. Public health is part of local government and as such responsive long term planning could be at risk of being politicized.

What connections does public health in your community already have?

The mandate of public health needs to be reviewed, standardized and revised as appropriate across Ontario's municipalities. Where public health has moved beyond its mandate this should be addressed. Public health needs to be a supportive partner within the local community. It should be working in a responsive and supportive way with all community primary care providers.

What additional connections would be valuable?

We look forward to making new connections with public health as the "Patients First" proposals are implemented.

In order to effectively implement an integrated healthcare model, we need regular and productive sharing of ideas between primary health care providers, public health, the LHIN, and representatives of the community at large. This needs to include other community groups/organizations working in areas that relate directly to the social determinants of health. This needs to be an inclusive and supportive regularly scheduled interaction that results in productive outcomes and deliverables.

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

Medical Officers of Health have an important role in ensuring that their Departments work within their provincially assigned mandate, informing or influencing decisions across the health care system consistent with the role that we would assign public health.

System Governance

What other tools are needed for effective governance? What would be the most effective structure for LHIN boards and their executive?

As noted earlier in this response, we are concerned that community based governance is not mentioned, which is fundamental to ensuring that programs and services are relevant to clients and ultimately accountable to people and the communities served.

The current LHIN structure does not embrace the community either directly in the governance process or through readily accessible and transparent mechanisms that support and maximize quality community input. We have found that having community members, who can speak directly about the barriers that disadvantaged populations face, involved in the governance process is critical to developing meaningful plans and ultimately promoting quality delivery.

How can LHINs promote leadership at the local level?

LHINs can continue to support locally governed primary health care organizations; use these as stepping stones for participation on LHIN Boards, Working Groups, Advisory Committees, etc. They can also use processes/forums that introduce community members to the LHIN, their mandate and the various roles they play. There should be more information about LHINs in local newspapers; more community events in venues where community naturally is; presentations through university courses e.g. LHIN connects with Brock/McMaster/etc.).

The Quest Board is pleased to be given the opportunity to respond in a preliminary way, recognizing that there are many decisions yet to be made regarding how best to create a system that ultimately does put Ontario's patients first.

We look forward to participating in further discussions in the months ahead and we feel that, as a community health centre designed to provide an integrated approach to primary care and other community health services, we have a unique contribution to make to the implementation process in the Niagara area.

February 25, 2016

Motion:

That Quest CHC Board of Directors approve this response to the Ministry of Health and Long Term Care's Discussion Paper "Patients First."

CARRIED