Association of Ontario Health Centres
Community-governed primary health care

Association des centres de santé de l'Ontario
Soins de santé primaires gérés par la communauté

Recommendations on how to strengthen the *Local Health System Integration Act, 2006* to enable a "People and Communities First" approach to Health System Transformation

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Purpose

As a supplement to AOHC's response to *Patients First*, we are taking this opportunity to provide further advice specifically as it relates to the *Local Health System Integration Act, 2006* (LHSIA). We are aware that amendments are currently under consideration; however we believe that lessons learned from Community Health Centres (CHCs) who have been under LHSIA for over nine years can significantly inform improvements to the Act.

The essence of these recommendations was included in AOHC's response to *Patients First* but we are taking this opportunity to focus on the recommendation specific to LHSIA and to provide more explicit recommendations. We hope that these recommendations will be incorporated to improve the health and wellbeing of people in Ontario, including the 3.5 million people facing barriers to health.

AOHC is committed to ensuring the unique needs of the Aboriginal population as well as the Francophone population are protected and enhanced in the revisions to LHSIA. LHSIA needs to be reviewed with this equity lens. Included in this submission are recommendations specific to the *Ontario's Francophone Health Centres Response to "Patients First" Discussion Paper*. Under separate cover are recommendations from the Aboriginal Health Access Centres Circle (*AHAC Proposed Changes to LHSIA March 14 2016*).

Rationale

The Association of Ontario Health Centres believes that the sustainability of Ontario's health system depends on our ability to keep Ontarians healthy and avoid the need for more costly care. We envision strong community based services that are integrated and coordinated with the acute care system; and a health care system that addresses the social determinants of health as key to a healthy society.

Minister Hoskins' proposed transformation in *Patients First* is very aligned with this vision. The amendment of LHSIA provides a vital opportunity to align the LHINs' mandate with this vision and to optimize the LHINs' full potential.

However, there is a balance that needs to be achieved. On the one hand, the LHINs' mandate as stated in LHSIA is too narrow to achieve the direction outlined in *Patients First*; and on the other hand, the lack of clarity and direction in the Act is too open to interpretation thereby allowing LHINs to structurally realign the system resulting in fourteen different health systems across the province.

The LHSIA opens by stating that the main purpose of the LHINs is to improve the health of people living in Ontario. But reading through the rest of the Act, and watching what's

happening on the ground, it is clear the LHINs' *raison d'être* is health service integration – especially the structural integration of organizations that provide health services. In our view integrated, coordinated, seamless service delivery – not structural integration – should be the goal. The Act focusses mainly on how to enable structural integration.

In our view, the LHINs' long-term goal should be the establishment of community health and wellbeing systems across their region that promote the best possible health and wellbeing and ensure equitable health outcomes for everyone. As called for in *Patients First*, we need a strong community based system that is integrated with the acute system – not subsumed under the acute system. Promoting a complete sense of health and wellbeing system requires objects that are currently not listed in the Act.

In addition, in reporting to the LHINs for over nine years, CHCs have consistently heard that many of their programs and services cannot be funded through the LHINs because it is "not their mandate". Many LHINs have consistently limited their interpretation of their role under the Act as "health care" and the treatment of illness; it does not encompass successful programs and services that advance health equity, address the determinants of health, prevent illness, or promote individual, family and community health.

As well, there are huge inconsistencies growing across the LHINs. It is the Minister's commitment that no matter where you live in Ontario, everyone should expect a similar level of service. This is not the direction in which the system is developing across the LHINs. While we fully recognize the need to meet diverse needs of the communities and that one solution does not suit the needs of all the communities, the Ministry still remains the steward of the system, and must ensure a consistent vision of the evolution of health care that is then adapted locally. This is why certain clauses of the LSHIA need to be strengthened to ensure clarity for interpretation by the LHINs.

To address these challenges and achieve the goals Minister Hoskins outlined in *Patients First*, the Act needs to be expanded to ensure the LHINs are responsible for planning, integrating, funding, monitoring and evaluating the entire local health system in ways that reduce health inequities and disparities. Further the LHINs need to be equipped with the authority, accountability and resources to do an effective job. This requires broadening of the objects and purposes of the Act, along with explicit accompanying definitions that allow for consistent, accurate interpretation of each of the objects.

PART I: Enhancement of LHSIA

1. Enhance the objects and purposes for the LHINs

As stated in AOHC's response to *Patients First,* we recommend that the *Local Health System Integration Act, 2006* be enhanced with the following objects and purposes for the LHINs:

a) **Advance health equity and reduce health disparities and inequities;**

b) **Advance interventions that address health promotion and prevention, including prevention of the root causes of illness, namely the determinants of health and community development;**

c) **Conduct comprehensive system planning that advances population health and equitable access to services for everyone in Ontario;**

d) **Plan, monitor and fund primary health care and publicly-funded oral health services;**

e) **Develop a high performing primary health care system with the capacity to fulfill its role as the foundation of the health system; and**

f) **Develop a high performing community-based system.**

For each of the overarching recommendations above, specific revisions and definitions are needed in the Act to ensure the LHINs accurately understand their expanded purpose and objects. If not, primary health care organizations under the LHINs will continue to experience significant challenges in fulfilling their mandates and health equity will not be advanced.

a) Advance health equity and reduce health disparities and inequities.

Only in the preamble of the Act is a commitment to equity briefly mentioned. It is not explicitly mentioned in the main body of the Act. The result has been that the LHINs have not taken health equity seriously and over the last nine years, the LHINs have not developed their capacity to implement a health equity approach.

If the MOHLTC is serious about implementing healthy equity and reducing health disparities and inequities, it needs to be clearly defined in the Act with requirements to plan, monitor and report progress, and the appropriate tools need to be utilized.

Recommendations:

1. **Include in the objects the requirement for the LHINs to develop, implement and report on progress in health equity.**

2. **Explicitly define "health equity" in the Act as:**

   - **Within the health system, equity means reducing systemic barriers in access to high quality health care for all by addressing the specific health needs of people along the social gradient, including the most health disadvantaged populations.**

   Equity planning acknowledges that health services must be provided and organized in ways that contribute to reducing overall health disparities. Health inequities or disparities are differences in health outcomes that are avoidable, unfair and systemically related to social inequality and marginalization. Research shows that the roots of health disparities lie in broader social and economic inequality and exclusion, and that there are clear social gradients in which people's health tends to be worse the lower they are on the scales of income, education and overall privilege. Health equity, then, works to reduce or eliminate socially structured differentials in health outcomes. Health equity builds on broader ideas about fairness, social justice, and civil society. (MOHLTC definition in Health Equity Impact Assessment)

3. **The Ministry LHIN Performance Agreements (MLPAs) include the requirement that the Health Equity Impact Assessment (HEIA), or its successor, be used in all regional planning, integrating, funding and evaluation activities, including province-wide initiatives such as HealthLinks.**

b) Advance interventions that address health promotion and prevention.

In our view, the LHINs' long-term goal should be the establishment of community health and wellbeing systems across their region that promote the best possible health and wellbeing and ensure equitable health outcomes for everyone.

In order for LHINs to take responsibility for their entire local health systems and advance interventions that address health promotion and prevention, the Act needs to enable LHINs to broaden their interpretation of the concepts of health, health promotion and community development.

Currently the word 'health' is used throughout the Act. However, there is no definition of health in the Act to enable consistent interpretation.

Recommendations:

4. **Include in the objects the requirement to advance interventions that address health promotion and prevention, including prevention of the root causes of illness, namely the determinants of health, and community development.**

5. **Explicitly define "health" in the Act as:**

- **A state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. (World Health Organization)**

6. **Explicitly define "health promotion" in the Act as:**
   - **The process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions. (World Health Organization)**

7. **Explicitly define "determinants of health" in the Act as:**
   - **The range of personal, social, economic and environmental factors that determine the health status of individuals or populations. The determinants of health can be grouped into seven broad categories: socio-economic environment; physical environments; early childhood development; personal health practices; individual capacity and coping skills; biology and genetic endowment; and health services. (Public Health Agency of Canada)**

8. **Explicitly define "community development" in the Act as:**
   - **The encouragement of community participation in health, with a focus on creating healthier communities and expanding understanding of the factors that sustain the health of communities. (Saskatoon Health Region)**

c) Comprehensive system planning that advances population health and equitable access to services.

To date, most LHINs are planning health system redesign from the perspective of diseases. The literature is strong that the LHINs must take a health equity population based planning approach. The SE LHIN and the SW LHIN are leaders in this work that could be implemented across all fourteen LHINs.

Patients First calls for population based planning on a subLHIN level. While we support that population based planning should happen at all levels, we believe that the MOHLTC needs to lead a province wide population based plan where data is collected consistently across the province but that can be disaggregated to appropriate LHIN, subLHIN or even community levels. This is particularly important for populations that may get lost if they don't have critical mass at a subLHIN level. Most notable is the Indigenous populations and the Francophone populations that require specific population based plans. This is an area where the MOHLTC needs to be a steward but where the LHINs need to be required to plan according to consistent population based data.

In addition, the LHINs have tended to see population based planning at a disease level; for example – how many people have COPD. This is not segmented into those at different income levels who would require different solutions. As well, this approach does not take into consideration the person with multiple co-morbidities.

Recommendations:

9. **Include in the objects the requirements to plan the health system using equity based population needs based planning.**

10. **Explicitly define "population health" in the Act as:**

    - **The health outcomes of a group of individuals, including the distribution of such outcomes within the group. These groups are often geographic populations such as nations or communities, but can also be other groups such as employees, ethnic groups, disabled persons, prisoners, or any other defined group. (David Kindig, MD, PhD)**

d) Plan, monitor and fund publicly-funded oral health services.

There is a direct link between poor oral health and a number of health conditions including poor nutrition, diabetes, pneumonia, gum disease and cardiovascular disease. Research is explicit about the link between access to oral health services and the costly use of emergency departments. A growing body of literature views oral health as an essential component of primary care.

In Ontario, publicly funded oral health services include low-income children and youth under 18 with a commitment to expand this to low-income adults by 2025.

Currently, the planning and funding for oral health is done through the public health units in isolation of the LHINs. This mandate should be transferred to the LHINs.

Recommendations:

11. **Planning, funding and monitoring <u>publicly funded</u> oral health services be mandated in the expanded role of LHINs.**

e) Develop a high performing primary care system with the capacity to fulfill its role as the foundation of the health system.

As stated in *Patients First*, "all high-performing health care systems are based on strong primary care services" and "effective primary care is essential to improving health outcomes". In the Minister's speech at *HealthAchieve 2015* he called primary care "the bedrock to the health care system".

The Ontario Primary Care Council has stated: "to improve population health, deliver people-centered services and strengthen our publicly funded health system, Ontario must create a stronger foundation for the delivery of primary care in this province".

Supported by research, the Ontario Primary Care Council further asserts that:

- Primary care is the foundation of a high performing health system;
- Planning for the system needs to be based on equity-informed population needs;
- Programs and services must be appropriate, accessible, timely, high-quality, comprehensive, continuous, evidence-informed, equitable and culturally competent;
- Care coordination is a core function of primary care; and
- Collaborative interprofessional teams working to full scope of practice are key to success.

The Council sees primary care as a core component of primary health care, an orienting philosophy and overarching strategy for promoting and protecting people's health.

In order to fulfil this vision, the LHINs need to have this mandate included and defined in LHSIA.

Recommendations:

12. **Recognize primary health care as the foundation of the health system and mandate the planning, monitoring and funding of primary care in the Act.**

13. **Explicitly define "primary health care" in the Act as:**

    - **Addressing the main health problems of the community, providing promotive, preventive, curative and rehabilitative services and involving in addition to the health sector, all related sectors and aspects of national and community development. (WHO's 1978 Alma-Ata Declaration)**

    - **Recognizes the broader determinants of health and includes coordinating, integrating, and expanding systems and services to provide more population health, sickness prevention, and health promotion, not necessarily just by doctors. It encourages the best use of all health providers to maximize the potential of all health resources. (Mable & Marriot 2002)**

2. Mandate meaningful community engagement

The LHINs need to build their knowledge and capacity to conduct meaningful community engagement.

From the experience of CHCs to date, each of the different LHINs approaches community engagement in a very different fashion. Unfortunately, some do the absolute minimum and fall on the "inform" side of the Public Participation Spectrum. Many do not engage on an ongoing basis. Very few report back the outcomes or results of community engagement opportunities to those who were engaged. This leads to "engagement fatigue" by highly engaged community members and providers and leads to decreasing engagement

effectiveness over time. A comment was recently made by a LHIN CEO at a multi-stakeholder meeting that he felt there was a lack of rigour in the area of community engagement to guide the LHINs' work in this area. However, the International Association for Public Participation and many other credible bodies have a long history and standing in this area and many best practices exist. It is clear that the LHINs require greater clarity and higher standards in this important area of their existing mandate.

There is currently no appeal or dispute resolution process in the Act if an HSP believes the LHIN has materially breached its role. The Multi Sectoral Accountability Agreement (MSAA) between the LHIN and HSPs is built on an assumption of trust and strong relationships. If that is missing, there is no recourse for the HSP. The accountability is one way – only if the LHIN determines it appropriate is a remedy process implemented.

For accountability, LHINs should be held accountable for their community engagement process, clearly outlining the process and reporting on the number of complaints per year in their MLPAs. In addition they should be required to do independent community engagement satisfaction surveys of community and HSPs and report annually.

Finally, to truly engage the communities, community governed not-for-profit health service providers must be maintained.

Recommendations:

14. **Strengthen Part III of the LHIN Act to better define community engagement, community and methods of engagement in order to ensure LHINs' best practices in this area. Specifically:**

    - **Add a definition of "community engagement" in Part II Section 16(1) so that it reads:**
        - **Community engagement means involving those who are affected by a decision in the decision-making process. (International Association for Public Participation)**
        - **Community engagement is the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, and/or similar situations to address issues affecting the wellbeing of those people. (Centers for Disease Control and Prevention, 1997)**

    - **Strengthen definition of "community" in Part III Section 16(2)(a) so that it reads:**
        - **"patients and other individuals in the geographic area of the network affiliated by geographic proximity, special interest, and/or similar situations including the impacts of health inequities" (variation on Centers for Disease Control and Prevention, 1997)**

- **Under Section 16(3), there is a section on Methods of Engagement. It also needs to be strengthened. In order to achieve effective community engagement, the LHINs should use the widely accepted International Association for Public Participation's "Public Participation Spectrum". See Appendix A for details.**

15. **The Act should identify an appeal or dispute resolution process for Health Service Providers (HSPs) if the LHIN has been alleged to breach their role.**

16. **The MLPA should require a public complaint process and reporting mechanisms and a community engagement satisfaction survey.**

17. **Community governed not-for-profit health service providers must be maintained.**

3. Comprehensive System Planning across the Full Continuum – But NO to service delivery

While the LHINs' roles should be planning, integrating, funding and evaluating local health systems, their expanded mandate should not include the delivery of frontline services.

With their existing roles related to planning, funding and accountability of providers, plus their proposed expanded mandate, the LHINs will be set up in a position doomed to eventually fail due to inherent conflict of interest, or at best, perceived conflict of interest. As our colleagues at RNAO eloquently wrote, it is challenging to "row" and "steer" at the same time. Service provision, including service allocation at the patient/client/individual level, should be the role and focus of provider organizations.

This means that CCAC staff should not become LHIN employees. Instead a transition strategy should be developed that leads to care coordinators being fully embedded (located and employed) within primary care within five years. Based on our preliminary analysis of the subLHINs, all but one subLHIN have at least one interprofessional primary care organization that could be supported to become the backbone support for the care coordinators in primary care.

Recommendation:

18. **LHINs' roles be planning, integrating, funding and evaluating local health systems, not service delivery (i.e. direct provision of frontline services). It is inappropriate for them to take on a service delivery role.**

4. LHINs and Public Health

AOHC supports formalizing linkages between LHINs and public health units to enable more consistent and meaningful collaboration and coordination in order to improve population health and address health inequities. This is aligned with AOHC's call in 2013 for the LHINs to be mandated to work with public health units as co-partners. Increased alignment

between public health units and LHINs will facilitate better opportunities for primary health care organizations to collaborate effectively with public health.

However, AOHC cautions that efforts to integrate local population health and public health planning with other health services should carefully ensure that the distinct and complementary roles of public health are protected and sufficiently resourced. Learning from efforts in other provinces where integration has resulted in diminished public health efforts and resources, Minister Hoskins needs to ensure that policies, structures and programs are set up in a way that allows for people in Ontario to fully benefit from the integration of population health approaches into health system planning without losing public health's broader mandate and functions.

Recommendation:

19. **AOHC supports formalizing linkages between LHINs and public health units, while recognizing the distinct but complementary roles of public health and ensuring sufficient resources in public health to fulfill their mandate, especially in addressing the determinants of health and population based planning.**

Part II: Ontario's Francophone Health Centres Response to *Patients First* Discussion Paper

1. The French Language Health Planning Entities and Their Role for Health Care in French

The 2006 *Local Health System Integration Act* is the legislative framework that created the French Language Health Planning Entities. In December 2015, MOHLTC reviewed the Planning Entities' model and renewed their mandate. The six Entities were created to assist MOHLTC and the LHINs with planning and French language health service delivery in Ontario. Nevertheless, their role has not been clearly defined in the legislation pertaining to health services in Ontario as far as Franco-Ontarians are concerned. The French Language Health Planning Entities are more than just "advisors" on the health service needs of the Francophone communities. They should be protected by clearly written legislation, recognized as equal LHIN partners, receiving the opportunities and necessary resources to achieve their mandate.

The MOHLTC and LHINs should engage the Francophone communities they serve in the planning of health care and call upon the French Language Health Planning Entities to facilitate dialogues with these communities.

Recommendations:

1. **The changes to the legislation that are required to transform the health care system must explicitly define the province of Ontario's obligations concerning the delivery of health services in French.**
2. **For greater efficiency, the French Language Health Planning Entities need to be supported by a clear and precise legislative framework recognized by the MOHLTC and LHINs and receive the necessary resources to achieve their mandate.**
3. **The MOHLTC must put in place measurable indicators that the LHINs will use to account for FLS.**
4. **The MOHLTC and LHINs should engage Francophone communities in the planning of health care and call upon the French Language Health Planning Entities to facilitate dialogue with these communities at the LHIN and sub-region levels.**

2. Third Party Regulation

Not only should these laws be changed to ensure that the Province's obligations to provide services in French are enshrined in the legislation, but the regulatory power of the Minister Responsible for Francophone Affairs would also need to be closely examined to ensure that the power delegated to the minister would also extend to any third party contracts carried

out by Local Health Integration Networks (LHINs). This is all the more important where LHINs could inherit home care service contracts currently in place with Community Care Access Centres (CCACs), where there is neither an obligation for third parties to provide FLS, nor develop the capacity to do so.

The health care system transformation announced in the *Patients First* report must also lead to an accountability framework for French language services (FLS). Gone should be the days when LHINs contract out home care services without taking into account the needs of the Francophone community. As LHINs are and will become more accountable for FLS, and in order to secure the future of French language services for the Francophone population, the Minister of Health must enforce this accountability using clear and precise language.

Recommendations:

5. **The Regulation on the Provision of French Language Services by third parties must ensure that the regulatory power of the Minister Responsible for Francophone Affairs also extends to any services contracted out by LHINs.**

6. **The MOHLTC should define the LHINs' accountability for FLS in relation to third-party contracts.**

3. Local Health System Integration Act, 2006

Given the changes that are expected to be brought to the legislative framework, it is important that future legislation and regulations governing LHINs reflect their unique responsibilities with regard to the health of Franco-Ontarians. Clear and precise language pertaining to the provision of French language health services must be used in the MOHLTC-LHIN accountability and performance agreements.

LHINs and the agencies that provide services to the Francophone population will need to comply with and meet the FLS indicators that should be put in place.

Recommendations:

7. **It is important that the changes brought to the legislative framework governing LHINs reflect their unique responsibilities with regard to the health of Franco-Ontarians.**

8. **Clear and precise language pertaining to the provision of French language health services must be used in the MOHLTC-LHIN accountability and performance agreements.**

4. Ensure sub-regions develop equitable service plans to ensure FLS needs are met

The creation of sub-regions will result in increased responsibility for LHINs. This responsibility must be carefully formulated and applied in a systematic and comprehensive manner. The objective is for Franco-Ontarians to receive high-quality health services. Past experience has shown that in many cases, living in a sub-region is synonymous to being underserved. This must be avoided at all costs.

The MOHLTC should clearly define the role of LHINs taking into account the proposed sub-regions. For this purpose, the French Language Health Planning Entities should be called upon to play a greater role in planning health services for Francophones.

The MOHLTC and LHINs will need to ensure that the sub-regions develop equitable service plans for these populations. The MOHLTC will need to develop principles and indicators and hold LHINs accountable for implementing French services in sub-regions.

Recommendations:

9. **The French Language Health Planning Entities should be called upon to play a greater role in the planning of services focused on the needs of the Francophone population.**
10. **The MOHLTC should clearly define the role of LHINs taking into account the proposed sub-regions. For this purpose, the French Language Health Planning Entities should be called upon to play a greater role in planning health services for Francophones.**
11. **Equitable access to French services by proposed LHIN sub-regions must be guaranteed by fulfilling regional needs.**
12. **The MOHLTC and LHINs will need to ensure that the sub-regions develop equitable service plans for Francophone populations. The MOHLTC will need to develop principles and indicators and hold LHINs accountable for implementing French services in sub-regions.**

5. FLS Capacity and Designation

The MOHLTC has stated that the health system transformation would not lead to the creation of new agencies. Nevertheless, this could still be an important opportunity to develop Francophone inter-professional teams within CHCs (through permanent or mobile satellite services as a lower cost and more flexible alternative to the creation of new agencies) or as part of community family health teams (CFHT) that do not yet have the capacity to serve the Francophone population in their region. If these teams are put in place, the MOHLTC or the LHIN in question could require that the agency pursue its designation under the *French Language Service Act* as a funding condition. This would

guarantee the quality and longevity of FLS in these centres. Such an approach could quickly increase accessibility to French language primary health services in many regions.

In addition, it has been suggested that home care services would continue to be provided by current service providers. One of the problems that exist and that should be reviewed by the MOHLTC is the fact that many service providers cannot provide French language services to the Francophone population. Furthermore, some providers are under the obligation to provide FLS and yet have never been held accountable for their inability to do so.

Recommendation:

13. **Require LHINs to sign new service agreements with agencies that have French language capacity where there is a need for FLS. The French Language Health Planning Entities to verify the agencies' capacity to provide FLS.**

6. CCACs and FLS

The MOHLTC will need to define the essential services offered by CCACs and third-party service providers, develop performance indicators and ensure that LHINs require them to offer services in French. In some cases, the MOHLTC will need to require LHINs to identify new agencies that have the capacity to offer FLS.

Recommendations:

14. **It will be important to protect what has been achieved thus far and to ensure that the transition does not entail a loss of French language services. Service providers should be evaluated on their ability to offer bilingual services with an emphasis on the value add should FLS capacity be identified.**

15. **Ensure that home care coordinators able to offer FLS be deployed into Francophone community agencies.**

16. **Ensure that the legal obligations with regard to language rights take precedence over the collective agreements in place in 10 of the 14 CCACs.**

17. **The MOHLTC will need to define the essential services offered by CCACs and third-party service providers, develop performance indicators and ensure that LHINs require them to offer services in French. In some cases, the MOHLTC will need to require LHINs to identify new agencies that have the capacity to offer FLS.**

7. Public Health and FLS

It will be key for the MOHLTC to define the requirements for FLS in the legislative framework governing public health units. It will also be very important to formalize the links between public health units, the LHINs and the Planning Entities in order to inform decision-

makers and service providers about the needs of the Francophone population in each region.

Recommendations:

18. **Define the requirements for FLS in the legislative framework governing public health units.**

19. **Since LHINs will have a more formal relationship with public health units, it is recommended that the French Language Health Planning Entities be directly involved in these new working relationships, with a focus on the complex determinants of health.**

Appendix A

IAP2'S PUBLIC PARTICIPATION SPECTRUM

The IAP2 Federation has developed the Spectrum to help groups define the public's role in any public participation process. The IAP2 Spectrum is quickly becoming an international standard.

INCREASING IMPACT ON THE DECISION

	INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
PUBLIC PARTICIPATION GOAL	To provide the public with balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions.	To obtain public feedback on analysis, alternatives and/or decisions.	To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered.	To partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solution.	To place final decision making in the hands of the public.
PROMISE TO THE PUBLIC	We will keep you informed.	We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how public input influenced the decision. We will seek your feedback on drafts and proposals.	We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influenced the decision.	We will work together with you to formulate solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible.	We will implement what you decide.