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

Shared Vision, Shared Outcomes:
Building on the Foundation of Collaboration between Public Health and Comprehensive Primary Health Care in Ontario

Submission from the Association of Ontario Health Centres regarding the Application of Standards for Public Health Programs and Services Consultation

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Summary of Recommendation regarding the Application of Standards of Public Health Programs and Services

1. **Ensure comprehensive primary health care leaders are actively included in the development and implementation of health promotion strategies within the LHINs aimed at implementing the objects for health promotion and health equity championed by the AOHC & OPHA.**

2. **Acknowledge the value and role of health promotion work performed across the spectrum of health care services ranging from population health to the 22% of Ontarians who face barriers to good health and wellbeing due to inequities in determinants of health[1].**

3. **Enter an in depth dialogue with primary care partners to develop mutually agreed to transition plans and to conduct an assessment of their state of 'readiness' to take on clinical services that have been previously performed by public health units.**

4. **Adopt the framework of the Canadian Index of Wellbeing, and/or some mutually agreed indicators therein, as a common and consistent measurement tool that can be used to advance a culture of health and wellbeing across the province of Ontario.**

5. **Generate a forum for the exchange of knowledge involving innovative collaborations between public health and primary health care in order to spread best practices to strengthened partnerships.**

6. **Ensure there is greater emphasis on oral health in the program standards entitled "Chronic diseases and Injury Prevention, Wellness and Substance Misuse" by including "dental decay and disease" in the list of chronic diseases of public health importance and adding a new program outcome that commits to improving the oral health of the population.**

1. Association of Ontario Health Centres (2012). Towards Equity in Access to Community-based Primary Health Care: A Population Needs-Based Approach. Ontario: AOHC.

Shared Vision, Shared Outcomes

Building on the Foundation of Collaboration between Public Health and Comprehensive Primary Health Care in Ontario

The Association of Ontario Health Centres is the voice for comprehensive primary health care in Ontario. Our vision is the best possible health and wellbeing for everyone living in Ontario. Our 107 member centres serve the most vulnerable populations including people living in poverty, Indigenous peoples, Francophones, new immigrants, people located in rural and northern communities and LGBT communities.

Critical to our success are the wide range of health promotion and community development services we offer. Recent research performed by our Association demonstrates that even relatively minor investments in health promotion work can result in improved individual and community health and wellbeing along with significantly lower health care utilization rates and costs.[2]

It is for this reason that we advocated for the inclusion of objects specific to health equity and health promotion in Bill 41 enacted in November 2016. These include:

- Health Equity

  To promote health equity, including equitable health outcomes, to reduce or eliminate health disparities and inequities, to recognize the impact of social determinants of health, and to respect the diversity of communities and the requirements of the *French Language Services Act* in the planning, design, delivery and evaluation of services.[3]

- Health Promotion

  To participate in the development and implementation of health promotion strategies in cooperation with primary health care services, public health services and community-based services to support population health improvement and outcomes.[4]

While we welcome many of the changes contained in the new standards for Public Health Programs and Services not the least of which are those pertaining to health equity as this is

2. Deepening Our Understanding of Who We Serve: Through the Lens of the Canadian Index of Wellbeing, North Simcoe Health Link, 2016.
3. Bill 41, Legislative Assembly of Ontario, December 8, 2016, pg 2.
4. Ibid, pg 3.

such a big part of what our sector does, we do nevertheless have some concerns pertaining to the 'application' of the standards, especially as they relate to the LHINs.

At the same time, we are positive that these can easily be addressed through increased dialogue due in large part to the shared vision and outcomes between those articulated in the new standards and those endorsed by all members of the AOHC. Better still, there exists the bedrock of numerous partnerships and collaborative initiatives between our members and public health across the province.

Very much, it is in the spirit of building on this solid foundation that we have crafted our recommendations. Knowing the enormity and urgency of this work, it is our sincere hope that we might seize this moment to support each other in achieving our shared visions and outcomes.

Our Recommendations pertaining to the Application of Public Health Standards

1. **Ensure AOHC Executive Leaders are actively included in the development and implementation of health promotion strategies within the LHINs aimed at implementing the objects for health promotion and health equity contained in Bill 41 championed by the AOHC & OPHA.**

   Our Position:

   Contained in the consultation document of Standards for Public Health Programs and Services is the recognition that "public health is disconnected from the broader health care systems."[5] [6] This is significant since this is one of the key drivers that triggered the review of Public Health Standards.

   For this reason, we support increased collaboration between Local Health Integrated Networks and Medical Officers of Health. In particular, we believe the work of the Local Health Integrated Networks will be enhanced by public health performing population health planning functions.

   Notwithstanding, we would respectfully remind those serving on the expert panel that had it not been for the leadership provided by the AOHC and OPHA, representing the extensive work of their members with respect to the aforementioned objects, and the follow through with the MOHLTC, these objects would not have been enacted. We are particularly pleased that the LHINs now have a clear mandate to address health equity and health promotion.

   We recommend therefore that executive leaders from comprehensive primary health care, and in particular AOHC members, be actively included in the development, implementation and evaluation of health promotion strategies aimed at addressing health inequities and the determinants of health under the umbrella of the LHINs.

5. Standards for Public Health Programs and Services, Consultation Document, Ministry of Health and Long Term Care, February 17, 2017.
6. This is also a point that we identified in People and Communities First AOHC Response to Patients First: A Proposal to Strengthen Patient-Centred Care in Ontario, February 2016.

It should be noted that our sector has a great deal to bring to the table in the way of expertise, resources, and a long standing track record of addressing health inequities and determinants of health through skillful and effective health promotion and community development work.

2. **Acknowledge the value and role of health promotion work performed across the spectrum of health care services ranging from population health to the 22% of Ontarians that face barriers to health and wellbeing due to inequities of determinants of health.**

<u>Our Position:</u>

One of the major struggles our membership has experienced is the LHINs lack of mandate to address determinants of health and their lack of understanding of the critical role that comprehensive primary health care plays in addressing the determinants of health and health inequities through its health promotion and community development work.

This lack of mandate and knowledge is significant as it translates into little or no funding for health promoters, very little interest in health promotion (unless it is lifestyle related) and community development programs offered through CHCs and often questioning why our members are offering these programs.

It is for these reasons that the AOHC is leading a rigorous research and knowledge mobilization programme aimed at 'connecting the dots' between comprehensive primary health care and positive individual, community and system outcomes with a special emphasis on health promotion interventions.

Health Promotion Across the Continuum

General Population	22% of Ontarians barriers to health	5% High Cost Users
Public Health	Comprehensive Primary Health Care	Health Links
Policy and planning	Capacity building/determinants	social isolation

Table 1. Health Promotion across Population Health Continuum

As depicted in Table 1, we believe it will be of strategic importance to offer greater role clarity for the LHINs in terms of the full range of health promotion work that occurs across the continuum of health care services[7]. Understanding that all health promotion performed across the population health spectrum is of value whether it be for the general population or the 3.5 million people in Ontario who face barriers to good health and wellbeing.[8]

We believe that discerning role clarity between public health and comprehensive primary health care providers will result in greater system integration, reduce duplication and increase efficiency.

3. **Enter an in depth dialogue with primary care partners to develop mutually agreed to transition plans and to conduct an assessment of their state of 'readiness' to take on clinical services that have been previously performed by public health units.**

Our Position:

We understand and support the definition of public health as one grounded in a population health approach[9], and we support public health transitioning out of the provision of direct clinical services. Prior to any transition we recommend that there be in depth dialogues with primary care partners regarding their state of 'readiness' to take on clinical services and that a transition plan be developed that ensures adequate support, capacity building and resources.

Many of our member centres are more ready than other parts of primary care to take on this increased role. As well, in many areas, public health units have filled the gap and have provided much needed clinical services where there were not comprehensive primary health care willing or able to provide these services.

However, increased responsibility for providing clinical services in these areas needs to be supported with adequate resources, funding and capacity building support.

7. Patient First: Health Promotion and Primary Health Care, Presentation for Ministry of Health, March 2017.
8. Association of Ontario Health Centres (2012). Towards Equity in Access to Community-based Primary Health Care: A Population Needs-Based Approach. Ontario:
9. Ibid, pg. 3.

In terms of the membership of the AOHC, the hard reality is that much like public health, our members have been contending with static budgets with little or no increase provided for non- negotiable costs such as soaring rent and hydro costs for the past decade or more. This, in turn, has necessitated the erosion of our staffing and capacity.

4. **Adopt the framework of the Canadian Index of Wellbeing, and some mutually agreed indicators therein, as a common and consistent measurement tool that can be used to advance a culture of health and wellbeing across the province of Ontario.**

<u>Our Position:</u>

Arising from our vision for the best possible health and wellbeing for individuals and communities, one major initiative spearheaded by the Association of Ontario Health Centres has been the promotion and adoption of the Canadian Index of Wellbeing at the local and regional levels.

The uptake of our membership serving as adopters of the Canadian Index of Wellbeing is extremely encouraging. Starting with just two centres four years ago, there are currently over 40 Community Health Centres that are applying the CIW with a variety of strategic applications. Several of these involve active collaboration with community stakeholders including municipal and regional government.

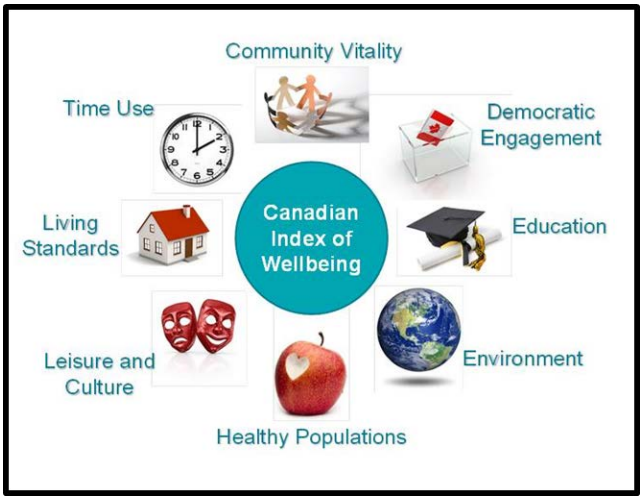

Table 2: Canadian Index of Wellbeing Framework

It has been our experience that both the framework and language used by the Canadian Index of Wellbeing resonates well with municipal and regional leaders.[10] We mention this since we are of the firm belief that municipal leadership will be of critical importance to advancing a culture of health and wellbeing.

At the same time, given the changes in the standards which now give public health a clear mandate to increase health equity and address determinants of health, it is our hope that we might look to public health to provide greater leadership with respect to the research and reporting aspects of population health that employs the CIW framework.

However, in order for us to be able to do so, it will be necessary for there to be receptivity on the part of public health to adopt a standardized health and wellbeing framework and measures that are **consistent** across the province. This would be of real benefit to our members and Health Links that are using measures derived from the CIW.[11]

5. **Generate a forum for the exchange of knowledge involving positive collaboration between public health and primary health care in the field with the aim of developing best practices that might inform future work leading to strengthened partnerships.**

   Our Position:

   Given the shared vision and common ground existing between public health and the AOHC in tandem with the new standards, it would seem a most opportune time to assemble some type of ongoing forum devoted to the exchange of knowledge focusing on positive partnerships.

   The good news is there are already many positive partnerships involving joint initiatives between our members and public health; be it collaboration with the delivery of clinical services such as smoking cessation and/or community development initiatives aimed at

10. It has been our observation in the field that the language 'determinants of health' does not resonate well with elected leaders and the general public, especially in rural and suburban communities. The beauty of the CIW is one can say essentially the same thing but wind up with vastly different outcomes in terms of building increased awareness. Furthermore, the CIW provides a lens that helps decision makers 'connect the dots' such as is missing with determinant of health frameworks.
11. The AOHC has developed a Be Well survey in partnership with the CIW that has been refined for comprehensive primary health care. Work is underway to embed these standardized measures into our information management systems.

building higher levels of community wellbeing such as food security work or delivering harm reduction programs to a marginalized population.

As such, we believe there is a wealth of field experience that could be gleaned to form the basis of what might eventually become best practices to help facilitate strong and positive working relationships between public health and comprehensive primary health care across the province.

One area, in particular, that would be well served by such an approach would be to explore ways we could collaborate to promote "higher levels of social connectedness".[12] Research demonstrates that belonging is a major factor impacting on individual and community health wellbeing.[13]

6. **Ensure there is greater emphasis on oral health in the delivery of program standards specific to chronic diseases and Injury Prevention, Wellness and Substance Misuse" by including "dental decay and disease" in the list of chronic disease of public health importance, and adding a new program outcome that commits to improving the oral health of the population.**

   One major area of collaboration between the work performed by public health and the membership of the Association of Ontario Health Centres entails joint efforts to combat chronic illness. For example, a number of CHCs work closely with health units to provide oral health care to children under the Healthy Smiles program.

   This program standard of "Chronic Disease and Injury Prevention, Wellness and Substance Misuse" should make greater reference to oral health. Tooth decay is the most prevalent and preventable chronic disease, yet it is referenced only once in this program standard. According to the World Health Organization, dental diseases are the most prevalent chronic disease globally with an estimated 5 billion people suffering from tooth decay. Dental disease treatment accounts for between 5% and 10% of total health care costs in industrialized countries.

12. Standards for Public Health Programs and Services, Consultation Document, Ministry of Health and Long-Term Care, February 17, 2017. pg. 7.

13. Journal of Public Health, "The role of the sense of community belonging on unmet health care needs in Ontario, Canada: findings from the 2012 Canadian Community Health Survey", October 2014, Volume 22, Issue 5, pp 467-478.

As described in the 2012 report by Ontario's Chief Medical Officer of Health Oral Health- More than Just Cavities[14], there is a link between poor oral health and the severity of a number of chronic conditions such as diabetes, cardiovascular and respiratory diseases. Of significance, the lack of access to oral health care services is very much a health equity issue. According to the Ontario College of Dental Hygienists, 2 – 3 million people in Ontario do not see a dentist each year largely because they cannot afford the costs. This, in turn, results in the costly and inappropriate use of other health care services.

Consider that in 2015 there were almost 61,000 visits to hospital Emergency Rooms for oral health problems, and in 2014 there were almost 222,000 visits to physician offices for dental complaints. Just to put this into perspective, there were more visits to ERs for oral health problems than diabetes.[15]

We recommend that "dental decay and disease" be added to the list of chronic diseases of public health importance as identified in Oral Health - More Than Just Cavities.[16]

We recommend that a new program outcome be added for the program standard: "the oral health of the population is improved by enabling access to oral health care for those populations most at risk: Indigenous people, people living on low incomes, seniors and the institutionalized elderly, immigrants and refugees."

14. Oral Health – More Than Just Cavities, Ontario Medical Officer of Health, 2012.
15. Ministry of Health and Long Term Care IntelliHEALTH ONTARIO
16. Oral Health - More Than Just Cavities, Ontario Medical Officer of Health, 2012