PEOPLE AND COMMUNITIES FIRST

Champlain Community Health Centre Response To Patients First: A Proposal To Strengthen Patient-Centred Health Care In Ontario

February 25, 2016

Champlain Community Health Centres:
Carlington CHC
Centretown CHC
CSC de l'Estrie
North Lanark CHC
Pinecrest-Queensway CHC
Rainbow Valley CHC
Sandy Hill CHC
Seaway Valley CHC
Somerset West CHC
South-East Ottawa CHC
South Nepean CHC
Whitewater Bromley CHC

TABLE OF CONTENTS

INTRODUCTION **1**

About the Champlain CHCs 1

RESPONSE TO PROPOSALS **2**

Address health equity 2

LHINs responsible for and accountable for all health services planning and performance 3

LHINs responsible for primary care planning and performance management 5

Transfer responsibility for home and community care in the LHINs 7

Stronger links between public health and other health services 8

CHC COMMITMENT MOVING FORWARD **9**

INTRODUCTION

The Champlain Community Health Centres (CHCs) welcome the opportunity to provide input to the Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario although our emphasis is on PEOPLE AND COMMUNITIES FIRST!

The Champlain CHCs support the majority (but not all) of the directions outlined in Patients First. While some consideration needs to be given to how implementation occurs, the overall direction is something CHCs have been working toward as a sector for many years**.**

We applaud the Government of Ontario for taking the bold step to address health inequities and to advance a policy direction that acknowledges primary health care as the foundation of a high performing health system. The direction has a solid base in research. Countries with a strong focus on primary healthcare have demonstrably better outcomes, better equity, lower mortality rates and lower overall health care costs.

The Champlain CHCs are excited by the vision and keen to assume their role in helping to make it happen.

About the Champlain CHCs

The Champlain Community Health Centre network includes 10 organizations offering primary health care services through 18 hubs and over 100 outreach sites across the Champlain region. CHCs offer programs and supports that respond to individual health issues as well as issues that affect the social determinants of health and community health. With over 40 years of experience in the delivery of primary health care and the integration of health and social services at both a planning and service delivery level, the Champlain CHCs are well positioned to provide a critical base on which to build a strong primary health care foundation in the region.

Interprofessional care

Collaborative practice is the essence of the CHC model with a range of professionals working to ensure clients see the provider with the most appropriate qualifications and benefit from case consultation. Champlain CHCs employ physicians, nurse practitioners, nurses, dietitians, chiropodists, respiratory therapists, social workers, midwives, health promoters and community health workers. This kind of team-based approach to primary health care has been proven to improve health outcomes, enhance the patient experience and reduce costs.

Hubs of service for the broader community

CHCs deliver services through 18 different sites and have over 100 different service locations. We work in partnership with health service providers, social service agencies and other organizations to respond to each community's specialized needs. These include, for example, mental health and addictions services, chronic disease prevention and management, child, youth and family services, seniors' services, education and employment supports, housing supports and community development and health promotion. Services are available to anyone living in the community – clients of all primary care providers.

Tailored services for clients with complex needs or barriers to accessing care

The Champlain CHCs respond to the diversity of many different communities (e.g., rural, urban, suburban), languages and cultures (francophones, indigenous, immigrants, refugees) and populations (e.g., the homeless or street involved; vulnerable seniors; people living on a low income; clients with mental health and addictions issues; lesbian, gay, bisexual and transgendered people). Even though they serve a greater proportion of people with complex needs, ICES research shows that CHCs do a better job than other primary care models of keeping people out of hospital emergency departments.[1]

The CHC approach to client care is what Health Links are striving to do for people that have not had access to this type of comprehensive interprofessional service.

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[1] Institute for Clinical Evaluative Sciences. (2012). *Comparison of primary care models in Ontario by demographics, case mix and emergency department use, 2008/09 to 2009/10.*

Leverage niche services and infrastructure

CHCs have developed specialized services in response to the needs of specific populations and in response to particular needs (e.g., diabetes education, mental health and addictions, primary care outreach for seniors, lung health, falls prevention, trans health, foot care, midwifery). Champlain CHCs have leveraged their collective infrastructure to offer sub-region or region-wide programs to serve clients of both CHCs and other primary care providers. For example, 77% of clients served through Primary Care Outreach Services are clients of non-CHC primary care providers. CHCs have established processes that streamline access and facilitate effective shared care, particularly for solo or small group practices of physicians without access to interprofessional teams.

Accountability/Governance/Quality

CHCs are governed by community-based Boards of Directors. Community engagement in governance and engagement of clients and family members in service design is what CHCs do and have done for years. In addition to strong governance models, CHCs understand and have experience with accountability requirements to funders, clients, partners and communities. CHC commitment to quality is evident in Quality Improvement (QI) plans, ongoing QI initiatives and CHC management of the Quality Practice Facilitation initiative that provides QI services to primary care practitioners across all models of care.

RESPONSE TO PROPOSALS

Champlain CHCs have specific responses to the proposals and questions outlined in the Patients First discussion paper.

Address health equity

Champlain CHCs applauds the government in its commitment to address inequities to access. We know that there are populations that are not well served by the health care system. This has an impact on people's ability to achieve their full health potential as well as negative cost implications for the health care system. It will be critical for the government to ensure planning and resource allocation reflects this important commitment to health equity.

A 2012 study estimated that a minimum 22% of the population faces barriers to health[2] including: Indigenous Peoples, Franco-Ontarians, recent immigrants and refugees or racialized groups, people with a disability or long-term physical or mental health issue, people living in poverty and people with geographic access barriers. Not included but increasingly recognized as a group facing barriers to health are lesbian, gay, bisexual and transgendered people. It is clear that many social identities intersect (i.e., recent immigrants with mental health issues), and that people living in poverty can transcend all population groups.

People require primary health care service delivery models that are targeted to ensure that they can access the services and support they require. The integrated Model of Health and Well-being offered by CHCs focuses on providing accessible primary health care services and implementing strategies that address determinants of health, sense of belonging and community capacity building. While the model benefits everyone it is particularly important for people with complex health issues. The most recent example is Syrian refugees who require primary care and support to find a home, get a job, place their children in school and connect to the community. An integrated approach to health services and the social determinants of health is critical. This requirement has been validated by the experience of CHCs for many populations and has been more recently recognized by partners in Health Links as they coordinate care for people that need support to address the social determinants of health (e.g., ability to pay for medications, to access food or to address housing issues). Addressing specific barriers to health saves money by stabilizing people's lives and reducing the need for higher cost health system responses. Action often requires the resources from across sectors for a whole community response to specific issues.

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[2] Patychuk, D. for the Association of Ontario Health Centres. (2012). *Toward Equity in Access to Community-based Primary Health Care: A Population Needs-based Approach.*

Rural populations experience unique challenges with geographic access to primary health care because they have no access or the access is insufficient (i.e., not close to home). In these cases the majority of the population requires access to CHC services. Within that population, people have diverse and sometimes complex needs (e.g., people with mental health and addictions issues).

Franco-Ontarians have yet another experience in that they require access to services, which are culturally sensitive and readily accessible in French. The francophone community is diverse and the service model must ensure that people with complex needs can access interprofessional care. CHCs are a demonstrated solution to meeting the needs of francophones; working with the francophone community to plan, deliver and monitor the quality of services. This is particularly vital in the Champlain region where Franco-Ontarians represent over 20% of its population.

To ensure that people living across Ontario benefit from the changes in the health system, a consistent primary health care population needs-based planning approach is needed across all fourteen Local Health Integrated Networks (LHINs). This will provide the LHINs with consistent, high-quality, equity informed population needs based planning data to inform the implementation of their expanded role in primary care. The work of the South East and the South West LHINs as well as the work by Champlain CHCs could inform this work.

CHCs located in some Champlain sub regions already serve a high percentage of priority populations. With further analysis of population health data, decisions can be made about where to invest additional resources to extend access.

LHINs responsible for and accountable for all health services planning and performance

CHCs agree with the expanded role for LHINs to include all models of primary care. This will foster more integrated planning across the region, within primary care and across the continuum of health resulting in enhanced services for residents.

Establish primary health care as the foundation of a high performing health system

If the LHINs are to fulfil their role in regional planning and strengthening the health system it is imperative that they be given responsibility for planning and monitoring the performance of all models of primary care; those offering primary health care and those offering primary care. The LHINs can build on their experience with CHCs for whom they are already accountable. Planning of other health services without primary care only perpetuates the fragmentation of the system.

With a strong foundation in primary care, services can be better coordinated across the continuum to ensure appropriate use of acute care services.

Champlain CHCs endorse the principles of the Ontario Primary Care Council[3] for strengthening the delivery of primary care:

- Primary care is central to the performance of whole system effectiveness
- Planning for the system needs to be based on 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
- Collaborative interdisciplinary teams working to full scope of practice are key to success.

Ensure the MOHLTC is the steward of the health system

Each of the fourteen LHIN structures have evolved in different ways over the past ten years leading to inconsistencies in planning and system integration. It is critical that the Ministry of Health and Long Term Care (MOHLTC) maintain its leadership role in strategy and policy development to foster consistency across the province.

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[3] Founding members: Association of Family Health Teams, Association of Ontario Health Centres, Nurse Practitioners Association of Ontario, The Ontario College of Family Physicians, Ontario Medical Association, Ontario Pharmacists Association. Registered Nurses' Association of Ontario

To ensure that all Ontarians will benefit, the MOHLTC must set the expectation that:

- Planning of the health system be based on equity-informed population needs and address access issues
- Planning of key services such as care coordination, mental health and addictions services, home care, community support, palliative care and midwifery be integrated with primary care
- All Ontarians, regardless of their postal code, will have equitable access to a core set of services, which can be tailored to respond to the unique needs of populations
- Evidence-based approaches and quality improvement guide service design and delivery.

A consistent primary health care population needs-based planning approach will benefit all Ontarians.

Health Quality Ontario (HQO) can play an important role in system design. Enhanced support at the regional level to focus on local priorities and processes will increase use of this important resource and expand sharing of knowledge across the province.

Integrate planning of key services in sub regions

Planning and service delivery of primary care, mental health and addictions services, midwifery, community support services, home care and palliative care needs to be integrated. The silo approach to planning does not consider the whole person – their physical and mental health and need for support in the home. The Patients First discussion document is silent on the importance of integration of community support services and home care.

Planning of these services in isolation from primary care ignores the essential role primary care must have for coordinating care.

Integrate mental health and addictions services with primary care

It is essential that mental health and addictions service planning evolve to address the intersection with primary care to provide primary health care. It has long been known that people living with mental health and/or substance use issues have difficulty accessing and maintaining primary care. CHCs serve many clients with mental health issues (ranging from mild and moderate to severe and persistent), with many suffering from concurrent mental health and addictions issues. CHCs have direct experience with the challenges of providing primary health care and coordinating care planning in a system that is not designed to support people with mental health and substance use issues in an integrated way.

We endorse the recommendations from the Centre for Addiction and Mental Health (CAMH):

- Increase accessibility of collaborative and interdisciplinary models of primary health care, such as family health teams and community health centres, for people living with mental health and/or substance use issues
- Explore strategies to improve communications between multiple health care providers working with an individual living with mental health and/or substance use issues

Champlain CHCs provide mental health and substance use services for many clients of other primary care models. The CHCs strive to ensure care coordination across professionals through deliberate relationships. Integrated planning will reinforce this effort and support the development of stronger working relationships ultimately enhancing competency of primary care providers in working with this population.

This work needs to start with the Mental Health and Addictions Leadership Council. It is imperative that primary health care representation be enhanced especially on the system alignment working group to ensure the service system evolves to address the intersection with primary care.

Integrate palliative care planning

Champlain CHCs believe that the work to develop a comprehensive strategy to palliative and end-of-life care, led by Parliamentary Assistant John Fraser, needs to emphasize an approach to palliative care that builds a strong and integrated foundation in primary care and enables robust interprofessional care. Like mental health and addictions services and home care, palliative care cannot be planned in isolation from primary care.

LHINs responsible for primary care planning and performance management

Focus on integrating services not system navigation

Local planning and delivery of primary care in sub regions will facilitate improved access and coordinated care at the community level however it needs to evolve to a more robust planning orientation that encompasses all sectors including primary care, mental health and addictions services, home care community support services, acute care and palliative care. The silo approach to planning cannot be perpetuated. Too many resources are being dedicated to system navigation as each sector works to facilitate linkages and continuity of care for clients requiring services across different sectors.

There is an opportunity to build on the success of the planning structures that are evolving through Health Links. The excellent planning partnerships that have evolved supports a broader population planning base and the co-ordination and integration of services to best meet the population needs. Direct service providers and managers can be engaged to leverage the extensive knowledge and expertise within the system and help to avoid duplication of planning processes.

This approach aligns with the Triple Aim Approach for optimizing health system performance outlined by the Institute for Healthcare Improvement. The "Triple Aim" strives to improve three things for a population simultaneously: people's health care experiences, the health of populations; and the per capita cost of health care. It requires:

- Focusing on individuals and families
- Redesigning primary care services and structures
- Managing the health of a particular population(s)
- Establishing a cost-control platform
- Reinforcing system integration and execution
- Building coalitions with other sectors.

Use a collective impact approach

A "collective impact" approach has strong potential to advance positive change toward shared goals within sub regions. It is clear that no one organization can accomplish what needs to be done alone. Utilizing a "collective impact" approach that focuses on relationships between organizations in pursuit of shared objectives is likely to be the most nimble and least disruptive response to moving forward. This approach will enable engagement of all models of primary care without payment models getting in the way of collaborative planning. Organizations would retain their own direct accountability. Funding would be allocated to support collaborative planning and performance measurement. Building on strengths and partnerships will foster collaborations whereas if new structures are created the process may be fraught with challenges. The focus must be the common agenda that will move the system forward.

CHCs can play a leadership role as "Backbone primary care organizations"; they have experience in accountability requirements with LHINs, skills in convening partners and building networks as well as experience in constructive approaches to planning.

The collective impact approach can also support enhanced clinical leadership. Currently within the Champlain LHIN individual primary care physicians are expected to lead primary care networks responsible for influencing change. The experience to date hasn't demonstrated that this model works nor does it align with a collaborative planning approach that is essential to address challenges and move systems forward. Building on the Health Links experience, a more collaborative approach that engages all sectors, including management and providers, and is targeted to engage primary care providers more effectively will have greater impact.

Ensure Health Links are led with a primary care orientation

In many locations, Health Links have demonstrated the commitment of health service providers from across the sectors to come together to plan and integrate services for the most complex clients. It mirrors a collective impact approach. There is an opportunity to leverage some of the progress made through Health Links as long as the Health Links are led from a primary health care orientation. When Health Links are being led by organizations that are not primary care based it may limit impact.

Analyse and realign boundaries

LHIN, Health Link and sub regional boundaries require review and analysis to ensure a shared understanding of the most appropriate boundaries and the implications for the population and the providers offering service. Efforts to enhance consistency of access are at times being thwarted by the LHIN and Health Link boundaries that have been established. Further analysis may result in realignment of boundaries to better plan for population health needs. Regardless of the boundaries that are ultimately identified, the MOHLTC, the LHIN and providers must acknowledge that there is no perfect boundary and people are entitled to equal access to the services they need regardless of their postal code.

Target resources

CHCs are a proven model for the 22% of the population that require comprehensive services that integrate health care and address social determinants of health. This includes access to interprofessional teams as well as integration of services that address the social determinants of health. Many CHC clients have complex needs but are not identified as Health Links clients because they have been well managed and are not making avoidable use of the health system. Even though they serve a greater proportion of people with complex needs, CHCs do a better job than other primary care models of keeping people out of hospital emergency departments.[4] This expertise needs to be leveraged.

CHCs support the importance of working with LHINs and other primary care models to ensure that those residents who need services from interprofessional teams can access those easily. CHCs already serve many clients of other primary care models. CHCs are committed to extend this work by developing deliberate relationships and service integration models with primary care practices to ensure clients with complex needs have access to the required services.

Leverage the CHC infrastructure to support consistency

The Champlain LHIN is committed to ensuring more consistent access to key services across the region. CHCs in the Champlain have a well-established infrastructure that enables CHCs to plan and manage regional and sub regional services for specific conditions or populations (e.g. diabetes education, primary care outreach, lung health, falls prevention). Individual CHCs evolve services and supports within hubs that are important to the health of individuals in their community (i.e. family and children's services, housing supports, employment supports). With a commitment to offer evidence-based services, the CHCs then work together to expand the service to other hubs where the need is evident. This is an efficient approach to expanding access to high quality services.

With CHCs partnering in primary care planning at the sub LHIN level these services can continue to be leveraged and expanded through other primary health care hubs.

Enhance focus on quality improvement

With the LHIN assuming responsibility for all primary care models, it can drive quality improvement initiatives, monitoring and publishing performance indicators to hold organizations accountable. This commitment to quality combined with the experience of CHCs and family health teams in quality improvement initiatives is a solid foundation from which to build.

Extend access to primary care together

Champlain CHCs are committed to timely access to services. More recently CHCs have extended their hours of service (with some adding more evening or early morning hours) and many now offer advanced access. Some CHCs like North Lanark offer daily urgent care for both CHC and non CHC clients which directly reduces the demand on community hospital emergency departments. With enhanced primary care integrated planning at the sub LHIN level, other agreements could emerge to provide more evening and weekend coverage.

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[4] Institute for Clinical Evaluative Sciences. (2012). *Comparison of primary care models in Ontario by demographics, case mix and emergency department use, 2008-08 to 2009-10.*

Address primary care gaps and plan for transitions

In 2014, Champlain CHCs developed a population health model for understanding gaps in access to primary care. It was intended as a platform to enable future primary care planning across the region.

The service gap in some areas is evident. Whitewater Bromley CHC now has a wait list of over 700 clients in an area where there are no other options for primary care. Some CHCs in urban areas no longer maintain waiting lists and accept clients only when there is additional capacity or they have been identified as a high priority.

Strong working relationships at a sub LHIN level will allow for more proactive joint planning to meet the needs of the population. This is important in rural areas when primary care access and stability become issues through retirement or illness of a primary care provider and there are limited options for attracting primary care providers without appropriate infrastructure. CHCs are particularly suited to delivering primary health care in rural communities, which often face shortages of healthcare professionals and limited access to services and supports. Primary care providers that are supported by an interprofessional team are more likely to commit to a practice. Proactive planning for transitions is also important in urban areas when a primary care provider that has specialized in serving a particular population group retires and there is no obvious option for transitioning clients. Some CHCs in other LHINs have absorbed primary care practices through a transition of funding when there were no options and the population base was vulnerable to being without primary care.

Some investment is needed in parts of the region to ensure communities and populations with barriers to access are served. In Renfrew County there is a need to extend the capacity to provide primary health care to more people through existing geographic hubs (i.e. Rainbow Valley) and to specific populations like Franco-Ontarians. Similar gaps exist in the Eastern Counties, in Lanark and within the City of Ottawa.

Transfer responsibility for home and community care in the LHINs

Integrate planning and delivery of home and community care with primary care

Community Care Access Centres (CCAC) have not evolved to be able to deliver quality services in a responsive and efficient way. The size of these organizations, the diverse population base to be served and the contracting out service model has challenged CCACs from ensuring access to services and has created much inefficiency that leads to higher costs and compromised service integration. The service model needs to change not just its management.

Many stakeholders consulted by the Expert Panel on Home and Community Care identified the engagement of primary care as a critical success factor for home and community care reform. The Expert Panel concluded that unless primary care and home and community care are well aligned, the needed transformation will not be possible.[5]

Planning and delivery of home care and community care, including community support services, needs to be integrated with primary care planning at a sub regional level.

Ensure access to a clearly defined basket of services

The current situation with wide variation in access to services through both CCAC and community support services (both clinical and non clinical supports) is untenable. As recommended by the Expert Panel, the MOHLTC must clearly define what services all Ontarians can expect and under what circumstances. The LHIN must then have the latitude to direct funds to respond to local realities and differences to ensure access to critical services.

The initiative, currently being piloted by the Champlain LHIN, to provide personal care services at no cost for individuals or families that could not otherwise afford them is critical. CHCs expend considerable resources in efforts to establish the required supports for clients that cannot afford to pay for services.

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[5] Expert Group on Home and Community Care. (March 2015) Bringing Care Home: Report of the Expert Group on Home and Community Care.

Integrate care coordinators with primary care

It is essential that responsibility for care coordination be integrated directly with primary care. Care coordinators need to become integral members of the interprofessional primary health care team. The role needs to go beyond managing access to home care services to partnering with the client and their family to assess and monitor needs, develop a care plan, communicate with everyone in the circle of care and ensure the integrated provision of services.

Currently CHCs and many partner agencies dedicate inordinate amounts of resources toward establishing working relationships with and advocating for client service from CCAC. Embedding the management and delivery of care coordination directly into primary care organizations and allowing for shared care plans across the circle of care will streamline access and create efficiencies within the system that can be redirected to direct service for clients.

This approach aligns with what is happening in some but not all of the Health Links. Integration of care coordination acknowledges the critical role of primary care.

Maintain LHIN focus on planning and performance management

CHCs do not support the transfer of responsibility of the delivery of a health service to the LHIN. The LHIN role needs to remain focused on system planning and performance management. It is a serious conflict of interest for the LHIN to directly manage services, a conflict of interest that is real and that will become an impediment to their role in evolving the health system. The LHINs cannot be expected to plan and make funding decisions about local health priorities when they are responsible for managing a service, nor will there be trust in decisions when the conflict of interest is so apparent. This will compromise the integrity and role of the LHINs.

Realign existing services

The breadth of services that have evolved through CCACs have diluted the focus on home and community care and created confusion about mandates. The CCAC mental health and addictions services offered within schools are a clear example. This function is better integrated with community mental health and addictions services and primary care.

Stronger links between public health and other health services

Integrate population health and public health planning

Public health is a very important part of the health system and CHCs have strong collaborative relationships with public health units in a range of areas including early years, sexual health, food security, mental health promotion, oral health, pre and post natal care and harm reduction.

Given that planning and accountabilities are different, it can be challenging to plan together. Enhanced integration of local population health and public health planning will provide a platform for joint action between public health, primary care and other sectors to improve health outcomes as well as create efficiencies. For example, a joint focus on strengthening evidence-based practice across primary care organizations could reduce the need for more costly interventions. Health promotion and primary health care services such as sexual health services would be embedded directly into primary health care hubs reducing duplication of effort.

Address funding inequities

CHCs are sensitive to the need for public health to maintain strong relationships with and continue to influence policy and planning decisions of local municipalities. In addition, data illustrates that public health funding is not consistent across the province. Addressing equity in funding, which will translate to equity in access to services, will be an important element of the plan.

CHC COMMITMENT MOVING FORWARD

Champlain CHCs welcome the LHINs extended planning role in the health system. We are committed to helping to advance a shared vision for change, working in partnership across the continuum of care with local and regional health sector partners as well as our partners in public health and community and social services sectors.

Working together with all models of primary care, CHCs can form the backbone for the evolution of a strong primary health care foundation in the Champlain region. In doing that CHCs will continue to lead in serving clients that face barriers to access, particularly those with complex health issues that require both interprofessional care and support to address the determinants of health.

The MOHLTC and the Champlain LHIN have invested in the Champlain CHCs. The opportunity exists to continue to leverage that infrastructure to establish a stronger base of primary health care in the Champlain region. CHCs can be a critical part of the Triple Aim solution - improve health outcomes, patient experience and reduce costs!

CHCs are important hubs of service located in eighteen communities across the Champlain Region. A great deal of capital funding has been invested to build and develop our purpose-built infrastructures that enable the delivery of a wide range of health and community services by both CHCs and community partners. Where there are clear gaps in access to primary health care services, CHCs could create additional hubs preferably in collaboration with other organizations to integrate health and community services.

The MOHLTC and LHIN have funded and supported the development of CHC information technology and information management infrastructure (i.e., Ontario Telemedicine Network, Nightingale-on-Demand electronic health records as well as human resource and financial management software). Agreements exist with other health system partners to allow sharing of client records with CCAC and some hospitals. This capacity can be leveraged to improve access to clients, facilitate performance monitoring and streamline administration.

CHCs have well established working relationships with many other primary care providers, facilitating access to a wide range of critical services for their clients. For example, 77% of the clients served through the primary care outreach service for vulnerable seniors are clients of non-CHC primary care providers. These types of arrangements can be expanded upon, particularly in support of clients of solo and small group primary care practices. The potential exists to expand on CHC region-wide services to enhance access to consistent quality services where they are needed.

CHCs have demonstrated capacity to work collaboratively with a wide range of partners - neighbourhood, sub region and regional. Some CHCs are leading Health Links and all are active partners. CHCs could leverage their leadership skills to assume the role as backbone community primary health care organizations dedicated to moving forward using the collective impact approach by leveraging and continuing to build collaborative relationships in respective communities, working in partnership with family health teams, family health organizations and other primary care models currently not reporting to LHINs.

The system of services needs to be responsive to the people who use those services. CHCs are governed by community-based Boards of Directors and are skilled at engaging clients and family members in service design. Board members from collaborating Champlain CHCs were involved in developing this response. CHCs are committed to helping evolve a health system that serves people and communities.