

into the future.....



**a review of the reports of groups
addressing nine priority initiatives
identified at the Central LHIN workshop**

February 2005

**Recommendations to the Central LHIN CEO and Board:
A Report of the Central LHIN Steering Committee**

TABLE OF CONTENTS

1	EXECUTIVE SUMMARY.....	1
2	NINE PRIORITY INITIATIVES FOR THE CENTRAL LHIN	3
2.1	PATIENT CARE/SERVICES INTEGRATION INITIATIVES.....	3
2.2	ADMINISTRATIVE SUPPORT SERVICES INITIATIVES.....	3
3	DEFINING AND EXPLORING THE NINE INITIATIVES	3
4	CONNECTIONS AMONG THE INITIATIVES	4
5	FIVE STRATEGIES FOR THE CENTRAL LHIN.....	6
5.1	THE FIRST STRATEGY: PRIORITY SERVICE AREAS FOR INTEGRATION.....	6
5.2	THE SECOND STRATEGY: ESTABLISHING CENTRAL LHIN KEY OBJECTIVES.....	7
5.3	THE THIRD STRATEGY: ADDRESSING CRITICAL ENABLERS FOR INTEGRATION	7
5.4	THE FOURTH STRATEGY: ADDRESSING CRITICAL SUCCESS FACTORS.....	8
5.5	THE FIFTH STRATEGY: RESOLVING KEY INTEGRATION ISSUES	9
6	CONCLUSION: PROPOSED FIRST ACTION STEPS	10
7	TEMPLATES “A” AND “B”: INITIATIVE DESCRIPTIONS	11
8	TEMPLATE “C”: HIGH LEVEL PLANS FOR THE INITIATIVES	37
9	TEMPLATE “D”: CHARACTERISTICS OF THE CENTRAL LHIN	43
9.1	UNIQUE CHARACTERISTICS.....	
9.2	ROLE OF ACADEMIC HEALTH SCIENCE CENTRES AND VOLUNTARY NETWORKS.....	
10	TEMPLATE “E”: TRANSFORMATIONAL THINKING: THE CENTRAL LHIN PROCESS AND KEY LEARNINGS	48
10.1	APPROACH AND PROCESS	
10.2	THE KEY LEARNINGS	
11	MEMBERS OF THE CENTRAL LHIN STEERING COMMITTEE	50
12	APPENDIX ONE: PATIENT/CLIENT CARE CONTINUUM	51

1 EXECUTIVE SUMMARY

Based on deliberations at a Ministry-hosted workshop for the Central LHIN area, nine priority initiatives were identified (five Patient Care/Services Integration Initiatives and four Administrative Support Services Initiatives). Nine small groups, coordinated by a Steering Committee, then further described the nine initiatives using templates provided by the Ministry. A list of Steering Committee members is included as Section 11 of this report. As well, the nine small groups developed high level plans for their initiatives (see Section 7). A description of the unique characteristics and features of the Central LHIN was also developed (see Section 8).

The Steering Committee then reviewed the reports of the small groups, identified patterns across the nine reports, and integrated the nine initiatives as well as the patterns into five key learnings which it calls **key strategies for the Central LHIN** (see Section 4). Finally the Committee identified eight first action steps the Central LHIN should take to begin moving forward on these five key strategies (see Section 6).

The elements developed in the course of the processes described above are shown graphically on the next page.

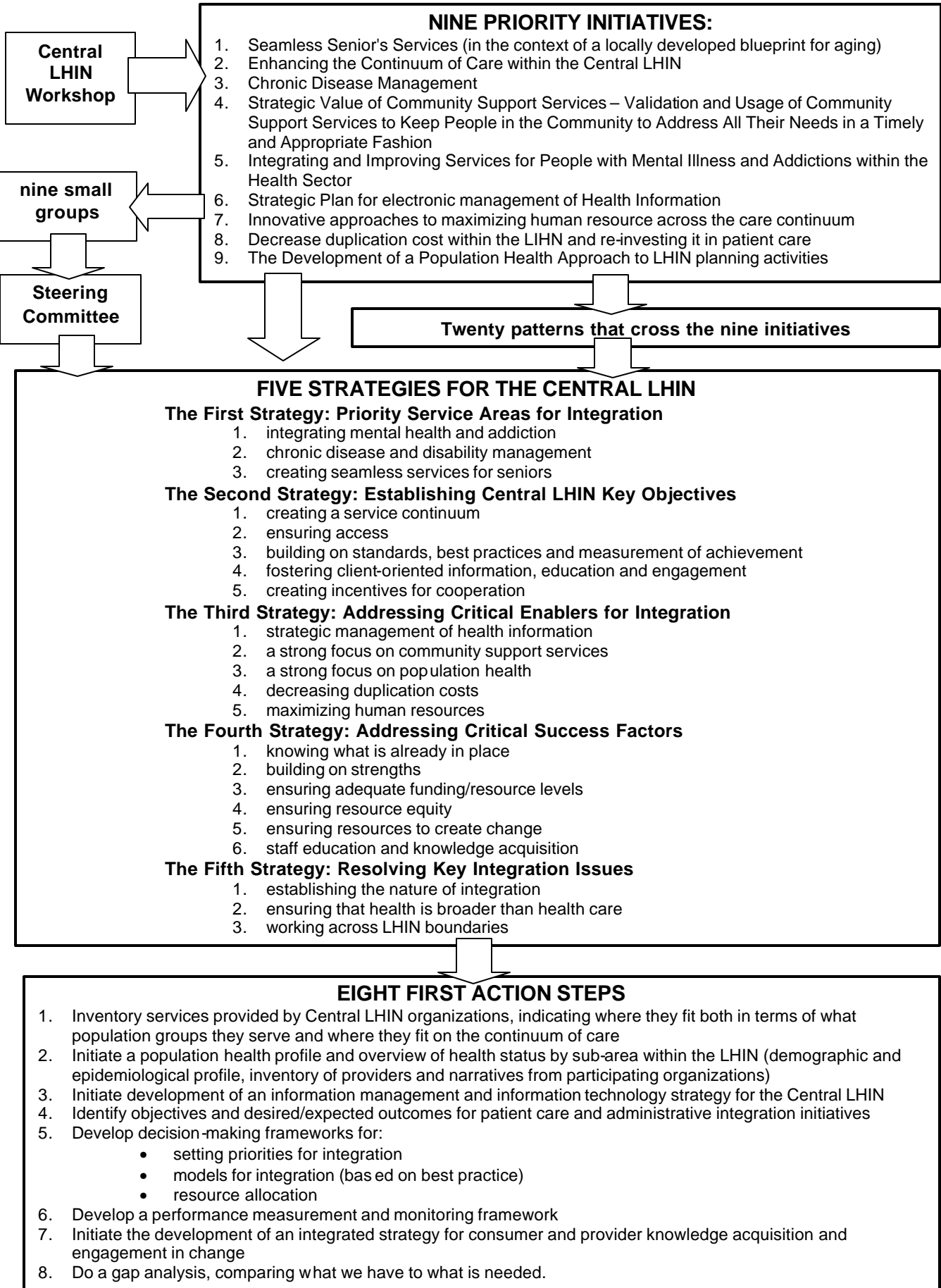
The Central LHIN Steering Committee recommends that the Central LHIN take action on five strategies to transform health within the Central LHIN area:

1. The First Strategy: Priority Service Areas for Integration
2. The Second Strategy: Establishing Central LHIN Key Objectives
3. The Third Strategy: Addressing Critical Enablers for Integration
4. The Fourth Strategy: Addressing Critical Success Factors
5. The Fifth Strategy: Resolving Key Integration Issues

The Central LHIN Steering Committee recommends that the Central LHIN initiate eight key action steps to begin the process of transformation:

1. Inventory services provided by Central LHIN organizations, indicating where they fit both in terms of what population groups they serve and where they fit on the continuum of care
2. Initiate a population health profile and overview of health status by sub-area within the LHIN (demographic and epidemiological profile, inventory of providers and narratives from participating organizations)
3. Initiate development of an information management and information technology strategy for the Central LHIN
4. Identify objectives and desired/expected outcomes for patient care and administrative integration initiatives
5. Develop decision-making frameworks for:
 - setting priorities for integration
 - models for integration (based on best practice)
 - resource allocation
6. Develop a performance measurement and monitoring framework
7. Initiate the development of an integrated strategy for consumer and provider knowledge acquisition and engagement in change
8. Do a gap analysis, comparing what we have to what is needed.

The authors of this report respectfully request a report back to the stakeholders on actions taken, within one year of the official launch of the Central LHIN.



2 NINE PRIORITY INITIATIVES FOR THE CENTRAL LHIN

The Central LHIN Workshop was hosted by the Ministry of Health and Long-Term Care on December 1 2004. At this workshop, participants identified nine priorities grouped in two categories¹:

2.1 Patient Care/Services Integration Initiatives

1. Seamless Senior's Services (in the context of a locally developed blueprint for aging)
2. Enhancing the Continuum of Care within the Central LHIN
3. Chronic Disease Management
4. Strategic Value of Community Support Services – Validation and Usage of Community Support Services to Keep People in the Community to Address All Their Needs in a Timely and Appropriate Fashion
5. Integrating and Improving Services for People with Mental Illness and Addictions within the Health Sector

2.2 Administrative Support Services Initiatives

1. Strategic Plan for electronic management of Health Information
2. Innovative approaches to maximizing human resource across the care continuum
3. Decrease duplication cost within the LHIN and re-investing it in patient care
4. The Development of a Population Health Approach to LHIN planning activities

3 DEFINING AND EXPLORING THE NINE INITIATIVES

After the Central LHIN workshop, nine small groups began working on fleshing out each of these nine initiatives, using a Ministry framework found in the document *Taking Stock: Setting Integration Priorities*. This document is a tool to allow the small groups that emerged from the Central LHIN workshop to record information related to the top priority initiatives identified at the workshop. The document contained several templates that allowed each group to:

- provide a title for the initiative it examined
- indicate whether its initiative patient care/services initiatives or an administrative/support services initiatives
- indicate them type of integration each initiative was meant to encompass
- indicate whether the initiative was initiated/existing or new
- list the partners involved in preparing the small group's report

¹ Workshop organizers required priorities to be generated under each of these two categories at all fourteen workshops.

- briefly describe the initiative
- describe the current status of the initiative if it was initiated/existing
- indicate the outcomes/lessons learned (if any) related to the initiative
- provide information on a contact person for the small group
- record a high-level action plan for each initiative.

Each small group then prepared a report based on these templates.

The leaders of the small groups formed themselves into a Steering Committee for liaison purposes as each small group developed its report. This Steering Committee analyzed the findings of the small groups and identified twenty patterns² within the nine small group reports. These patterns, grouped into five strategies, are shown in the next section. As well, the basis for calling them “patterns” is found in Appendix One.

Note that the initiatives and strategies described in this report do not represent the only issues to be planned and addressed by the new Central LHIN. However as the initiatives tend to intersect in various thematic ways, they represent key planning needs for the area.

4 CONNECTIONS AMONG THE INITIATIVES

It is quite possible that the initiatives arising from any LHIN workshop might be “stand alone” initiatives, not related to each other. To determine if this is the case with the initiatives from the Central LHIN workshop, the initiatives were analyzed to see to what degree each initiative refers to any of the other eight initiatives. The results are shown graphically on the next page. Note that an arrow from an initiative represents a reference within the initiative to another initiative (the one to which the arrow points).

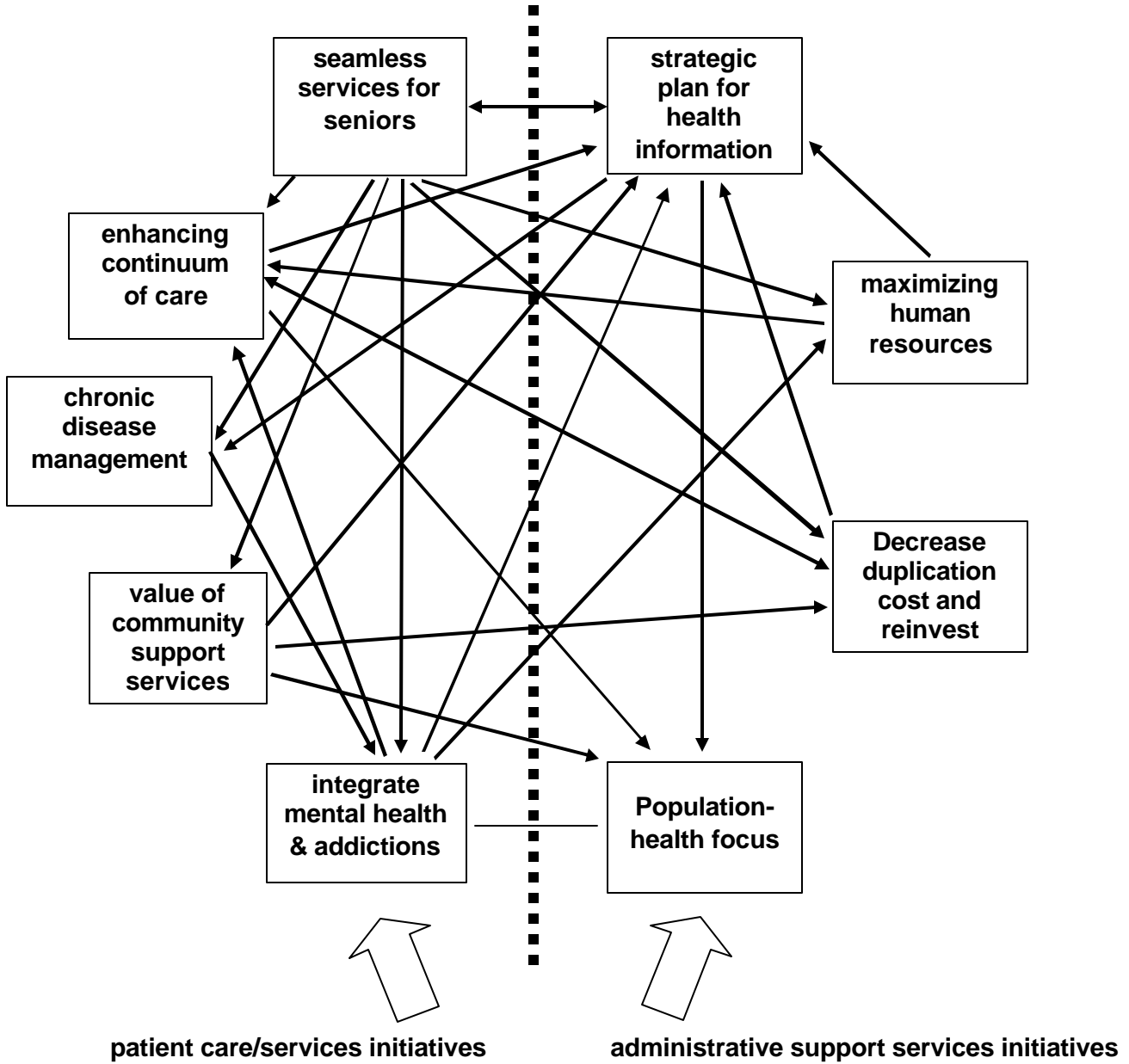
Note that the initiative ***strategic plan for health information*** receives the most “hits” or links (six arrows point to it out of a possible eight).

Note as well that every initiative receives at least on link, and sends out at least one link.

This analysis suggests that the initiatives are linked to each other and should be implemented keeping in mind these links.

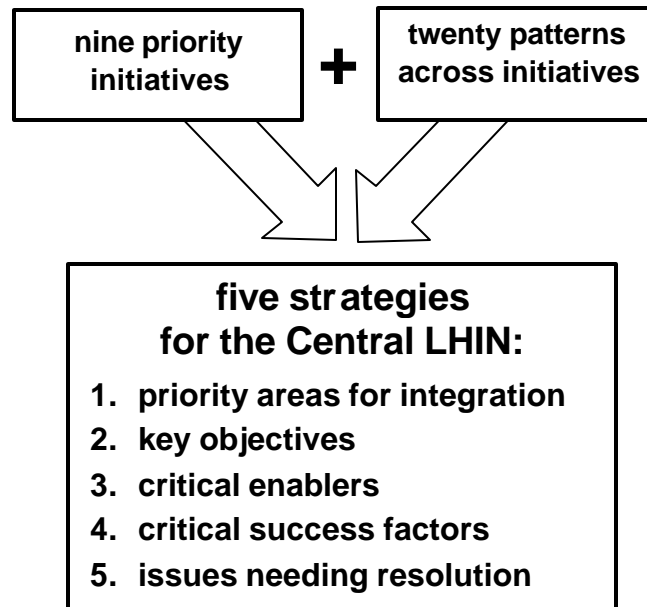
² A pattern identified as a result of this analysis does not necessarily mean that a majority of small groups reflected the pattern. In a few instances, only two of the nine groups reflected a pattern – but the pattern was considered of enough significance and importance to warrant its inclusion. Most patterns, however, reflect issues raised and discussed by more than two groups.

CONNECTIONS AMONG THE INITIATIVES



5 FIVE STRATEGIES FOR THE CENTRAL LHIN

An integration of the nine high priority initiatives, and the twenty patterns that cross the initiatives, yields *five strategies the Central LHIN should consider*:



The five strategies are described on the next few pages of this report.

5.1 *The First Strategy: Priority Service Areas for Integration*

The priority initiatives highlight three priority service areas:

1. *integrating mental health and addiction*

This integration should be based on a recovery model, it should incorporate the determinants of health, it should be client-directed and it should ensure that the consumer and family voice is heard in the planning and delivery of services.

2. *chronic disease and disability management*

This approach, spanning the whole care continuum, should emphasize disease and disability management in ways that help individuals maintain independence and keep as healthy as possible, as long as possible.

3. *creating seamless services for seniors*

This seamless system should be comprehensive, co-ordinated and accessible for seniors across the care continuum provided by energized staff, based on health delivery that is patient/client and family focused and delivered in a culturally competent/diversity-friendly way in the client's home whenever possible.

5.2 The Second Strategy: Establishing Central LHIN Key Objectives

Five key objectives should be considered paramount by the Central LHIN:

1. creating a service continuum

This involves creating a seamless continuum³ of client-focused care from health promotion/prevention to primary care to acute care to continuing/chronic care, in order to improve timely and reasonable access, continuity, health outcomes and efficiency for consumers. All parts of the continuum should be linked, with emphasis in primary care, hospital/acute care and health promotion and disease prevention.

2. ensuring access

Since a continuum is of little use if people cannot access it, a great deal of attention must be paid to fostering access and providing navigation resources to people in need, and to their family and agency caregivers. Ensuring that the cultural diversity of the population is taken into account in designing, funding and evaluating services will also bolster access.

3. building on standards, best practices and measurement of achievement

Standards, best practices and measurement should be strengthened so health services in the Central LHIN area are as accountable as possible to the people they serve and to their funders.

4. fostering client-oriented information, education and engagement

Clients and families can make more effective and more efficient use of the health system and can participate in planning and evaluating the system if they are provided with information and opportunities and are educated about their own health issues and about how to use the system for themselves or for family members.

5. creating incentives for cooperation

Incentives must be built into the transformed system to motivate stakeholders to build, maintain and change the system and to take action to remove or reduce counterproductive competition.

5.3 The Third Strategy: Addressing Critical Enablers for Integration

Five critical enablers were identified:

1. strategic management of health information

This includes a strategic plan and implementation of the plan, that addresses information management and information technology, and that involves key clinical and administrative users in development and implementation of the plan.

³ See Appendix One of this report for a graphic representation of a care continuum

2. a strong focus on community support services

This focus should help seniors, people with disabilities and people with special needs to remain comfortably and safely at home and in their communities through provision of personalized services to enhance esteem and promote independence and client choice.

3. a strong focus on population health

This should begin with development of a population profile and overview of health status by sub-area within the LHIN (demographic and epidemiological profile, inventory of providers and narratives from participating organizations) to form the basis of logical and effective health service integration planning and to help determine which initiatives are priorities in terms of need or impact.

4. decreasing duplication costs

This involves exploring opportunities to share resources, reduce duplication, achieve economies of scale and capitalize on competencies across the continuum of care between and among sectors. Savings that will be achieved by consolidating and integrating support services can be reinvested back into client/patient care.

5. maximizing human resources

This includes reducing employee turnover by improving benefits with an integrated approach to contract management (ie. benefits), reallocation/reorganization of service delivery so the right service is delivered in the right location by the right provider, using technology to manage e-learning for clients and providers, and integrating information access.

5.4 The Fourth Strategy: Addressing Critical Success Factors

To achieve the objectives through critical enablers, six critical success factors must be addressed.

1. knowing what is already in place

Inventories of what exists within the health system in terms of care and support resources, processes and structures is a precondition to transformation. Inventories should be supplemented by evaluation of the efficiency and efficacy of what exists within today's system.

2. building on strengths

Change in the Central LHIN area must be based on existing strengths in this area. These strengths include many people, organizations, structures and processes that are currently working well to plan, deliver and evaluate health services in the Central LHIN area.

3. ensuring adequate funding/resource levels

Adequate funding, through new funds or reallocation of funds, must be made available, particularly for high priority health issues.

4. ensuring resource equity

System inequities in health funding must be resolved, particularly concerning:

- inequities in funding between different kinds of health agencies, even when their workers carry out identical or equally complex work
- inequities in parts of the Central LHIN area that are high growth, where health infrastructure has not grown apace with population growth. As well, there may be areas with poor profiles in terms of the social determinants of health (e.g. poor socioeconomic profiles) where services have also not developed commensurate with the burden of ill health in these areas.

5. ensuring resources to create change

Resources (including funding and time) are necessary to make the paradigm shift required by Ontario's transformation strategy.

6. staff education and knowledge acquisition

Knowledge acquisition by health service personnel, through opportunities to share information and through formal and formal educational opportunities, will be crucial in maintaining and enhancing quality and in helping personnel to make the paradigm shifts necessary to move toward a more integrated system.

5.5 The Fifth Strategy: Resolving Key Integration Issues

Three issues must be resolved both locally and provincially if the three strategies cited above are to be carried out.

1. establishing the nature of integration

Partnership and coordination rather than merger and amalgamation are the most promising ways to achieve integration in the Central LHIN area. however, a more thorough analysis and debate on the full range of forms of integration is needed, so the forms of integration can be tailored to fit individual integrative initiatives.

2. ensuring that health is broader than health care

Strong links to Ministries other than health and long-term care will be crucial, as well as links to societal sectors other than government. These links will help to provide a broader continuum of support and to allow the full range of determinants of health to be addressed.

3. working across LHIN boundaries

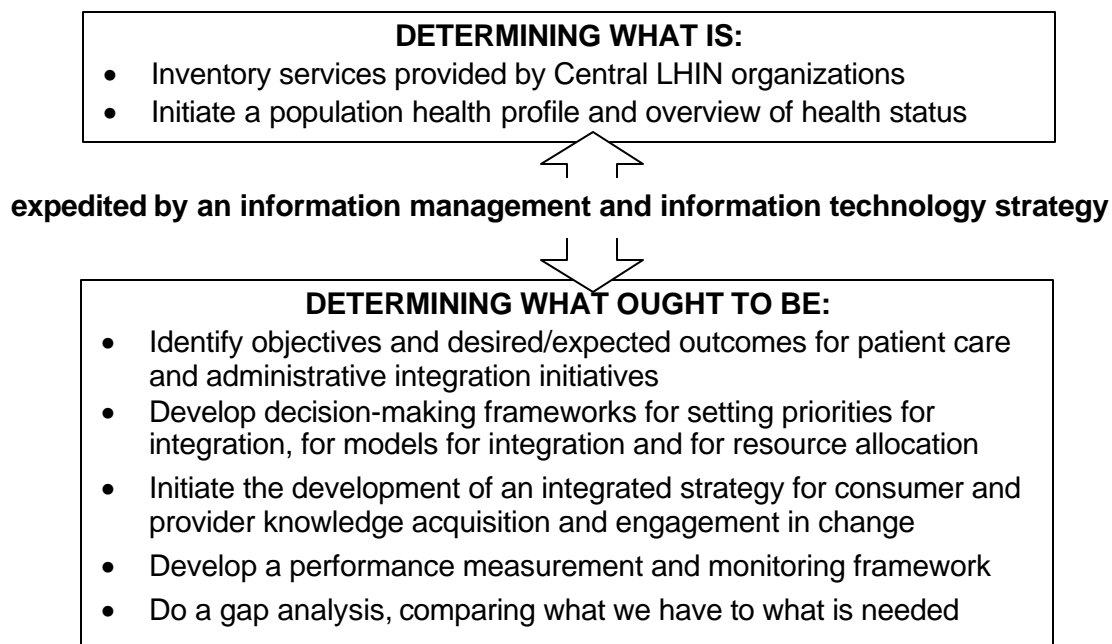
It will be crucial for LHINs to work together province-wide and in Central Southern Ontario. This will allow economies of scale to bear on some activities, and will also allow cross-boundary referrals and service patterns to be taken into account.

6 CONCLUSION: PROPOSED FIRST ACTION STEPS

Based on analyses described earlier in this report, the Central LHIN Steering Committee proposes eight first action steps as starting points for the Central LHIN:

1. Inventory services provided by Central LHIN organizations, indicating where they fit both in terms of:
 - what population groups they serve
 - where they fit on the continuum of care
2. Initiate a population health profile and overview of health status by sub-area within the LHIN (demographic and epidemiological profile, inventory of providers and narratives from participating organizations)
3. Initiate development of an information management and information technology strategy for the Central LHIN
4. Identify objectives and desired/expected outcomes for patient care and administrative integration initiatives
5. Develop decision-making frameworks for:
 - setting priorities for integration
 - models for integration (based on best practice)
 - resource allocation
6. Develop a performance measurement and monitoring framework
7. Initiate the development of an integrated strategy for consumer and provider knowledge acquisition and engagement in change
8. Do a gap analysis, comparing what we have to what is needed.

Conceptually these eight steps represent the core of good planning – moving from ***what is***, to ***what ought to be***:



7 TEMPLATES “A” and “B”: INITIATIVE DESCRIPTIONS

This appendix contains the completed Template A for the following initiatives:

Patient Care/Services Integration Initiatives

1. Seamless Senior's Services (in the context of a locally developed blueprint for aging)
2. Enhancing the Continuum of Care within the Central LHIN
3. Chronic Disease Management
4. Strategic Value of Community Support Services – Validation and Usage of Community Support Services to Keep People in the Community to Address All Their Needs in a Timely and Appropriate Fashion
5. Integrating and Improving Services for People with Mental Illness and Addictions within the Health Sector

It also contains the completed Template B for the following initiatives:

1. Strategic Plan for electronic management of Health Information
2. Innovative approaches to maximizing human resource across the care continuum
3. Decrease duplication cost within the LIHN and re-investing it in patient care
4. The Development of a Population Health Approach to LHIN planning activities

A. Description of Patient Care/Services Integration Initiative (Copies of Template A available at the end of this document. Please limit your response to 2 pages per initiative.)

Title of patient care/service initiative:		Type of integration (more than one box can be checked)	
Seamless Senior's Services, initiative #6: (in the context of a locally developed blueprint for aging)		<input checked="" type="checkbox"/> Horizontal <input checked="" type="checkbox"/> Vertical <input checked="" type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe: COMSOC, housing	
Existing or new initiative?	List of partners involved:		
<input checked="" type="checkbox"/> Initiated/existing integration activity* <input type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	Victor Formasier Patricia Miller Ilene Cohen–Ackerman Esta Wall Louise Goldhar Pat Dayle Colleen Laing Glen Boyd (Financial) Olivia Rettinger Debbie Sedore-Kola Krista Robinson Helen Ferley Amo Nandlall Maria Kavanagh Gregory Konigshaus Required Additional Consultation: RGP, CCAC, Rehab Hospitals, OHA, Ontario Long Term Care Association, Canadian Mental Health Association, Provincial Branch/Toronto Branch/Other, Consumers, Chronic Disease Associations, e.g., Arthritis Society, Heart and Stroke Foundation, OANHSS		
Please briefly describe the initiative:			
<p>The need for comprehensive, co-ordinated and accessible services for seniors across the care continuum provided by energized staff. Services include but are not limited to:</p> <ol style="list-style-type: none"> 1. Addictions & Mental Health Services 2. Housing 3. Supportive Care 4. Psychogeriatric & Mental Health Consulting Services 5. Hospital services (inpatient/outpatient) including rehab and complex continuing care. 6. Social work services 7. Community Day Centres 8. Acute care 9. Long Term Care - Institution and community based 10. End of Life Care 11. Primary Care including Family Health Networks, Family Health Groups and Family Health Teams 			

12. Palliative care/hospice.

Improve coordination of information for both patients/clients, and their families and caregivers (including physicians). Inventory of available services, including those not related to seniors to enable individuals to navigate the system. Development of Standards of Care both within sectors and between sectors. Preventative health and wellness inside and outside of institutional settings and educational opportunities related to wellness, prevention/delay, chronic disease management and self management, assessment, risk identification and follow-up. Maximize integration between sectors by enabling cross-appointments of community providers within institutional settings. Ensure that seniors health delivery is patient/client and family focused and is delivered in a culturally competent/diversity friendly manner in the patient/client's home whenever possible. Population health must be considered with an emphasis on promotion/prevention/delay versus healthcare thus improving long-term system efficiency. Redundancy in the system should be minimized by ensuring that the right service is delivered at the right time in the right way by the right person/organization (recognizing the need to find the correct balance between unnecessary duplication and patient/client choice). Wait times for all services should be minimized and/or appropriate standards established.

*If this is an **initiated/existing** activity...*

What is the current status?

Current care provision is fragmented and difficult to navigate for clients, families and providers. Service provision is dependant on perceived local need, availability of local resources and facilities, interest and expertise. Major implications include underserved needy populations, exacerbated morbidity, and unnecessary system cost. As our population ages we will need to promote an innovative system that empowers the client, supports independence and maximizes choice. Elders consume the largest percentage of health resources, family dynamics and needs vary, and the diversity of the population is increasing; delivery of services within existing frameworks is becoming harder. Multiple agencies/providers deliver often overlapping service, however, gaps still remain and flow could be improved. Patients/clients, families and health care professionals currently utilize the services of the CCACs to obtain any information on services. Some seniors' centres/LTCFs, as well as some physicians, offer wellness-based initiatives. The majority of seniors in the community do not have access to these initiatives within a cost framework they can manage. Seniors have identified wellness and preventative health as a major need. People accessing services between ministries find the process

What are the outcomes/lessons learned (if any)?

Define who does what and when, e.g., community versus hospital based provision; integration of health records; central access for records; improved hours of operation; support for unpaid caregivers; flexibility in the provision of care; developing evidence based quality indicators that cross systems. Create a navigation system that can manage gaps between services/ministries for seniors while enhancing continuum of care options to promote independence and aging in place. Marketing strategy to be employed to ensure 'hard to reach' populations have access to information. Health professionals would benefit from shared best practices and models of care information to provide optimal services to clients and to promote evidence based decision making within organizations. Funding is required to create wellness based educational programs that can be promoted across various health care sectors. Wellness and preventative health is a priority, now and in the future. If morbidity can be reduced less people will need to access the system. Intersectoral planning would help identify

frustrating, confusing, and time consuming. Persons who receive services from more than one ministry should be able to call one person who will then navigate the different ministries for them. Systems should be integrated and streamlined where possible. In order to maximize the HR potential in the province the following actions (at minimum) need to occur:

- Minimize competition between the LHINs for scarce resources – where possible share resources
- Expand scope of practice for health care workers where appropriate to better utilize skills of regulated health care workers to achieve cost effectiveness
- Introduce mentorship programs to help retain staff
- Share best practices/outcomes with other providers to maximize knowledge
- Marketing strategies that target the staff we are trying to reach (i.e. RN's, youth)
- Knowledge transfer
- Inability for staff to work within/with other organizations. Current strengths include but are not limited to health care professionals and other caregivers who are dedicated to ensuring excellent care for patients/clients. Major failures include people getting sick with preventable/ delayable disease and not being able to have their care provided in their homes.

which services could be aligned to provide more educational opportunities. Recognition that a cultural paradigm shift is necessary from an acute/chronic focus to prevention and wellness. Persons who receive service from more than one ministry must be able to navigate the system more efficiently. Ontario has a shortage of health care workers. Effective planning, consistent messaging and marketing strategies need to be implemented to ensure the future needs of health care services are met. Health care workers need to accept accountability for the care and services they provide. Need to focus on safe care including cross-system education on the use of standardized equipment and processes.

Lead contact person:

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Lead Contact person: Name: Greg Konigshaus

Title: Program Director, Medical Program
 Organization: North York General Hospital
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A. Description of Patient Care/Services Integration Initiative (Copies of Template A available at the end of this document. Please limit your response to 2 pages per initiative.)

Title of patient care/service initiative:		Type of integration (more than one box can be checked)	
Enhancing the Continuum of Care within the Central LHIN		<input checked="" type="checkbox"/> Horizontal <input checked="" type="checkbox"/> Vertical <input checked="" type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:	
Existing or new initiative?	List of partners involved:		
<input checked="" type="checkbox"/> Initiated/existing integration activity* <input type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	potential partners within the full patient/client continuum of care should be involved		
Please briefly describe the initiative:			
<p>The objectives of this initiative are to ultimately improve access, continuity, health outcomes and efficiency for consumers by:</p> <ol style="list-style-type: none"> Facilitating a seamless continuum of patient-focused care from health promotion/prevention to primary care to acute care to continuing/chronic care Allocating/reallocating resources to the most cost-effective provider(s) that can do the best job in the most appropriate setting for the consumer Minimizing duplication of administrative and support services within the health care system; and Creating a vertically integrated "system" where patients/clients have timely and reasonable access to a broad range of coordinated, effective (best practice) and efficient services <p>Requirements:</p> <ul style="list-style-type: none"> Relationship-building Information sharing Collaboration and consultation A phased approach A focus on integrating processes among health providers A system-wide patient-focused perspective, rather than an organizational-perspective Possible specialization and/or consolidation of services Possible changes in roles and responsibilities Possible reallocation of resources Considerable time, effort and resources to implement <p>Enablers:</p>			

- A shared vision among the care continuum players
- Common information systems
- Performance measurement framework
- Incentives that will encourage joint decision-making among the providers in the continuum
- Education and training to help shift thinking from an organization perspective to a systems perspective
- Use of strategy mapping as a tool to define who does what across the continuum

Potential Partnerships Models:

A number of partnership models can be considered to integrate services along the continuum of care (or horizontally), each with varying degrees of control, governance changes and risk. Some examples include: Joint Ventures/Shared Service Agreements, Alliances or Networks.

Existing Examples of Integration across the Continuum of Care

Although not all formalized, the following are a few examples in the Central LHIN of partnerships along the continuum of care:

- Palliative Care continuums in York Region and Toronto (Hospices, Palliative Care Services, hospitals)
- Toronto/GTA Regional Geriatric Program – LTC, Rehab, Hospitals
- Rapid Response Geriatric Psychiatry Services in TO (COTA, St. Elizabeth, CCAC, NYGH)
- Power Program for Osteoporosis Wellness (Public Health, LTC, Hospitals)
- Mental health – a) crisis assessment and intervention in York Region (community mental health, housing, addiction services, York Central, Whitby Psychiatric) b) formal partnership agreement among 18 TO mental health agencies for case management, housing and family support.

*If this is an **initiated/existing** activity...*

What is the current status?

Although not all formalized, the following are a few examples in the Central LHIN of partnerships along the continuum of care:

- Palliative Care continuums in York Region and Toronto (Hospices, Palliative Care Services, hospitals)
- Toronto/GTA Regional Geriatric Program – LTC, Rehab, Hospitals
- Rapid Response Geriatric Psychiatry Services in TO (COTA, St. Elizabeth, CCAC, NYGH)
- Power Program for Osteoporosis Wellness (Public Health, LTC, Hospitals)
- Mental health – a) crisis assessment and intervention in York Region (community mental health, housing, addiction services, York Central, Whitby Psychiatric) b) formal partnership agreement among 18 TO mental health agencies for case management, housing and family support.

What are the outcomes/lessons learned (if any)?

The expected outcomes of integration along the full continuum of care are:

- Improved Access**
- Simplified, coordinated, facilitated services, and timely access
 - Increased capacity and ability to respond and intervene early
 - Geographical convenience and flexibility of service offering and delivery mechanisms
 - Less people “falling through the cracks”
- Better System Navigation**
- Smooth, seamless transition between services for patients/clients
 - Decreased barriers within and between organizations
 - Common purpose and goals ... congruent non-competitive objectives
 - Key role for consumers in navigation of the

A. Description of Patient Care/Services Integration Initiative (Copies of Template A available at the end of this document. Please limit your response to 2 pages per initiative.)

Title of patient care/service initiative:		Type of integration (more than one box can be checked)	
Chronic Disease Management		<input checked="" type="checkbox"/> Horizontal <input checked="" type="checkbox"/> Vertical <input checked="" type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:	
Existing or new initiative?	List of partners involved:		
<input checked="" type="checkbox"/> Initiated/existing integration activity* <input type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	<p>Christine Lee-Bun, Dementia Society; Dennis Brown, Toronto Grace Hospital; Georgina Veldhorst, North York General Jim Nason, Loft Community Services; Malcolm Moffat, St. John's Rehab Hospital; Maria Herrera, Toronto Public Health; Susan Ross, Arthritis Society; Bill Innes, York Region CCAC; Dr. Gabriel Chan, North York General Laurie Hurley, Arthritis Society; Dr. David White, North York General; Rose Dumsha, North York General</p> <p>The following partners should be included in any future consultations:</p> <ul style="list-style-type: none"> • Community Care Access Centres, Public Health, Community Health Providers, including home care, long term care, day programs, and hospices. Support groups, including disease specific organizations (Heart and Stroke, Cancer Care Ontario, Diabetes Association, Lung Association, Canadian Mental Health Association, Canadian National Institute for the Blind, Arthritis Society, etc.) • Primary Care Physicians and Family Health Teams (including physiotherapists, occupational therapists, speech/language pathologists, nutritionists, chiropractors, nurses, nurse practitioners, etc.) • Specialty Physicians (dependant on chronic disease - eg Rheumatologists and Orthopaedic Surgeons for arthritis, Respirologists for emphysema, Oncologists for cancer, Psychiatrists for Mental Health, Cardiologists for COPD, Geriatricians for many chronic diseases, etc) • Specialty Clinics, Hospitals (especially emergency departments, day hospitals, ambulatory clinics, and discharge planners), CHCs • Community and recreation centres to help promote healthy life styles. 		
Please briefly describe the initiative:			
<p>Chronic diseases are the leading cause of death and disability worldwide. Individuals with chronic diseases represent the fastest growing numbers of patients in Ontario. They take up an inordinately high number of health care resources, because these patients are not appropriately managed in the community. The current approach is often of an episodic nature, with</p>			

little focus on prevention or integrated follow-up. That approach is a sickness care one, with little emphasis on healthy lifestyle or on self management in the community, with appropriate education and supports. Chronic disease management is an approach to health care that emphasizes helping individuals maintain independence, and keep as healthy as possible, as long as possible. This initiative would include primary and secondary prevention, common approaches to care among partners, early detection, diagnosis and intervention, and appropriate follow-up in the community after acute episodic care. The disease prevention aspect will not only prevent the occurrence of disease, through such mechanisms as risk factor reduction, but will also help to arrest the progress of disease, and reduce its consequences once established. This coordinated and integrated approach to care across health sectors will provide longitudinal management and consultation with limited hospitalization. It can support self-management and prevent, delay or minimize disease and disability progression, and maximize health and wellbeing, which will also reduce costs. Some examples of chronic diseases that could be better prevented and managed include dementia, asthma, cardiovascular disease, COPD, HIV/AIDS, arthritis, cancer, mental health and addiction, diabetes, osteoporosis, Parkinson's disease, etc.

*If this is an **initiated/existing** activity...*

What is the current status?

The current status is highly dependant on where the individual is receiving care. For example, there are excellent programs of coordinated care for diabetes patients, but they are not universal. Similarly, there are excellent examples of management of arthritis patients in the community while they wait for joint replacement (eg pilot project in London), but again the approach is not universally available.

The recent report from The Change Foundation "Seeking Program Sustainability in Chronic Disease Management: The Ontario Experience - May, 2004" outlines the current state of chronic disease management in Ontario.

The recent report "An Overview of the Ontario Chronic Disease Prevention Alliance" - September, 2003 - is an excellent source document.

Some excellent models for chronic disease management include: Regional Geriatric Programs of Ontario
Comprehensive Home Option of Integrated Care for the Elderly (CHOICE)

Many of the approaches to Seniors include a systems navigator, someone to help the individual access the right services in the right place, at the right time. Two excellent documents which discuss a coordinated approach to seniors care are:

"Coordinated, Accessible Community Health Care for Elders in Toronto: The CACHET Model" - Toronto DHC, December 2004

"Report on Health System Navigator Models" - York Simcoe

What are the outcomes/lessons learned (if any)?

Education is key to maintaining the individuals in the community, and to avoiding crises. Education includes the patients themselves, their family (or other supports), and their primary care physicians. It also includes the public and all health care professionals. Self management programs led by trained volunteers, including those with chronic diseases acting as peer supports, are essential.

Integrated and longitudinal care, including the use of clinical pathways, is essential.

The American experience (especially that of the US Veterans Administration) suggests that high leverage targets for chronic disease management for the LHIN would include:

- Development of care networks involving community long term care programs and the Family Health Teams
- Development of clinical pathways and integrated methods and tools that follow the patient across the system
- Strengthen primary care and complex care management capabilities in serving high risk patients
- Develop predictive modeling and risk screening
- Develop clinical methods in hospitals that respond to co-morbidities, disability and frailty

District Health Council, November, 2003.

- Move hospitals from a model of discharge planning to one of transitional care planning
 - Develop system performance measures and cumulative care cost for chronic conditions
 - Involve the "consumers" in planning the system and their individual care
 - Reward appropriate system-wide behaviours and quality.
- Funded research is essential for the development of innovative ways to prevent, treat and manage chronic diseases.

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A. Description of Patient Care/Services Integration Initiative (Copies of Template A available at the end of this document. Please limit your response to 2 pages per initiative.)

Title of patient care/service initiative:		Type of integration (more than one box can be checked)	
Strategic Value of Community Support Services – Validation & Usage of Community Support Services to Keep People in the Community to Address All Their Needs in a Timely and Appropriate Fashion		<input checked="" type="checkbox"/> Horizontal <input checked="" type="checkbox"/> Vertical <input checked="" type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:	
Existing or new initiative?	List of partners involved:		
<input checked="" type="checkbox"/> Initiated/existing integration activity* <input type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	J. Wilson, S. Hart, J. Pearce, M. Mathieson, A. Beloff, C. Smaelson, C. Turkork, C. Lee Bun, D. Wright, D. Sedore-Kola, D. Hardy-Rose, E. Takacs, E. Anthony, E. Chan, E. Wall, E. Mitchell, I. Cohen-Ackerman, J. Kerzner, J. Barragan, J. Berman, J. Wright, J. Scofield, J. Downer, K. Emsig, K. Morrison, L. Jeffery, K. Kenny, L. Marshall, M. Kavanagh, M. Luzier, M. Badsha, O. Rettinger, P. Stoddart, P. Miller, P. Hubbert, T. Dell’Aguila, U. Rehdner, V. Fornasier.		
Please briefly describe the initiative:			
<p>Community Support Services (CSS) help seniors, people with disabilities & people with special needs to remain comfortably & safely at home in their communities. CSS values friendly, caring, personalized service to enhance esteem & promote independence. CSS help promote mental & physical well-being, help people maintain independence & reduce emergency room visits & hospital stays (taken from the Ontario Community Support Association's (OCSA) website www.ocsa.on.ca). CSS, unlike CCAC services, are long term services helping people stay in their homes & not be institutionalized due to need for ongoing long-term support. CSS align with Ministry directions of bringing people out of acute care services & providing services close to home & in the community. According to OCSA, CSS extend the health sector’s limited pressured funding. For every government dollar, \$1.48 in community support service is provided by agencies via fundraising, in-kind assistance, donations & fees from the community. Community support services are directly accountable to their communities. Their not-for-profit status means dollars their efficiencies save are put back into service, not to profit shareholders." CSS have knowledge & experience working closely with clients & other CS Services. The philosophy & values of CS services include providing timely & appropriate services to people in their homes (or close to home). Ensuring that this commitment to the consumer is continued should be the main focus of services from LHINs. To ensure the strategic value of CSS is accessed fully & to fully serve clients in our communities, these initiatives have been developed:</p>			
1. Ensure an integrated system			
? Least intrusive, close to home, client choice, client focus		? Ability to move information around (common IT) – shared information	
? Partnerships – referrals to each other		? Referrals between CSS and Acute Care sectors	
? Existing community networks/partnerships are strong		? Need to build stronger partnerships with the Acute Care Sector	
? Seek out potential opportunities to share resources		? Common payroll system, HR, benefits, etc	
? Permeability of LHINS boundaries		? Transparent boundaries as required	

? Use expertise & experience to provide appropriate specialized services that already exist. ? Continue to use solid volunteer base that has been established

? Ensure a holistic approach to meeting needs ? CSS involvement in Hospital admission/discharge planning/co-ordination at all points along the way

? Effectively link different sectors/communities/funding/knowledge bases ? Create a safer environment through high quality service standards/accreditation

? Community services can follow the person into Hospital/Rehab/LTCF to ensure continuity of services

2. Equity (We need re\$ources to do it all)

? Funding and resources (between urban/rural community and between providers of similar services) ? Purchasing services

3. Building capacity

? Services available in community – close to home ? Ensure full range of services are available

? Co-ordinated access – through multiple points ? Ensure reduction in waiting lists

? Move people out of acute care facilities and into the community ? Help reduce stress on the acute care system

? Ability to maintain fiscal responsibility

? Build on strong knowledge of the community population needs and ability to provide services - CSS understands the needs of the community

? Utilizes family dynamics to support people in their own communities

? Take appropriate/traditional services out of the Hospital and into the community

4. Scale

? Not too big – daunting, creates a barrier to use ? Needs to be smaller, closer to community is better

? on-profit – as much money as possible in services ? Partnerships (uniqueness and choice), not amalgamation

? Share resources (HR, payroll, benefits, etc) – economy of scale ? Permeability of LHINs – boundaries

5. Health promotion

? Keep community healthy and well ? Build on existing framework to build a stronger framework for collaboration

? Health care should focus on prevention, social well-being, curative and rehab.

6. Education

CSS - each other about the full range of services currently available Acute care – about CSS services

Gaps – how to fill them ? Population – what’s available/choice ? Communication to the public about our services (general public)

If this is an initiated/existing activity...
What is the current status?

Stakeholders in this group felt strongly that there is a high level of experience and expertise already existing in the community service sector that can be used as examples of effective and efficient partnerships. These partnerships have been shown to increase the accessibility of services to clients in the community. These lessons can be shared with other community support services and used as models for the acute care and long-term care

What are the outcomes/lessons learned (if any)?

- concentrates on the individual and communities
- higher level of client satisfaction
- clients receive services in home
- draw on existing levels of expertise
- higher level of community integration
- increased communications between service providers

<p>sectors. It is acknowledged that there is lots of work to be done, but the foundation already exists to build a stronger health care system in this region.</p>	<ul style="list-style-type: none"> • sharing of information increases efficiencies • standardized way of providing services • access to services close to home • improved access to services through coordinated access points • elimination of silos • strategic use of resources • opportunities for creativity and innovation • reduces pressure on hospitals and long-term care systems • cost efficiencies
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Top Ten Strengths of Community Support in Ontario

1. Community support agencies extend the limited, pressured funding of the health sector. For every dollar of government funding, \$1.48 in community support services is provided by agencies via fundraising, in-kind assistance, donations and fees from the community
2. Community support services are directly accountable to their local communities. Their Boards of Directors are community volunteers. Their not-for-profit status means that dollars their efficiency saves are put right back into service improvement, not to profit shareholders.
3. Being on the ground, community support agencies are often the first place older and disabled people try in order to maintain their independence.
4. Front-line community agency staff are the key that opens the door for many people in accessing the services they need to stay healthy.
5. The work of community agencies makes the difference between people staying at home or going to the Emergency Room or an institution.
6. Community support prevents personal and family breakdown due to the strain of coping with care-giving. Family caregivers provide up to 90% of the care of older or disabled people. Community support services make it possible for them to continue.

7. Flexibility means that community agencies are more cost-effective and responsive to the needs of people. This supports other areas of the health care system.
8. Volunteer management and service delivery are the strength of community support services.
9. The preventive nature of community support services underlines their importance as a critical component of the long-term care system, eg. preventing falls.
10. The Ontario Community Support Association (OCSA) and community agencies lead the field in developing standards, quality services and training programs for the community long-term care sector.

A. Description of Patient Care/Services Integration Initiative (Copies of Template A available at the end of this document. Please limit your response to 2 pages per initiative.)

Title of patient care/service initiative:		Type of integration (more than one box can be checked)	
Integrating and Improving Services for People with Mental Illness and Addictions within the Health Sector		<input checked="" type="checkbox"/> Horizontal <input checked="" type="checkbox"/> Vertical <input checked="" type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:	
Existing or new initiative?	List of partners involved:		
<input checked="" type="checkbox"/> Initiated/existing integration activity* <input type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	Alan Cudmore (CAMH); Harry Spindel (Bayview Community Services); Jane Kuchma (Bayview Community Services); Jim Nason (Loft Community Services); John O'Mara (Addiction Services of York Region); Karen O'Connor (CMHA Toronto); Linda Jeffery (CMHA York); Marlene Berry (Crosslinks); Mary Compton (Saint Elizabeth); Mohamed Badsha (CMHA Toronto); Patti Reed (Simcoe York District Health Council); Philip Dodgson; Ron Ballantyne (Whitby Mental Health Centre); Susan Smither (CAMH); Tanya Shute (Krasman Centre)		
Please briefly describe the initiative:			
<p>The initiative seeks to improve mental health and addictions services. Both are based on a recovery model, incorporate the determinants of health, are client-directed, and ensure that the consumer and family voice is heard in the planning and delivery of services. Within the health sector, both have historically been grossly under-funded, and yet each contributes significantly to relieve the pressure on other parts of the health system (see "Why Fund Addiction and Mental Health Services", Ontario Federation of Community Mental Health and Addictions Programs, February, 2004). Much planning work has been completed in both streams, with strong working relationships established amongst providers -- relationships that can serve as the foundation for future development. Components would include:</p> <ul style="list-style-type: none"> • creation of integrated, multi-disciplinary teams with strong linkages to primary care (see recommendations of Mental Health Implementation Task Forces) • creation of a funding strategy for mental health and addictions which remains discrete within the health sector, and provides multi-year, annualized, stable, sustainable funding • ensuring that the voices of mental health and addictions' consumers are included in all LHIN structures <p>The initiative also seeks to integrate mental health and addictions services within the health care system. Components include:</p> <ul style="list-style-type: none"> • coordinated access to services and information for mental health and addictions consumers and families so that timely access and the ability to link people to all sectors, including primary care and specialized services, will ensure better health outcomes and improved quality of life • development of a diversity strategy to ensure that issues of culture, language, age, disability, and concurrent disorders, do not create additional barriers to appropriate health care • intra- and cross-sectoral agreements, and agreements across LHINs, to recognize the importance of determinants of health in creating overall well-being, and to protect the defined geographic areas of existing resources for mental health and 			

addictions consumers and families, which do not follow the geography of hospital usage patterns

- standardization and consistency of infrastructure supports (HR, technology, compensation) across the health sector, to address wide discrepancies between the institutional and the community sectors

*If this is an **initiated/existing** activity...*

What is the current status?

TEAMS: existing pilots; concept developed in local Mental Health Systems Designs and in Mental Health Implementation Task Forces
DISCRETE MULTI-YEAR FUNDING ENVELOPE: new
VOICE OF MENTAL HEALTH CONSUMERS and FAMILIES: exists to a limited degree
COORDINATED ACCESS: currently in process of development
DIVERSITY STRATEGY: developed by DHC
CROSS LHIN STRATEGY: new
CONSISTENCY OF INFRASTRUCTURE: new

What are the outcomes/lessons learned (if any)?

LESSONS LEARNED:

- Funding disparities create barriers to integration and innovation
- Consumer Survivor Initiatives and input from consumers and families strengthen planning processes
- The addictions sector has a wealth of experience to share in terms of success of the recovery model, use of standardized assessments, and incorporation of peer support models
- Targeted investments provide good results
- Working relationships are built over time, and are critical to system integration
- Capacity-building is largely based on relationships
- Participation in integration activities requires a significant investment in time and resources

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B. Description of **Administrative Support Services Integration Initiative (Copies of Template B available at the end of this document. Please limit your response to 2 pages per initiative.)**

Title of administrative support service initiative:		Type of integration (more than one box can be checked)	
The Development of a Population Health Approach to LHIN planning process		<input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:	
Existing or new initiative?		List of partners involved:	
<input type="checkbox"/> Initiated/existing integration activity* <input type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>		Kay Morrison, Sandi Pelly, Denise DePape, Jennifer Tredinnick, Cary Milner, Leslie Sorensen This initiative will require any and all health care service providers within a LHIN as well as involve input and participation from partners in other sectors such as education, housing welfare, etc.	
Please briefly describe the initiative:			
<p>The new LHIN Board needs to adopt a true Population Health Focus that is in keeping with stated mandate of the LHINs.</p> <ul style="list-style-type: none"> • That focus will lead to a development of the understanding of what the needs of the community are and where those needs reside • This initiative would begin with the development of a population profile / overview of the health status by sub area within the LHIN (sub area is important in order to develop a full understanding of where within a particular community the needs are the greatest. If this is done over too large an area, the need will be diluted and not seem as great) • This profile needs to include: <ul style="list-style-type: none"> • The development of a demographic profile which describes the sub areas within the LHIN by characteristics that are known to be determinants of health • The development of an inventory and location of providers by service type, volume and location • An epidemiological analysis of disease incidence as well as patterns of health care utilization • A narrative from participating organizations which indicates where there are issues in accessing health care services at all of the various levels. This can be done via survey. <p>This work will form the basis of logical and effective health service integration planning throughout the LHIN and will also help to determine which initiatives are priority in terms of need or impact.</p> <p>Along with population health status, planning for the future integration initiatives must also consider:</p> <ul style="list-style-type: none"> • Building on existing and logical relationships, as they are likely to have been forged in order to address gaps in service provision etc. • Capacity issues which exist within certain communities – i.e. where health care is “thin on the ground” but need is great • Development and use of population health based indicators • Development and use of a consistent funding formula for the allocation of resources across and between LHINs based on population health goals 			

- **the population health framework should reflect the values found in documents such as the Ottawa Charter and WHO definitions and should be consistent across the province.**

*If this is an **initiated/existing** activity...*

What is the current status?

Not applicable.

Although some organizations have done a significant amount of research on population health status and demographic characteristics of particular communities, such a large-scale integrative approach to this topic has not been previously seen.

What are the outcomes/lessons learned (if any)?

We know that the current system is not sustainable or effective with respect to improving the health status of the population. We cannot continue to plan for only the short term but need to take a long term more permanent approach.

We know that the health status of a population cannot be the purview of only the health care sector, but in fact most of the determinants of health care are impacted by the work of a number of other ministries – i.e. housing, social services, education, employment, welfare, etc.

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B. Description of **Administrative Support Services Integration Initiative (Copies of Template B available at the end of this document. Please limit your response to 2 pages per initiative.)**

Title of administrative support service initiative: Strategic Plan for electronic management of Health Information		Type of integration (more than one box can be checked) <input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:
Existing or new initiative? <input type="checkbox"/> Initiated/existing integration activity* <input type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	List of partners involved: : Any/ all organizations involved in the delivery of health services within our LHINS and outside referral partners e.g. Regional Cancer Centre; Long Term Care Facilities; CCAC; Hospital; Physicians; Lab; Pharmacy; Community Service Partners; Public Health; Mental Health; etc. The Consultation Process comprised: <ul style="list-style-type: none"> • LHIN Community Workshop - Dec. 1/04 • Members of IT/IM Strategy - Central LHINS (Peter Wegener, Co-Chair, Humber River Regional Hospital; Vera Zimbovski, Co-Chair, Saint Elizabeth Health Care; Israel Aharoni, Montpetit Group Inc.; Lois Cormack, Specialty Care; Latchmie Singh, Extendicare; Andrea Lax, Extendicare; Diane Bladek-Willett, Regional Municipality of York, Health Services; Mary Lou Ackerman, Saint Elizabeth Health Care; • Central Region LHIN e-Health Forum - Jan. 11/05 - Information gathering & feedback from information days - reps from organization in our LHINS. 	
Please briefly describe the initiative: The Central LHIN should develop its own IM/IT Strategic Plan. IM/IT planning should involve key users including physicians, administrators, nursing and allied representatives from all sectors within the LHIN. This plan and resulting functionality is critical as an enabler for other integration opportunities clinical and administrative. The plan should include consideration of an: <ol style="list-style-type: none"> 1. Executive Summary 2. LHIN IM/IT Strategic Plan and Vision - with information needs and requirements; What are the information needs; 4. Gap Analysis, Strategic Priorities, Implementation Plan 5. Alternatives 6. Risks/Critical Success Factors/Strategic Underpinnings 7. Financial Summary 8. Conclusion. We support existing provincial/federal initiatives to develop and exchange patient care information between providers electronically and capitalize on existing investments. Specifically we wish to ensure that IM/IT Plan works to reduce the		

burden of data collection amongst providers. Add value and/or meaning to improve data quality in order to develop system wide performance measure enabling improved decision making. For example LHIN boundaries were determined through hospital data as there was no reliable data from other sectors, home care, LTC etc.

This would improve:

- cost effectiveness: linking data to financials, resource utilization etc.
- improve health outcomes; streamlined disease management process
- health promotion: population based health management
- standardized data collection sources across the sectors within a LHIN and between LHINS supporting a provincial data exchange, ensuring meaningful data exchange
- opportunity to maximize potential for connectivity and sharing resources

LHIN must:

- define what information is meaningful for this community
- develop data standards and definitions
- cross sector performance indicators
- ensure connectivity is enabled across all sectors
- support local agencies within its boundaries to develop effective IM systems
- ensure a common IM strategy is developed provincially
- consent strategy
- privacy and confidentiality program in alignment with regulations
- ehealth funds should be accessed to support these initiatives and/or look at new funding models.

Realizing this opportunity becomes an enabler for better decision making in health care.

*If this is an **initiated/existing** activity...*

What is the current status?

Assessment needs to be done to determine what practices & initiatives are currently being used between partners.

What are the outcomes/lessons learned (if any)?

- Beginning small steps and successes.
- Use proper project management.
- To be steered by those that are involved in the delivery of the health care services - not consultants, administrators or IT experts although their input is important.
- Use of risk assessment on proposals.
- Utilize existing investments and expertise within our organizations.
- All sectors and partners need equal involvement.

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Lead Contact person: Name: Vera Zimbovski
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B. Description of **Administrative Support Services Integration Initiative** (Copies of Template B available at the end of this document. Please limit your response to 2 pages per initiative.)

<p>Title of administrative support service initiative:</p> <p>Innovative approaches to maximizing human resource across the care continuum</p>		<p>Type of integration (more than one box can be checked)</p> <p><input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:</p>
<p>Existing or new initiative?</p> <p><input type="checkbox"/> Initiated/existing integration activity* <input type="checkbox"/> New integration opportunity</p> <p><i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i></p>	<p>List of partners involved:</p> <p>Carla Holyk Ont. Physiotherapy Association; Cherry Hanson Leisureworld LTCF; Chuck Seguin St. Johns Rehab.; Helen Ferley Seniors Health Centre; Kelly Graham King City Lodge; Leah Walters Cummer Lodge; Mary Brazier Sherwood Court LTC; Nancy Wisker River Glen Haven; Diane Hardy-Rose SRT Med-Staff; Mary Lou Ackerman St. Elizabeth; Nancy Wisken River Glen Haven; Pat Malone St. Elizabeth; Tim Berry CCAC Simcoe County</p> <p>Potential Partners:</p> <ul style="list-style-type: none"> • Acute Care Hospitals • Long-term Care Facilities • Rehab/Chronic Care Facilities • Community Services • Mental Health & Addication 	
<p>Please briefly describe the initiative:</p> <ul style="list-style-type: none"> • Reduce employee turnover by improving benefits with an integrated approach to contract management (ie. Benefits) • Reallocation/reorganization of specialty service delivery, ensuring that the right service is delivered in the most effective location. Use technology to manage some level of care> ie eLearning for client self education • Deliver care by the most appropriate provider: Introduce the role of the nurse practitioner to manage primary health care needs • Deliver care in the most appropriate setting: LTC and Home Care to manage an expanded level of care IE> Cardiac rehab, diabetes education , etc The ability to free-up acute care beds by providing specialized services, geared to the elderly, which will support lengthier needs while utilizing existing specially trained and educated staff with the enhancement of Nurse Practioner Programs • Integrating services to decrease fragmented delivery of care • Common shareable pathways that support care across the continuum across all sectors • Integrated health information access • Partner with hospitals to determine continuity care needs of clients • Identify Long Term Care Homes that can specialize in specific care dimensions within the LIHN – ie: stroke programs, 		

post-op, physical therapy (hips), dialysis. LTC can be viewed as the bridge from acute care to intense rehabilitation to home discharge

- Allows the client to experience the stepping stone of LTC which may in the end result in the client's desire to live in a LTC home

*If this is an **initiated/existing** activity...*

What is the current status?

not applicable

What are the outcomes/lessons learned (if any)?

As there is a shortage in human resources it is vital that we look at who is providing services & review practices in all health care sectors to determine the best usage of human resources. By ensuring that the right person, with education & resources are providing the service there will be more effective usage of financial resources, as well as human resources. By reviewing health care as a continuity of needs for our clients, across all sectors, it will allow us to provide care in the most cost effective setting.

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B. Description of **Administrative Support Services Integration Initiative (Copies of Template B available at the end of this document. Please limit your response to 2 pages per initiative.)**

Title of administrative support service initiative:		Type of integration (more than one box can be checked)	
Decrease duplication cost within the LHIN and re-investing it in patient care		<input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:	
Existing or new initiative?		List of partners involved:	
<input type="checkbox"/> Initiated/existing integration activity* <input type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>		Asmita Gillani -York Central Hospital; Bernita Borgh -Don Mills Foundation for Seniors; Donna Hessler -York Central Hospital; Jim Kirk- York Central Hospital; Leah Walters -Cummer Lodge; Steve Bagworth -Agnew Peckham Sue Munro -Saint Elizabeth Health Care	
Please briefly describe the initiative:			
<p>Outside of direct client/patient care, a number of opportunities exist to share resources, reduce duplication, achieve economies of scale and capitalize on competencies across the continuum of care between and among sectors. The savings that will be achieved by consolidating and integrating the various components of support services can then be reinvested back into client/patient care.</p> <p>Opportunities Identified for Consolidation/Integration: Opportunities identified for potential consolidation/integration include, but are not limited to:</p> <p>Information Management</p> <ul style="list-style-type: none"> • Organize, share and manage data across the continuum based on episode of care for the client rather than sector-specific • Minimize the handoffs with health record and decrease duplication • Share information technology resources(systems) where standardization is required • Invest in minimum information technology platform requirements for efficient data exchange across sectors <p>Human Resources Management</p> <ul style="list-style-type: none"> • Outsource functions where possible (e.g. payroll) • Share human resource policies, processes and people where standardization is required • Harmonize wages, benefits, etc. in order to have equal meaningful exchanges <p>Resource Management</p> <ul style="list-style-type: none"> • Share resources among providers or across the continuum where applicable (people and systems) • Develop and track centralized resources so individual networks within the LHIN can access <p>Supply Chain Management</p> <ul style="list-style-type: none"> • Explore Purchase agreements to increase bargaining power • Consider central commissaries 			

- Evaluate opportunities to improve quality and lower prices using private sector models
- Staff Education**
- Explore e-learning opportunities
 - Share education and library resources (e.g. through use of websites)
 - Centralize training and education for common needs (e.g. implementation of new legislation and leadership training, etc.)
 - Staff exchange projects to build knowledge across sectors and maximize expert resources
- Standards/Benchmarks**
- Inventory and centralize common standards and best practices across sectors
 - Multi-sectoral evaluation of client satisfaction across the continuum
- Funding**
- Integrate funding from all Ministries so it comes from one source and move it across the continuum
 - Decrease incidents where stakeholders are competing for common monies and reinventing.

*If this is an **initiated/existing** activity...*

What is the current status?

Background initiatives to build upon

- BOT (Back Office Transformation) Project
- Among 18 TEEN (Toronto East Emergency Network) hospitals
- Consolidation of common functions underway for 18 months (finance, payroll, supply chain)
- Peterborough Area Hospitals
- Created separate corporation to outsource common services (e.g. linen services)

What are the outcomes/lessons learned (if any)?

Outcomes

- More efficient use of resources and increased productivity
- Economies of scale achieved where fixed resources/costs are shared
- Better accountability and less role ambiguity
- Reduced conflicts and reduced duplication regarding resources
- Timely access to information/measures among stakeholders
- Achieve greater critical mass to provide education and maximize expertise of professionals

Lessons Learned

- Baseline technology required - initial investments for technology catch-up will be required for some
- Need to manage/balance competition factors or conflicts of interest
- Balance integration with the time required to change
- Need to create system of support to enable

resource sharing
• **Need to find efficiencies in back office and non-clinical areas to reinvest in patient/client care as new dollars will be limited**

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8. TEMPLATE 'C' HIGH LEVEL PLANS FOR THE INITIATIVES

C. Priority Setting of new Integration Opportunities

Guide for Priority-Setting

The following list of questions may facilitate and guide your priority-setting of top 5 new initiatives for patient care/services and admin support services. It is recognized that some are competing questions and require a balanced evaluation for priority-setting:

- ✓ Does the initiative have the potential for high-impact (direct or indirect) enhancements to patient care services and outcomes?
- ✓ Does the initiative include a broad-spectrum of providers/stakeholders (e.g. horizontal *and* vertical integration)?
- ✓ Is the initiative conceptually feasible? Does the initiative have the potential to succeed, if the appropriate incentives, etc. are in place?
- ✓ Is there strategic alignment of the initiative with other existing health care priorities/initiatives? Can it build on existing strengths/efforts?
- ✓ Can the expected outcome of the initiative be measurable/quantifiable? In the short-medium term? In the long-term?
- ✓ Can the initiative be replicated/duplicated across the province or adopted as a province-wide approach?

Based on the new integration opportunities identified and the above criteria for priority-setting, please recommend 5 priorities (at a maximum) for each category and a corresponding high-level action plan (please limit your response to 4 pages for Patient Care/Services Integration priorities & 4 pages for Administrative Support Integration priorities):

I. Patient Care/Services Integration Opportunities		
	Priority Opportunity	High-Level Action Plan
1	Seamless Senior's Services Year 1	<ul style="list-style-type: none"> • Inventory Services • Determine duplication and gaps as well as integration opportunities with other initiatives, eg., FHTs • Principles for provision of safe services • Develop evidence based standards of care • Develop outcome measures (process and efficacy) • Develop database and information needs to track illness, prevalence and incidence • Develop a local vision for Seamless Seniors' Services <p>(Focus groups with consumers and providers will be necessary to help achieve the above plan and vision).</p>
	Seamless Senior's Services Year 2+	<ul style="list-style-type: none"> • Implementation necessary information systems to track progress • Develop processes for research and knowledge transfer • Shift resources as necessary

I. Patient Care/Services Integration Opportunities		
	Priority Opportunity	High-Level Action Plan
		<ul style="list-style-type: none"> • Define and eliminate duplication and any unnecessary competition for resources • Implement Systems Navigators • Enhance promotion and prevention • Concentrate on wellness and primary care (including funding initiatives)
2	Enhancing the Continuum of Care within the Central LHIN	<ol style="list-style-type: none"> 1. Develop an integrated continuum of care framework outlining “what” services are required, “who” the various providers are in each part of the continuum and “where” the services are typically provided. See attached draft. Align Central LHIN partners to the framework. 2. Develop decision-making frameworks/criteria for: <ul style="list-style-type: none"> • Setting priorities (what should we start with e.g. chronic diseases?, highest users of health system?) • Identifying partners in the continuum (for each priority) This includes the consumer. • Allocation of resources 3. Select priority/ies for vertical integration (pilot) based on #2 above and identify principles, objectives and desired outcomes for each 4. Develop criteria, evaluate options and select the most appropriate care delivery model and partnership model 5. Clarify roles and accountabilities of the players within the integrated continuum with input from stakeholders including consumers 6. Develop key performance indicators to measure what success would look like
3	Chronic Disease Management	
	Year 1	<ol style="list-style-type: none"> a) determine rates for various chronic diseases in local population b) determine admission rates for various chronic diseases in local population c) identify high admission rate chronic diseases d) initiate public education programs re primary and secondary prevention e) identify the functional structures to implement chronic disease management programs
	year 2+	<ol style="list-style-type: none"> a) develop and implement programs for high priority chronic diseases, including: <ul style="list-style-type: none"> • care networks (community programs, Family Health Teams, Long Term Care Facilities) • clinical pathways and integrated tools and methods that follow the patient across the system • strengthen primary care and complex care management capabilities • predictive modeling and risk screening • clinical methods in hospitals that respond to co-morbidities, disability and frailty • transitional care planning models in acute care facilities b) ensure geriatric nursing consultation is available to emergency departments

I. Patient Care/Services Integration Opportunities		
	Priority Opportunity	High-Level Action Plan
		c) develop system performance measures d) develop cumulative care costing for key chronic conditions e) develop appropriate ways to reward system-wide behaviours and quality f) develop community based programs to help shift the focus from illness and disability to prevention (include CCAC's and other community agencies in these programs) g) initiate a Regional Geriatric Program in the LHIN, and pilot a CHOICE program
4	Strategic Value of Community Support Services – Validation and Usage of Community Support Services to Keep People in the Community to Address All Their Needs in a Timely and Appropriate Fashion	Description of the Tasks / Actions 1. Identify Partners: <ul style="list-style-type: none"> Identify all the community partners that should be involved and promote linkages to increase the consumers' access to services 2. Build on Existing Partnerships: <ul style="list-style-type: none"> expand and utilize the present system to incorporate and increase the capacity of the whole health care system 3. Recognize and Promote the Value of Community Support Services: <ul style="list-style-type: none"> build on the positive effects CSS have on individuals and the community as a whole CSS are an integral part of the full care continuum Not-for-profit status increases dollars spent on service provision and improvements educate the community and all sectors on what services are available and what CSS does to promote health and community 4. Plan for Human Resources Recruitment and Retention and Management: <ul style="list-style-type: none"> develop and implement a strategy that offers equal opportunity for equal pay for jobs performed 5. Develop a Common Information Referral: <ul style="list-style-type: none"> connectivity between CSS, hospitals, CCACs, physicians, health clinics share existing data bases of services

I. Patient Care/Services Integration Opportunities		
	Priority Opportunity	High-Level Action Plan
5	Integrating and Improving Services for People with Mental Illness and Addictions within the Health Sector	<ul style="list-style-type: none"> • Consumer and family participation in LHIN Structures • LHIN mandates and funds a coordinated access mechanism for consumers of mental health and addictions services, which includes outreach and information, assessment, and urgent response. • Creation of Multi-Disciplinary Community Teams • Development of Diversity/Inclusivity Strategy Across Services within the Health Sector • Development of Cross-Sector, Cross-LHIN Agreements • Coordinated Access to Supports and Services for Persons with Mental Illness and Addictions • LHINs will establish as a priority: • a Human Resource strategy that addresses compensation discrepancies within the health sector • resources to ensure that community agencies acquire the hardware and technical support consistent with the technological capability of the the rest of the health sector • creation of opportunities to share resources and expertise for technology and evaluation • Terms of Reference for LHIN committees and structures will include a requirement for consumer and family participation in governance and planning structures • Consistent Infrastructure Supports

II. Administrative Support Services Integration Opportunities		
	Priority Opportunity	High-Level Action Plan
1	<p>Priority opportunity Development of a strategic Plan for electronic management of health information:</p> <p>Examples:</p> <ol style="list-style-type: none"> 1. Smart Systems for Health – Secure Email 2. Ontario eHealth Strategy – OLIS, ODB, CRIM, IPHIS 	<p>high-level action plan:</p> <p>Appoint a Task Group of stakeholders to oversee the development of the strategic plan. They would identify resources required.</p>

II. Administrative Support Services Integration Opportunities		
	Priority Opportunity	High-Level Action Plan
2	<p>Innovative approaches to maximizing human resource across the care continuum:</p> <p>priority opportunity:</p> <p>Innovative approaches to maximizing human resource across the care continuum</p>	<p>high-level action plan:</p> <ul style="list-style-type: none"> • an evaluation of current integration practices to establish an understanding of what partnerships already exist & how effective they are • establishment of a Provincial Human Resource Plan - to include compensation review • do a Gap analysis - evaluate who & where current services are being provided to determine if it is the most cost effective approach to the service • then develop plan that ensures resources are available to alternate service providers to meet the identified needs of clients • assess Educational Institutional Partnership • review degree of cross LHIN involvement that would occur with a Provincial Human Resource plan • evaluation of compensation plans in place & feasibility of amalgamation of same especially within sectors
3	<p>Decrease duplication cost within the LHIN and re-investing it in patient care</p>	<p>Description of the Tasks / Actions:</p> <ol style="list-style-type: none"> 1. Identify all the community partners that should be involved. 2. Create a framework for conducting a multi-sectoral inventory of processes/practices among identified partners. The framework should consider the following: <ul style="list-style-type: none"> • Existing standards (e.g. standards for financial indicators) • What functions and processes should be examined • What activities are conducted in house and what are outsourced • % of budget spent on various activities (e.g. education) 3. Conduct inventory and collate results 4. Examine results to identify best practices and opportunities to reduce costs <ul style="list-style-type: none"> • Identify key resources/functions that can be shared or outsourced • Consider existing models that are working well and how they can be expanded to avoid re-inventing the wheel (both from within and outside LHIN area) • Consider models outside of health care (e.g. outsourcing of food services by airlines) 5. Make recommendations for consolidation or innovative arrangements that allow reallocation of savings to patient care based on analysis 6. Examine further potential efficiencies with cross LHIN initiatives
4	<p>The Development of a Population Health Approach to LHIN planning activities</p>	<ol style="list-style-type: none"> 1. develop a population profile for the Central LHIN, including sub area analysis 2. identify indicators to track health in the community 3. Identify plan for local area health improvement (engage community and providers in health goals exercise; in collaboration with public health) 4. report yearly to the community on health goals and health indicators

II. Administrative Support Services Integration Opportunities		
	Priority Opportunity	High-Level Action Plan
5		

8 TEMPLATE “D”: CHARACTERISTICS OF THE CENTRAL LHIN

This section comprises Template D, which is meant to describe:

- unique characteristics of the Central LHIN that impact this process and/or future Integrated Health Service planning activity
- what role academic health science centres and voluntary networks play within each LHIN.

SUMMARY OF UNIQUE CHARACTERISTICS

METHODOLOGY & LIMITATIONS (from TDHC)

Since LHIN boundaries are not aligned to traditional geographic boundaries such as former CSDs or FSAs, it is not possible to obtain accurate estimates. Data presented are based on Census Subdivisions (CSDs)/Counties that fall mainly in this LHIN. The Central LHIN covers the northern parts of Toronto, most of The Regional Municipality of York and the southern parts of Simcoe County. It contains the following CSDs/counties:

Toronto

Major part of common municipality of North York
Small sections of former City of York.

York

most of Vaughan;
small portion of Markham;
Richmond Hill;
King;
Aurora;
Newmarket;
part of Whitchurch-Stouffville;
East Gwillimbury;
Georgina

Simcoe

New Tecumseth;
Adjala-Tosorontio;
Bradford West Gwillimbury;
Essa;

For this report, it was not possible to break up the municipalities that are partially included in this LHIN, hence, total numbers for the municipalities are included. This means that there is an overestimation of the numbers. The information was obtained from 4 sources: 1) TDHC ; 2) the York Simcoe DHC Profiles for 2003; 3) Toronto Health Profiles <http://www.stmichaelshospital.com/content/research/Torontohealthprofiles/index.htm>; 4) Information for the Central LHIN as a whole was obtained from the MOHLTC Website.

Geographic Profile

The Central LHIN contains a mix of urban areas that are very densely populated, suburban areas and rural areas.

9 Demographic Profile

York Region is one of the fastest growing counties in the province and in the country. According to the 2001 Census adjusted for undercoverage, Canada experienced one of the smallest census-to-census growth rates between 1996-2001 (4.8%), while the population of Ontario and Northern Toronto grew by approximately 7%, York Region grew by 23%, ranking first nationally in percentage growth. The former municipality of North York had a growth rate of 3.2%. Over the past five years, the populations of selected Central LHIN municipalities, such as Vaughan and Richmond Hill, have seen amongst the highest municipal growth in Ontario at 37% and 30% respectively. Such growth in York has resulted in, and will continue to require, increased demand for all types of health care and social services, as well as affordable housing and other social and community resources available in the Central LHIN district.

The Central LHIN district is anticipating continued growth, which will affect every service sector over the next few decades. From 2001-2016, York's population is projected to experience a growth rate of 46%, compared to a provincial growth rate of 17%. The age sex structure of the population is also expected to change considerably where there will be a significant percent increase in the older cohorts. The growth in the size of the oldest age categories is important because people in this age group typically have greater social support and health care needs than younger seniors. Additionally, a substantially larger 80+ female population will also require a large emphasis on senior women's health planning.

Sociodemographic Profile

The Central LHIN represents a diverse population.

York Region and Toronto have seen high immigration rates over the last decade, contributing to a diverse community where residents speak many languages, observe different religions and self-identify with a variety of ethnicities. Throughout York Region, Canadian, Italian and English continue to be the largest ethnic groups. Ethnic origins across York Region vary considerably. Georgina, East Gwillimbury and Whitchurch-Stouffville show the highest percentage of residents reporting to be Canadian and English, whereas Vaughan shows the lowest, but the highest percentage reporting to be Italian and Jewish. In the Northern Toronto area, Chinese, South Asian, Black and Filipino are the largest ethnic groups. In the southern municipalities of Simcoe County, "Canadian" and "English" are the largest self-identified ethnic groups, however there are a significant proportion of residents who have immigrated from, and identify with European countries such as England, Scotland, Ireland, France and Germany.

Educational attainment is associated with income levels, health behaviours, and health status. A higher level of education does not ensure higher employment satisfaction or income, however research indicates that the well educated experience better health, are more likely to be employed and have an improved standard of living. In 2001, the majority of York and South Simcoe residents aged 20 and over had at least a high school education, with less than 10% not having completed Grade 9. By contrast, approximately 22 % of the Northern Toronto residents have not completed Grade 9. However it is important to note that the age and ethnic structure of a population may influence the average educational attainment levels, where immigrant and older populations generally have lower education levels due to decreased access over time and place.

The composition of the population in terms of income and the distribution of income greatly influences health status and health service utilization in a community. Studies have consistently shown a relationship between income and health, where people with low income have

increased risk of illness and mortality, as well as higher utilization of health services. There are significant, negative consequences to living under the low-income cut-off (LICO), particularly for children and youth. Children living in families below the LICO are more likely to adopt high-risk behaviours, perform poorly academically and be exposed to environmental hazards. York Region and all of the municipalities in York fall under the provincial average for unattached individuals (32% vs. 34%) and families (9% vs. 12%) who are classified as “low income”. In the southern Simcoe municipalities, the proportion of low-income individuals ranged from 20%-26% and the proportion of low-income families was considerably lower than neighbouring York Region and the province at approximately 5%. In the Northern Toronto district, the proportion of unattached low-income individuals is considerably lower than York, Simcoe and the province at 22%, however the proportion of low-income families is higher at 20%.

9. TEMPLATE 'D' CHARACTERISTICS OF THE CENTRAL LHIN

D. Capturing **Unique Characteristics** of each LHIN

What role Academic Health Sciences Centres and voluntary Networks (e.g. Emergency Network, Child Health Networks) play within each LHIN (please limit your response to 2 pages)?

No academic health sciences centre is located within the Central LHIN area. However, the southern portion of this LHIN area is very close to the health sciences centre located in the Toronto Central LHIN area, and many people in the Central LHIN area use teaching hospitals in the Toronto Central LHIN area as their "community hospitals". This suggests a close working relationship between the two LHINs is necessary, on hospital issues as well as primary care and community care issues.

Describe any unique characteristics/features of your LHIN that impact this process and/or future Integrated Health Services planning activity (please limit your response to 2 pages.)

GEOGRAPHY:

- Central LHIN contains a mix of urban (densely populated), and suburban and rural areas (York Region is the highest growth region for province/county).
- Central LHIN has very large population - 1,179,765 (Ministry data re Centra LHIN)..

POPULATION CHARACTERISTICS:

- Areas of high income and other areas of high poverty
- Significant ethnic diversity and proportion of immigrants in some areas (immigrant population - 40% in South York region; in former North York percentage is 56% with 46% being recent immigrants, i.e. immigrated between 1999 and 2001, for North York is 46%.
- Fastest growth rate of seniors in the province
- Overall central LHIN has healthier population than rest of Ontario - related to wealth and education levels with better performance than Ontario on most health indicators
- Many parts of the Central LHIN are "suburban" communities, where many residents are fairly new to their communities and where a number of infrastructures (including health infrastructures) have not grown to keep pace with population growth. In the newest and fastest growing of these suburban areas, many residents are new to their communities and may not have established roots and contacts in the communities, thereby leading to social isolation.
- The northern parts of the Central LHIN area are a mix of rural areas (some still devoted to agriculture), and smaller towns and villages. Population centres in these parts of the Central LHIN area are often "bedroom communities" whose residents migrate out of their communities (usually to the south) to work. This has implications for the primary care allegiances of many people in these communities.

HEALTH SERVICES:

- 10 hospital sites (1 private): 6 community; 1 ambulatory care; 2 rehab
- 39 long-term care facilities
- 1 community health centre
- only 60% of the people in the Central LHIN boundaries use Central LHIN hospitals - this is the 2nd lowest of the 14 LHIN and has big implications for cross boundary use.

10. TEMPLATE “E” TRANSFORMATIONAL THINKING; THE CENTRAL LHIN PROCESS & KEY LEARNINGS:

E. Describing the **Transformational Thinking and the Process** that guided your approach to the task

Please describe the approach and process used to complete this task (please limit your response to 3 pages)

APPROACH AND PROCESS:

A Central LHIN Workshop was hosted by the Ministry of Health and Long-Term Care on December 1 2004. At this workshop, participants identified nine priorities grouped in two categories.

A. Patient Care/Services Integration Initiatives

6. Seamless Senior's Services (in the context of a locally developed blueprint for aging)
7. Enhancing the Continuum of Care within the Central LHIN
8. Chronic Disease Management
9. Strategic Value of Community Support Services – Validation and Usage of Community Support Services to Keep People in the Community to Address All Their Needs in a Timely and Appropriate Fashion
10. Integrating and Improving Services for People with Mental Illness and Addictions within the Health Sector

B. Administrative Support Services Initiatives

5. Strategic Plan for electronic management of Health Information
6. Innovative approaches to maximizing human resource across the care continuum
7. Decrease duplication cost within the LIHN and re-investing it in patient care
8. The Development of a Population Health Approach to LHIN planning activities

After the Central LHIN workshop, small groups began working on fleshing out each of these nine initiatives.

At each of the fourteen workshops sponsored by the Ministry, participants were provided with the document **Taking Stock: Setting Integration Priorities** as a tool to allow the small groups that emerged from the Central LHIN workshop to record information related to the top priority initiatives identified at the workshop. The templates in this document formed the major outline for central East LHIN small group deliberations.

The nine leaders of the small groups formed themselves into a Steering Committee for liaison purposes as each small group developed its report. This Steering Committee also identified twenty patterns across the nine reports. The Committee then integrated the nine priority initiatives and the twenty patterns, to produce five strategies the Central LHIN should address (see next page).

Please describe key learnings that came out of this process (please limit your response to 2 pages)

The Key Learnings

Five strategies should be addressed by the Central LHIN:

The First Strategy: Priority Service Areas for Integration

The priority initiatives highlight three priority service areas:

- 1. integrating mental health and addiction**
- 2. chronic disease and disability management**
- 3. creating seamless services for seniors**

The Second Strategy: Establishing Central LHIN Key Objectives

Five key objectives should be considered paramount by the Central LHIN:

- 1. creating a service continuum**
- 2. ensuring access**
- 3. building on standards, best practices and measurement of achievement**
- 4. fostering client-oriented information, education and engagement**
- 5. creating incentives for cooperation**

The Third Strategy: Addressing Critical Enablers for Integration

Five critical enablers were identified:

- 1. strategic management of health information**
- 2. a strong focus on community support services**
- 3. a strong focus on population health**
- 4. decreasing duplication costs**
- 5. maximizing human resources**

The Fourth Strategy: Addressing Critical Success Factors

To achieve the objectives through critical enablers, six critical success factors must be addressed.

- 1. knowing what is already in place**
- 2. building on strengths**
- 3. ensuring adequate funding/resource levels**
- 4. ensuring resource equity**
- 5. ensuring resources to create change**
- 6. staff education and knowledge acquisition**

The Fifth Strategy: Resolving Key Integration Issues


Three issues must be resolved both locally and provincially if the three strategies cited above are to be carried out.

- 1. establishing the nature of integration**
- 2. ensuring that health is broader than health care**
- 3. working across LHIN boundaries**

11 MEMBERS OF THE CENTRAL LHIN STEERING COMMITTEE

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12 APPENDIX ONE: PATIENT/CLIENT CARE CONTINUUM



	Prevention/ Promotion	Primary Care	Secondary Care	Tertiary Care/ Quaternary	Rehabilitation	Complex Continuing Care	Continuing Care (non-complex)	Palliative Care
Type of Care	<ul style="list-style-type: none"> Screening/detection Preventive treatment and risk reduction Education Counselling 	<ul style="list-style-type: none"> Assessment Diagnosis Treatment Monitoring Education Counselling Emergency Care 	<ul style="list-style-type: none"> Assessment Diagnosis Treatment Monitoring Education Counselling Emergency Care 	<ul style="list-style-type: none"> Assessment Diagnosis Treatment Monitoring Education Counselling Emergency Care 	<ul style="list-style-type: none"> Education Prevention Restorative Maintenance 	<ul style="list-style-type: none"> Assessment Diagnosis Treatment Monitoring Education Counselling 	<ul style="list-style-type: none"> Rehabilitation Supportive care Personal Care Homemaking Respite Care Quality of life Spiritual Care 	<ul style="list-style-type: none"> Pain and symptom control Respite Counselling Quality of life Spiritual Care
Who provides the care	<ul style="list-style-type: none"> Public Health professionals Primary Care Physicians Other health professionals Consumer organizations <p><i>Support:</i></p> <ul style="list-style-type: none"> Lab DI Pharmacy Dietician 	<ul style="list-style-type: none"> Family Physicians Some Specialists Nurse Practitioners Midwives Rehab professionals Other profess. Paramedics <p><i>Support:</i></p> <ul style="list-style-type: none"> Lab DI Pharmacy Dietician 	<ul style="list-style-type: none"> Physician Specialists Crisis workers Midwives Nurses Other health prof. <p><i>Support:</i></p> <ul style="list-style-type: none"> Lab DI Pharmacy Dietician Respiratory ther. 	<ul style="list-style-type: none"> Physician Specialists and Sub-Specialists Nurses Other health prof. <p><i>Support:</i></p> <ul style="list-style-type: none"> Lab DI Pharmacy Dietician Respiratory ther. 	<ul style="list-style-type: none"> Physicians Physiotherapist Occupational therapists Mental health professionals Respiratory therapists <p><i>Support:</i></p> <ul style="list-style-type: none"> Assistive Devices providers 	<ul style="list-style-type: none"> Physician Specialists and Sub-Specialists Nurses Other health prof. Rehab professionals <p><i>Support:</i></p> <ul style="list-style-type: none"> Lab DI Pharmacy Dietician Respiratory ther 	<ul style="list-style-type: none"> Physicians Rehab profess. Homemakers and aides Professionals Spiritual care-givers <p><i>Support:</i></p> <ul style="list-style-type: none"> Community support agencies Support Groups Pharmacy, labDI 	<ul style="list-style-type: none"> Physicians Nurses Counsellors Families Lay people Spiritual care-givers <p><i>Support:</i></p> <ul style="list-style-type: none"> Pharmacy Palliative support agencies and groups
Where the care is provided	<ul style="list-style-type: none"> Physician offices Schools Resource Centres Associations Senior Centres Fitness Centres Hotlines, internet Media Other providers 	<ul style="list-style-type: none"> Hospitals (outpatient) Physician offices Clinics In-home (CCAC) Rehab facilities Community Health Centres Ambulance Community agencies 	<ul style="list-style-type: none"> Hospitals 	<ul style="list-style-type: none"> Teaching Hospitals and Academic Health Science Centres Large Community Hospitals (often as regional program) 	<ul style="list-style-type: none"> Hospitals Community Rehab facilities In home (thru' CCAC) LTC facilities 	<ul style="list-style-type: none"> Hospitals 	<ul style="list-style-type: none"> In-home (CCAC) Nursing Homes/ Long Term Care Facilities Supportive Housing Day Programs Specialized agencies 	<ul style="list-style-type: none"> Hospitals LTC facilities Hospices In-home