

Identifying System Integration Opportunities: A Guide for the Transformation Process

Central East LHIN

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Central East LHIN Planning Group

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EXECUTIVE SUMMARY

On December 2, 2004, over 400 Health Service Providers from the newly identified Central East LHIN met with the Health Results Team to begin the journey of transforming and creating a true health system for our local community. We were challenged through the Open Space methodology to identify and prioritize integration activities that would benefit our clients both within the LHIN and across LHINs. The ultimate goal was to begin the planning to create an integrated, coordinated, patient-centred health care system.

As we exited this first session, we had prioritized ten key areas and identified work teams to further explore the possibilities of integration. The following report highlights the explicit work within each priority for integration and includes references to both existing and new opportunities as requested by the Ministry of Health and Long-Term Care and will reflect the degree of engagement and commitment from the Central East LHIN working team.

The report details the demographics and topography of the new LHIN and demonstrates a clear understanding of the client requirements in urban, rural and remote locations of our LHIN. The findings do not limit themselves to only needs within the LHIN boundary but reflect on the needs for cross- LHIN integration and provincial standards where necessary. As an example, ALL priorities included integrated needs around a common electronic health record and a funding model that is patient centred. Similarly, the needs of addictions and mental health providers and for seamless, coordinated care for seniors reflect a need for a provincial strategy. Yet every priority has identified specific local integration that has occurred or can occur at the local level.

What the report template does not include is the opportunity to express the commitment, capability and passion of the Central East LHIN working team to continue to be involved as part of the transformation of health care in Ontario. The process has drawn together a cross-section of skilled, knowledgeable health care providers whose experience, leadership and teaming will be invaluable to the new LHIN organizations. These include both formal and informal networks of providers and individuals who can represent and engage the local client in the priorities of the LHIN.

Through this process the working group has increasingly come to think of this empowering exercise as the beginning of a process for cultural change and not just a step or end in and of itself. As a group, those involved have accepted accountability and have produced reports as asked within the deadlines requested; shown a commitment to the transformation process and to system integration; and have demonstrated the capacity, responsibility and motivation to provide leadership as the transformation process moves forward.

The report will illustrate to anyone reading it that transformation is clearly a top priority for the Central East LHIN working group and is supported by a significant and diverse

"brain-trust" of passionate service providers who can both help to integrate health care to the local client and step back and look at the broader transformation agenda for health care.

The report outline is as follows.

A. Patient Care Integration Initiatives

1. Community Support Services

Community Support Services includes Home Support Services, Addiction and Mental Health Services, Palliative Care / Hospice and Caregiver Support Services. This priority group presents a new integration opportunity to enhance the continuum of care for consumers and service users. An integrated approach is proposed that promotes independent living and ageing in place through streamlined services and increased collaboration among providers.

2. Comprehensive and Seamless Services for Seniors

This report provides detail for the creation of a comprehensive, coordinated and accessible system of services for seniors. It incorporates the concepts of equitable access (e.g. clients get what they need regardless of where they reside), assistance with navigation (e.g. case management) and “seamless” transitions (e.g. movement between and among different services is as smooth as possible from the clients perspective). There are a number of formal and informal voluntary networks that exist today on which to build the integration opportunities. With services for seniors identified as a priority by fourteen LHINs, this priority group sets an important foundation for a new integrated opportunity.

3. Mental Health and Addiction Systems

This priority group identifies an initiative that builds on the work of existing alliances and leverages two recent provincial and regional reports that represent regional planning involving a wide range of stakeholders. This report proposes development of a Central East Mental Health and Addictions Network that will identify gaps and overlaps in service delivery, explore regional opportunities, propose new collaborative initiatives, and ultimately provide advice to the Central East LHIN Board.

4. Moving People Across the System

New integration opportunities are identified in this report that build upon current work. This priority group report recognizes that successful integration of services within the LHIN will require the development of tools and protocols to facilitate the timely flow of people across the health care continuum. To overcome the barriers of technology for sharing information and allowing universal access to resources including both technology and staff, several forward thinking recommendations are included such as the implementation of common referral protocols through multiple entry points, and system-wide case management.

5. Innovation in Rural Health Care

Given the massive geography of the Central East LHIN, topography can be a challenge for patients reaching care and for staff providing care.

A new integration opportunity is proposed that includes maximizing the use of e-solutions technology for remote health, web-based training, and access to specialty services with the use of mobile resources for both team and individual interventions.

B. Administration Integration Initiatives

1. Common Health Record & Electronic Exchange of Information

Building on existing infrastructure, provincial initiatives and the numerous local initiatives in place within the LHIN, in local CCAC's Community agencies, and hospitals, work will begin that will develop and implement a common virtual health record for residents of the Central East LHIN. This report outlines how a standards based common health record will be built and will form the basis for the electronic health record and the exchange of information. The basis and the approach will be to build a solution focused on patient needs, not technology.

2. Fair Population Needs Based Funding

This priority group proposes the introduction of a population health, needs based funding formula to allocate funding to the LHINs based on the population size and growth, age, income, rurality, remoteness and other social demographic characteristics unique to each LHIN region. This report outlines the types of relevant data that should be included, seeks to ensure the provision of care is as close to home as possible, and that fair funding is the much needed result. The proposal is for a funding formula that matches health-related needs with appropriate levels of funding to avoid over- or under-funding of regions.

3. Integrated Services – Acute and Community, Ageing in Place

With the current lack of capacity and poor coordination among services, this report calls for a model in the system that is designed to efficiently and effectively deliver a continuum of high quality services to seniors as they age in place. Key enablers identified for this new integration opportunity includes the use of technology for information sharing across areas of health, integrated funding, and maximizing the linkages among services across sectors. As background, "aging in place is a philosophy, based on the preferences of seniors to remain in their homes and communities, of supporting seniors by providing in-home services as their needs change and they move along the health care continuum. (Toronto District Health Council. Coordinated, *Accessible Community Healthcare for Elders in Toronto: The CACHET Model*, December 2004)."

4. Public Education and Community Engagement

A new integration opportunity is identified and highlights the importance of the public knowing how to access services, the changes to service delivery that have or are already occurring, and awareness of the responsibility for health. It acknowledges a role for system navigators that focus on getting the right person to the right place at the right time for the right reason, as opposed to an advocacy role. The report proposes the LHIN Board needs a mechanism to gather information about its communities. It might consider providing a core group of services creating efficiencies and system support which could include epidemiology, information officers / communications support, and research / planning staff to gather communication information and develop program / service plans.

5. Maximizing HR Potential through Innovation and Integration.

The priority group for maximizing health human resources potential has identified the need for a new integration opportunity of developing both a local and a provincial strategy that is focussed on the recruitment and retention of all health care workers. A key enabler is a provincial health human resource plan that incorporates input from government, colleges, employers and unions.

C. Priority Setting of new Integration Opportunities

The methodology utilized in the original Central East LHIN Workshop gave contributors equity of voice among a disparate group of health care providers spanning geography (urban, rural, remote), distance, and demographics. The five clinical and five administrative priorities identified at that workshop are deemed important enablers to the health system transformation. Template C presents each priority. The original order of these priorities have been preserved i.e., priority areas are listed as they were presented in the Workshop report (December 7, 2004). For each priority, the top three recommendations for a high level action plan are presented.

D. Capturing Unique Characteristics of Central East LHIN

This section contains a response to the question of the role of Academic Health Science Centres (AHSCs) and voluntary networks. It is noted that AHSCs provide tertiary and quaternary care not available locally. With the pivotal role in education of health human resources, AHSCs also are part of longer term responses to current and projected health human resource shortages in the LHIN.

It is recommended that the LHIN can enhance current practices by clarifying and standardizing patient referral and repatriation processes between AHSCs and community hospitals. For example, the use of formal repatriation agreements might be established with community hospitals in the GTA so that patients who no longer require specialized acute care are repatriated in a timely manner to the appropriate level of care.

Additionally, there are a large number of alliances / networks in the Central East LHIN, reflecting the geographic expanse of the region. It is suggested that those networks

which focus on improving care for high needs populations and moving high needs and mainstream clients through the system will likely be most successful as networks are developed or expanded within the LHIN area.

Other unique characteristics of the Central East LHIN are presented, including geography, population and growth (recent and projected), incidence of low income, ethnicity and data related to under serviced area designation. Significant calculation and analysis were performed using both Dissemination Area and FSA data to produce a comprehensive Central East LHIN profile using the borders defined by the MOHLTC during production of this report (January 2005).

E. Describing the Transformational Thinking and Process Guiding Approach

Transformation is a journey that entails looking beyond existing Central East health provider structures, processes and hierarchies in an interdisciplinary manner, across organizational boundaries. The grassroots type approach used at the December 2, 2004 Central East workshop helped remove barriers and traditional ways of thought. This section describes the process of collaboration that was adopted by the Central East LHIN working group. There was explicit understanding that outcomes would not be pre-determined but would come about as a result of thorough explorations to determine optimal solutions. For many, this process built upon past collaboration successes. Outcomes of the process include gaining an understanding of both the interconnectivity between initiatives / priority areas, as well as the breadth and scope of the knowledge and skills available to be explored for solutions.

The working group is committed to continue to act as an ambassador for change and as a local resource for the new Central East LHIN Board and its CEO.

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A. PATIENT CARE INTEGRATION INITIATIVES

This section includes the five reports as requested in Taking Stock: Setting Integration Priorities document. Reports provide a description of each patient care / service integration.

The reports are:

1. Community Support Services, including Home Support, [Community] Mental Health, Wellness, Education and Caregiver Support
2. Comprehensive and Seamless Services for Seniors
3. Transforming the Mental Health and Addictions System in Central East
4. Developing the Means and Methods to Move People Across the Health Care Continuum
5. New Innovations in Rural Health

Title of initiative:		Type of integration
<i>Community Support Services</i> (including Home Support, (community) Mental Health, Wellness, Education and Caregiver Support)		X Horizontal X Vertical <input type="checkbox"/> Intersectional <input type="checkbox"/> Other, describe:
Existing or new initiative?	List of Partners involved	
<input type="checkbox"/> Initiated / existing integration activity* X New integration opportunity	Representatives of community support services, mental health and addiction services, hospice care providers, long-term care facilities, associations, health care providers and member of provincial parliament.	
Brief description of the initiative		
Community Support Services including Home Support Services, Addiction and Mental Health Services, Palliative Care/Hospice and Caregiver Support Services must be an integral part of an integrated Health Care system.		
What is the idea:		
Community Support Services be a vital part of the continuum of care model in all aspects of LHIN planning and funding priorities:		
<ol style="list-style-type: none"> 1. Enhance the continuum of care for consumers and service users through an integrated approach to health care that promotes independent community living and aging in place. 2. Streamline services to improve client access through collaboration and to ensure proper navigation through the Health Care service system. 3. Recognize partnership initiatives among providers that are sensitive to cultural, linguistic, and special needs clients that facilitate availability, accessibility and affordability of health care community services. 4. Integration of client/patient data health information in order to ensure clients/patients is provided with and is receiving the best level of care they need. 5. Provide incentives and opportunities for best practice models that have been researched and implemented in other catchment areas. 6. Enhance and integrate community support programs and services in order to ensure accessibility and availability of services in the community with special attention to caregiver support needs. 7. Standardize training and education of direct providers staff and volunteers in order to ensure high quality care to all users. 8. Integrate access to services through a navigator model that acts on behalf of high need clients for seamless access to services. 9. Recognize the vast catchment area in Central East LHIN where accessibility and affordability of health care services is inequitable. 10. Engage consumers (clients/patients) and their caregivers in planning and priorities setting for funding of health care services. 		
Current Status		Outcomes / lessons learned
Community Support Services are currently provided by a number of community-based non-profit organizations. These organizations have a long history of engaging the community in the planning, funding (fundraising/donating), and delivery (volunteering/staffing) of services in order to maintain their accessibility and affordability. Planning, priority-setting, and funding of community support services are		Integrated and coordinated community health care services that is affordable, available and accessible to consumers when and where they need it. Planning, priority-setting and funding of community based services that are consumer driven.

not equal to other health care services system such as hospital and long-term care facilities. A holistic approach is needed in order to ensure community-based programs and services form an integral part of a transformed health care system.	
Lead contact person	
Name: Odette Maharaj Donna MacDonald Title: Executive Director Executive Director Telephone: 416-701-4800 / 905-477-4006	Organization: Scarborough Support Services Haliburton County Home Support Services e-mail address: omaharaj@ssse.ca donnamacdonald@haliburtonhomesupport.com

High Level Action Plan

#	Description of the Tasks / Actions
1.	Compile and review inventory of the programs and services currently funded by the MOH and other funding supporters in order to identify best practice service delivery and funding methods and models.
2.	Review the current funding ‘managed competition’ and grants that have no ‘built-in’ cost of living allowance) that invitingly effect wage reimbursement for direct service staff on a daily basis, e.g.; no referrals = no hours to staff = no wage; no increase in funding = reduction in hours = no wage.
3.	Implement strategies that would encourage organizations to collaborate in order to integrate programs and services that address the needs of the community.
4.	Set expectations and provide incentives for new partnerships and sharing of innovation among service providers, e.g. linkages between hospitals, institutions, and agencies.
5.	Encourage and engage consumers (clients/patients) in the planning, priority-setting and funding strategies through various avenues including; consumer info hotline where a person can call in and leave messages, suggestions, complaints; email and other IT wed conferencing, for feedback.
6.	Review client-centered coordination and accessible service systems that is in operation in other areas and choose model that would meet the needs of the Central East LHIN region.
7.	Develop provincial standards for education and training requirements of direct service personnel.
8.	Develop provincial strategy for the role and responsibilities of LHINs in order to ensure equitable funding and access for health care services.
9.	Pilot "integrated model" in smaller designated catchment areas (rural/urban) so that issues could be addressed before full implementation.

Title of initiative:		Type of integration	
<i>Comprehensive and Seamless Services for Seniors</i>		<input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral	
Existing or new initiative?		List of Partners involved	
<input type="checkbox"/> Initiated / existing integration activity* <input checked="" type="checkbox"/> New integration opportunity		LTC facilities, Hospitals, CCACs, Regional Geriatric Program, Community Support Services, Mental Health service providers, caregivers, Frail Elderly Alliance of Durham Region, Dementia Networks	
Brief description of the initiative			
<p>What is the idea?</p> <ul style="list-style-type: none"> • The creation of a comprehensive, coordinated and accessible system of services for seniors that incorporates the concepts of equitable access (e.g. clients get what they need regardless of where they reside), assistance with navigation (e.g. case management) and “seamless” transitions (e.g. movement between and among different services is as smooth as possible from the clients perspective). • Comprehensive – The system of services for Central East must include ALL services necessary to support aging individuals, including the more highly specialized services. This includes access to Comprehensive Geriatric Assessment (CGA), hospital and community-based Specialized Geriatric Services (SGS), and other home support and community services within the LHIN region. • Coordinated – The system of services must include a component of intensive case management (the identification of high risk individuals, comprehensive assessment of need, and ongoing assistance with managing transitions across and between services). In addition, the need to have a common electronic health record to prevent duplication and ensure continuity will be critical to success. The creation of a system that is linked/coordinated with seniors’ mental health services is essential given the high proportion of frail seniors with dementia and other psycho-geriatric conditions. • Accessible – For the most part, comprehensive services must be based on an individuals’ local community. This is paramount for managing frail home-bound individuals where travel is complicated at best and frequently impossible. It will be necessary to create a system with multiple entry points, yet centralized access to a broader system of more specialized services. It is recognized, that some highly specialized services must be centralized due to critical mass and associated efficiencies. Using both the North Network IT infrastructure and mobile assessment capabilities/teams, equitable access to services can be ensured in a cost effective way throughout a region that has a low density, yet high numbers, of older persons. • A health system that is truly integrated will meet the needs of most Ontarians, regardless of age. The system must be accessible, comprehensive and coordinated for all seniors and their caregivers and be able to provide “navigator” services and pointers to education prior to the need for critical health care and individual case management. • It is primarily when an older individual is *frail that quick and easy access to multiple, coordinated services becomes essential. It is only when multiple issues (both health and social) affect an older individual that the risk for hospitalization, physical and functional decline and institutionalization become high and intensive case management/coordination is critical. (* frail – typically 75+ with multiple complexities, both biological and psychosocial, a decline in functional independence and often socially isolated) • Currently there are a number of models, both Canadian and international, that has either been articulated or implemented/piloted in various communities. Examples include the CHOICE, SIPA, PACE and CACHET models, as well as the National Service Framework for Older People (U.K.) 			

Why is this important?

- It has been well documented that poorly coordinated/fragmented services are both costly to the health system, but also results in a socioeconomic impact on caregivers and often results in high rates of institutionalization and acute care hospital-use by frail older persons.
- Individuals age 75+ are the highest consumers of health services in Canada; yet they comprise only 3% of the population.
- Although in Central East only 12% of the population is age 65 or older (insert actual number), the number is growing at a disproportionately higher rate than the rest of the Province. By 2010, in Durham alone, the number of those aged 75+ is projected to increase two-fold...the impact on the health care system will be unprecedented unless the creation of coordinated, accessible and preventative services for seniors becomes a priority for action.

Assumptions/Enablers and Risks.

- Given that all 14 LHIN’s identified Services for Seniors as a high priority, it is strongly recommended that the Province endorse a Provincial Framework for Health and Aging that outlines the principles upon which local systems/solutions can be developed (e.g. aging in place, equitable access, portability, client-centered, etc...).
- Accepting the notion that seniors often relocate to other regions closer to their children, it would be critical to ensure that a system/model to support aging individuals is in place in all regions across Ontario.
- It is assumed that technology (North Network/Smart Systems for Health) will be used to ensure access to highly specialized and scarce resources (e.g. Geriatricians and Geriatric Psychiatrists) and that models for physician remuneration will be developed that encourage and facilitate access for seniors living in rural and remote regions of Ontario.
- The risk with new initiatives is the tendency to overlook the work that has gone on before, both good and bad. In order to gain from the valuable input that has already been given across the sector of Seniors Services, it is critical that the priorities build on the wisdom and knowledge that already exists as a solid foundation. Again, this would assist to “reduce unnecessary redundancy whilst preserving requisite diversity” across the Province.

Current Status	Outcomes / lessons learned
<ul style="list-style-type: none"> • It is essential that new initiatives should build upon current activity in the region. Formal voluntary networks such as the <i>Dementia Networks and Elder Abuse Networks</i> and less formal alliances such as the <i>Frail Elderly Alliance of Durham Region</i> are rich sources of information and can function as steering committees or focus groups as the new integrated system is designed and implemented. • The <i>DHKPR District Health Council</i> recently completed a Long Term Care Multi-Year Plan (2004-2009) that outlines clearly gaps in services for seniors in a significant portion of the Central East LHIN; this work was also recently completed in Durham as part of the <i>Frail Elderly Integration Project</i>. • Another collaborative initiative in 	<ul style="list-style-type: none"> • Work has been under way in several jurisdictions in Central East to create models for the delivery of SGS in the absence of priority funding. Several specialized high intensity services are now in place in hospitals; however, they have been developed largely in isolation and continue to be fragmented from other necessary community services. The development of, and funding for, both specialized community-based services (such as Geriatric Assessment Clinics and Geriatric Outreach capacity) and preventative community-based services is critical in the creation of a truly integrated and comprehensive system. • Education development and communication to ALL clients is essential to ensure there is an understanding of a comprehensive system. This initiative will also provide the

<p>Durham Region, the Specialized Geriatric Services Steering Committee, recently completed a proposal for the MOHLTC entitled “<i>Specialized Geriatric Services in Durham Region; Inventory of Service Gaps and Proposed New Service Delivery Model</i>” (February 2005).</p> <ul style="list-style-type: none"> • From a broader perspective, the development of a Seniors Health Strategy by the Registered Nurses Association of Ontario is noteworthy and provides an existing mechanism to complete the necessary critical work at a provincial level. • There are significant achievements resulting from the Ontario Alzheimer Strategy role out over the past five years. The evaluations of those initiatives as well as the key goals of the Transition Project of the Alzheimer Strategy continue to offer conceptual frameworks that may be useful in the broader context. 	<p>opportunity for on-going consultation with our community prior to needing the specialized and critical services required.</p> <ul style="list-style-type: none"> • There is already a willingness of providers to work together and the LHIN will provide the vehicle for integration to happen by capitalizing on the significant knowledge, skills and expertise (“brain trust”) that will allow localization of solutions in Central East.
Lead contact person	
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High Level Action Plan

#	Description of the Tasks / Actions
1.	<p>Create a Central East Seniors Health Advisory Committee for the LHIN.</p> <ul style="list-style-type: none"> • Given the high priority, consistent messaging from stakeholders and likelihood of immediate success with high impact, an Advisory Committee to guide local action and connect with provincial activity is essential. • Current stakeholders (consumers, caregivers and providers) are already organized throughout the region; a multitude of expertise and interest already exists. • It will be necessary to move forward quickly on local integration efforts, yet remain connected to the provincial group, the Advisory Committee can assume this dual function. • The committee should be responsible to guide the strategic planning process for seniors health at the Central East LHIN recognizing that the current level of investment in health services is not achieving optimum health outcomes for seniors.
2.	<p>Participate in a Provincial Working Group to address Health Service Integration for Seniors.</p> <ul style="list-style-type: none"> • Although local solutions are necessary to continue to move the Transformation Agenda forward, a Provincial Strategy/Policy Framework is necessary to ensure that 14 different LHIN’s do not create 14 different solutions to Elder Health issues. • Although the National Framework on Aging exists in Canada, it falls short of providing any real direction for provincial policy makers re-integration models or provincial standards/approach to health service delivery for seniors • The provincial working group should establish province wide guidelines that establish

	planning principles but allow for the creation of local solutions to integration, e.g. <i>Reduce unnecessary redundancy whilst preserving requisite diversity.</i>
3.	<p>Identify a comprehensive “basket” of health services for seniors for the Central East LHIN and a process that ensures timely, equitable and transparent decision-making that is responsive to the LHIN’s needs and to its’ financial circumstances.</p> <ul style="list-style-type: none"> • a GAP analysis (including a complete and detailed inventory re: the current state of service delivery/availability) of Seniors Services in the Central East LHIN needs to be completed building upon the work of the DHKPR Long Term Care Multi-Year Plan (March 2004) • The determination of what is meant by “comprehensive” is critical to the completion of this work and is necessary to move forward with addressing gaps in service – this should include both funded MoHLTC services as well as other critical inter-sectoral services and linkages.
4.	<p>Determine the most suitable seniors’ integration model for the Central East LHIN building upon the work already done in the community and outcomes from successful models in existence.</p> <ul style="list-style-type: none"> • The Coordinated, Accessible Community Healthcare for elders in Toronto (CACHET) document and the premises upon which it was formulated is a recommended starting point for model development in the region. • A hybrid model may need to be developed based upon the local geography and demography and the recommendations from the provincial working group re: basic tenets for integrating Seniors Services in the province. • Features to be determined include level of integration (organization and governance), access points, referral process, case management model, key participants, etc...
5.	<p>Develop system-wide performance indicators that become part of service provider performance agreements that are elder-sensitive and include the ability to capture these in the E-health record.</p> <ul style="list-style-type: none"> • Currently performance indicators that are reflective of elder care include Alternate Level of Care (ALC) indicators and individual service utilization indicators (number of admissions by CMG, discharge disposition, etc...). • It is necessary to develop indicators of successful elder care such as recidivism rates and wait times in ER’s). • It is necessary to build in incentives/funding for good performance with elder-sensitive performance indicators rather than utilization indicators that often result in premature discharge or institutionalization.
6.	<p>Develop a detailed specification of the data required and fields required that represent the "basket of services" a senior experiences as a necessary input to the creation of the common Electronic Health Record.</p> <ul style="list-style-type: none"> • Input at the design level will ensure integration and comprehensiveness in that each contact with the health system can be documented once and follow the client to other services within the LHIN, across other LHINs or to service providers that fall outside the funding model of the LHIN. • It is strongly recommended that this work ideally be constructed as a provincial effort but at a minimum, should reflect the needs of the Central East LHIN in having a common electronic health record.
7.	<p>Ensure ongoing education/communication resources are in place that focuses on enabling senior clients and their caregivers to ensure they understand how and when and where to get access to the right services at the right time in the right place.</p>

Title of initiative:	Type of integration
<i>Transforming the Mental Health and Addictions System in Central East</i>	<input checked="" type="checkbox"/> Horizontal <input checked="" type="checkbox"/> Vertical <input 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 checked="" type="checkbox"/> New integration opportunity	Consumers and families Community mental health agencies Community addictions agencies General hospital psychiatric programs Specialty psychiatric hospital
Brief description of the initiative	
<p>What is the idea</p> <p>I. Strengthening the Infrastructure</p> <p>Central East comprises several ‘sub-regions’, including part or all of: York Region, Durham Region, Haliburton Kawartha and Pine Ridge, and Scarborough. Each of these ‘sub-regions’ has some form of mental health alliance with some connectivity to addictions organizations. A Central East Mental Health and Addictions Network would bring these stakeholders together to:</p> <ul style="list-style-type: none"> • provide advice to the Central East LHIN Board • identify gaps and overlaps in service delivery • develop proposals for new collaborative ventures at a local and regional level • explore regional opportunities, e.g., information management, housing and employment inventories, and a regional call and information resource <p>II. Expanding the Current Resources</p> <p>Each ‘sub-region’ requires:</p> <ul style="list-style-type: none"> • a general hospital psychiatric unit with schedule 1 status and associated crisis team, holding beds, community mobile crisis and safe beds • teams with links to community psychiatrists, family physicians and programs with a specialized mental health focus – these teams need to be ‘concurrent disorder capable’ with an ability to screen for substance abuse and manage these issues in collaboration with local addictions agencies • addiction services including medical and non-medical withdrawal management, assessment and treatment programs and recovery homes • consumer/survivor and family initiatives with links to the traditional service delivery system and capacity to respond in innovative ways to local needs • access to specialized regional services and resources including tertiary psychiatric hospital and specialized outreach, consultation and residential care, and specialized supportive housing, i.e., forensic and dual diagnosis <p>There is a wide variation in the availability of these essential service components in different parts of the region. Targeted needs-based investments are required to ensure that each ‘sub-region’ has the required range of services and supports, and an annual increase in base funding is required to ensure that the sector remains competitive.</p> <p>III. Building New Capacity</p> <p>The Central East Region lacks a number of specialized resources which are identified as ‘best practices’ in the field. Proposals for seniors will be described in other patient care initiatives, and the needs of children and adolescents will be incorporated later in the planning cycle. Other specific areas require investment in the near future –</p> <ul style="list-style-type: none"> • early intervention programs, which target young people with first episodes of serious mental illness, 	

should be established in each of the sub regions

- a regional concurrent disorders program, providing specialized treatment, consultation and outreach is needed to augment the services provided by the local mental health and addictions agencies
- specialized courts dealing with mental health and addictions issues should exist in each sub-region
- access to language and culture competent services and diversity capacity is required in each sub-region

Why is this important?

Incidence of addiction and mental health problems:

- Canadian Health Network states that 10% of adult Canadians report problems with their use of alcohol and 50% report problems related to someone else's drinking.
- 20% of Canadians will experience a mental illness in their lifetime. (Health Canada Report, 2002)
- One in eight Canadians will be hospitalized for mental illness at least once in their lives, more than are hospitalized for cancer or heart disease. (*Community Integration Planning: Key Issues in Mental Health and Addictions*, Joint Paper of Centre for Addictions & Mental Health [CAMH], Ontario Federation of Community Mental Health and Addiction Programs [OFCMHAP] and Canadian Mental Health Assoc. [CMHA] Ontario)
- Ten per cent of Canadians surveyed by Stats Canada in 2002 reported symptoms consistent with alcohol or drug dependence and 5% reported problem or high-risk gambling behaviour. (Canadian Community Health Survey, 2002)
- Research indicates that people with concurrent disorders (co-occurring addiction and mental health problems) experience poor treatment outcomes, high rates of relapse, suicide and homelessness.

Health, economic and social costs of mental health problems and addiction problems:

- A meta analysis of 62 research studies conducted from 1980 to 2003 indicates that depression increases the risk of mortality for people with coronary heart disease. (Psychosomatic Medicine)
- Over 30 % of lifetime users of illicit drugs (excluding cannabis) report harm to their physical health arising from drug use (Canadian Addiction Survey, 2004)
- Research indicates that people with serious mental illness have higher rates of grave medical illnesses and higher rates of premature death than the general population (CMHA Ontario)
- Heavy alcohol use raises blood pressure and increases risk of stroke, heart failure and liver, throat, breast and other cancers and alcoholic liver disease is a major cause of illness and death in North America. (CAMH)
- Alcohol and illicit drug abuse accounted for \$4.9 billion in lost productivity due to illness and premature death, \$1.7 billion in law enforcement and \$2.1 billion in direct health care costs last year. (Kirby Report, November, 2004)
- Mental illness accounted for \$6.3 billion in direct health care costs and \$8.1 billion in lost productivity due to illness and premature death. (Kirby Report, November, 2004)
- 90% of suicide victims have a diagnosable mental illness or substance use disorder. (Kirby Report, November, 2004)
- Problematic gambling for one untreated person represents an economic burden of \$56,000.
- According to the World Health Organization, addiction and mental illness account for the greatest degree of disability worldwide.
- Harvard University and the World Bank predict that, over the next 20 years, depression will become the leading cause of workdays lost through disability and premature death.

Why is it a priority to integrate mental health and addiction services throughout the continuum of client health care?

- Research indicates that prognosis worsens in relation to the length of time that psychotic symptoms are left untreated and there is greater evidence of brain damage in persons who experience long,

untreated psychotic episodes versus those who experience shorter, more efficiently treated episodes. (Kirby Report, November, 2004)

- “Without early intervention and treatment, child and adolescent disorders frequently continue into adulthood...these childhood disorders are likely to persist and lead to a downward spiral of school failure, poor employment opportunities and poverty in adulthood. No other set of illnesses damages so many children so seriously” (Kirby Report, 2004)
- By two years following treatment for substance use, there are significant declines in the use of health services, resulting in considerable cost savings to the overall health care system (OFCMHAP, 2003)
- Between \$4 and \$12 in long-term societal, economic and medical costs is saved for each dollar spent on the treatment of alcohol use disorders. (OFCMHAP, 2003)
- People with mental health and/or addiction problems (including problem gambling) comprise a significant proportion of the population of Ontario and these problems represent a tremendous burden for those individuals, their families, the community and the health care system.
- Despite the prevalence and impact of addiction and mental health, and credible planning documents commissioned by MOHLTC that demonstrate the need to prioritize such problems, mental health and addiction services are marginalized within the health care system. Service gaps and waiting lists for mental health and addiction services are no less important than other health care priorities.
- The substantial impact of addiction and mental health problems on other health areas demands that the full continuum of health care is able to intervene and recognize those with problems and those at risk.
- Planning reflects that mental health and addictions are logical partners with many shared clients and issues, but they are also separate sectors and integration with other health partners is an investment in population health and well-being.
- Identifying mental health and addiction issues as health care priorities significantly reduces the stigma associated with these problems by giving them the same value as other sectors in the continuum.
- Multi access points are created in the continuum of care and which promotes triage to quickly and effectively address needs.
- In the 2002 Statistics Canada Community Health Survey, those who reported feelings and symptoms of the surveyed mental disorders or substance dependencies, only 32% saw or talked to a health professional during the 12 months prior to the survey.
- The vast wealth of knowledge and expertise in the addiction and mental health systems of consumer/survivor/family/self-help groups or individuals is undervalued by the general health care system and requires legitimacy and financial support.
- The administrative infrastructure of community mental health agencies and addiction agencies has been eroded by the failure of the system to provide adequate funding for direct services and by a “cookie cutter” approach to determining organizational needs.
- The needs of transitional age, children, youth, older persons and other populations (by age and specialization) are not recognized or adequately addressed in the current systems.
- Addiction and mental health treatment/interventions and support are effective and there is a funding crisis in the addiction treatment system in particular and in community mental health services in general.

The benefits of early, accessible, timely and appropriate interventions provided in a complete continuum of health care by equal, collaborative partners cannot be over stated. The approach is client centred, comprehensive, community based and cost effective.

Other significant benefits of the integration of mental health services and addiction services throughout the continuum of care:

- Sends a clear message to the community, including consumers, their families, and the organizations providing services, that the need for an effective, responsive and adequately resourced mental health and addiction system is important and legitimate.
- Development of vertical and horizontal integration of services could improve and standardize client information and record keeping and provide a solid foundation for the development of a seamless system of electronic information sharing.
- It enables the LHIN to build on existing planning and service integration initiatives within the mental health and addiction systems and recognizes the commitments of the provincial government. (Central East (Whitby) Mental Health Implementation Task Force and “Setting the Course.”(CAMH))
- It provides an opportunity to develop a comprehensive mental health and addiction strategy within the health care system that:
 - ✓ secures dedicated funding for mental health services and addiction services
 - ✓ builds system capacity
 - ✓ ensures the availability of core supports and services throughout the LHIN
 - ✓ develops mental health and addiction service delivery partnerships, with clearly defined roles, responsibilities and accountabilities, between community agencies, Schedule One and tertiary level facilities
 - ✓ promotes client-centred and family-focused service that can logically collaborate with Family Health Teams
- It fosters collaboration within the health care system related to health promotion, identification and early intervention with at risk populations.
- It promotes integrated treatment of co-occurring mental health and addictions problems and integrated approaches to other health problems that are impacted by mental health and/or addiction.

Expected Outcomes of integration of addiction services and mental health services throughout the health care system:

- Increased understanding of mental health and addiction issues, including their influence on general health, and improved capacity to identify those with problems and those at risk.
- People with mental health and/or addiction problems get an effective response from a complete health care system that works together to ensure timely and appropriate referrals, service coordination and continuity of care.
- Provides deserved legitimacy of mental health and addiction services and increases awareness, acceptance and use of those services within the LHIN
- More appropriate and cost-effective use of acute care services:
 - ✓ bed utilization and efficiency benchmarks met
 - ✓ more appropriate use of ER services
- Mental health and addiction services are accessible, responsive, coordinated and comprehensive.
- Decreased stigma and discrimination of persons with addiction and mental health problems.
- Standardized delivery of mental health and addiction services across the LHIN catchment area (standardized admission and discharge criteria and protocols, assessment tools and evaluation framework)
- Recovery oriented practices based on broad determinants of health are incorporated.
- Existing alliances, networks and partnerships are enhanced and expertise and experience is shared by the system.
- Standardized human resource practices can be developed to reduce loss of staff and increase abilities to attract qualified staff.
- Cross-sectorial training (mental health, addictions, acute and tertiary care, etc) will increase understanding and awareness and encourages linkages and exchange of data, documents and

High Level Action Plan

#	Description of the Tasks / Actions
1.	Strengthen the Infrastructure: Establish a Central East Mental Health and Addictions Network to build on existing alliances, identifying new opportunities for integration, and provide ongoing advice to the new LHIN Board.
2.	Expand the Current Resources: Ensure that each sub-region has integrated community mental health teams, a range of addictions services, a fully functioning Schedule I general hospital psychiatric unit, consumer/survivor and family initiatives, and access to specialized tertiary care.
3.	Build New Capacity: Develop early intervention programs, a regional concurrent disorders program, specialized courts for mental health and addictions issues, and culture competent services for new Canadians.

Title of initiative:		Type of integration
<i>Developing the means and methods to move people across the health care continuum</i> (Giving people access to the right service or bed at the right time.)		X Horizontal X 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 X New integration opportunity	Representatives of long term care homes, hospitals, community support services and Community Care Access Centres.	
Brief description of the initiative		
<p>What is the idea: Successfully integrating services within the LHIN will require the development of tools and protocols that will facilitate the timely movement of people across the health care continuum. An easier, more efficient and more client-focused navigation system will ensure people have access to appropriate services and care, in the right place, at the right time. For providers, integration provides the chance to reorganize services, build innovative partnerships, address duplication and overcome systemic disincentives or barriers that inhibit the movement of people from service to service.</p> <p>Presently, there are a number of barriers that hinder the realization of this integration opportunity. Included among these barriers are:</p> <ul style="list-style-type: none"> • Providers have different understandings and interpretations of terminology and need; • Technology is incompatible or cannot interface, making the sharing of information difficult or cumbersome; • Providers have differing access to resources including technology, staffing and particular expertise and varying opportunities to build partnerships; • The system lacks evidence-based criteria to support decisions about when to move people from one service to another; • There are inadequate community supports and limited or inconsistent access to specialized long term care programs to meet patient needs when they are medically stable and not requiring hospitalization; and • Providers do not have a shared accountability framework and may work from differing objectives <p>Current competition among LTCHs for new residents or among community providers which have contracts with CCACs can inhibit cooperation.</p> <p>Enabling strategies for an integrated system include:</p> <ul style="list-style-type: none"> • Explore any examples of current successes in the Central East LHIN or elsewhere in the province where an innovative or cooperative approach has been taken to ease and speed the movement of people from service to service. • Exporting successes and best practices from one area of the LHIN to another. • Common referral protocols through multiple points of entry. • System wide case management for significant populations to assist people in moving through services at time of need. 		

- Investigate initiatives elsewhere in the province where care-mapping has allowed for an all inclusive approach to sharing information between providers as the consumer moves between them.
- Encourage partnerships between acute and rehab hospitals and the long term care facility sector in order to develop programs that provide supportive care in the long term care setting
- Foster the development of services in the long term care setting that meet the needs of under-serviced specialty programs.
- Develop system-wide means of illustrating client movement from service to service and a forum for stakeholders to review trends.

Current Status	Outcomes / lessons learned
Two existing Scarborough examples include: a) The Community Advisory Council of the CCAC, in concert with representatives from all partners, identified a minimum data set needed for referrals of any kind across the health care continuum. b) The hospitals in Scarborough and Durham have hired a Joint CIO (Chief Information Officer) to work together with the relevant CCACs to enable a more integrated electronic system to manage service delivery.	It is difficult to gain consensus on required data elements from providers of considerably different services. In order to move such an initiative forward, participants must be engaged in a visioning process which requires imagining “what might be”. Also, the means, i.e. electronic exchange, cannot be divorced from the ends.
Lead contact person	
Name: Julie Foley / Christine Nuernberger Title: Executive Director Telephone: 416-701-4800 / 905-477-4006	Organization: Scarborough CCAC / Leisureworld Caregiving Centre e-mail address: Julie.foley@scarborough.ccac-ont.ca / cnuernberger@leisureworld.ca

High Level Action Plan

#	Description of the Tasks / Actions
1	Develop process for the sharing of human resources in order to create common thresholds in areas such as IT, infection control, staff education and training etc.
2	Foster partnerships that allow providers to create joint services that meet community needs (i.e. short stay or rehab services or convalescence care in LTCH for geriatric patients who would otherwise occupy an acute care bed)
3	Use the excess capacity in long term care homes for geriatric out-patient clinics
4	Set expectations and provide incentives for new partnerships and sharing of innovation among service providers.
5	Coordinate with applications for Family Health Teams in the area in order to enhance the navigation through the system

Title of initiative:	Type of integration
<i>New Innovations in Rural Health Care</i>	X Horizontal X Vertical X Intersectoral
Existing or new initiative?	List of Partners involved
X Initiated / existing integration activity X New integration opportunity	Representatives from Community Support Agencies, Community Care Access Centres, District Health Councils, Community Health Centres, and Municipalities.
Brief description of the initiative	
The rural population should not be at a disadvantage because of the area they live in. Given the advancements in technology primary, secondary, and tertiary care should be available in all areas. Rural clients/patients can be treated, followed and maintained through a variety of mechanisms including e-solutions; web based training, and access to specialty services. Additionally, given the human resource crisis in rural areas, the use of technology to provide education and training should be utilized.	
Why this is important: “Rural” does not fully describe or capture the issues and problems. There is a need for equitable access to services. The Central East LHIN has a massive geography and population. Topography is a challenge for patients reaching care; also for staff providing care (remote vs. rural). There are limited resources with the appropriate skill level to service these areas. Cost of care is higher and there are transportation issues for rural areas.	
Current Status	Outcomes / lessons learned
<u>Technology</u> <ul style="list-style-type: none"> • Remote health care i.e. nursing supported by television / tele-monitoring (Telemedicine, Telenorth) • ET Specialist consult re wound care using digital pictures (WOW Wound Care – London, ON) • Tele-health Ontario • Teleconferencing • 211 information line • Live video link to specialists (cardiac surgery) • On line caregiver support groups • Pain and symptom management (resources available by phone to walk staff through procedures i.e. titrate meds) <u>Educational Opportunities</u> <ul style="list-style-type: none"> • On line access re prevention / interventions available and new initiatives • Access to support groups (enabled by technology /reducing travel, isolation) • On line resources / links to hospital libraries • Ability to network with other providers – communities of learning / sharing of best practices • Web based / on line training (@yoursidecolleague) • Degree programs (BSN program established in Kenora through Lakehead University) 	<ul style="list-style-type: none"> • The best health care is the health care provided as close to home as possible. • It is more cost effective to bring the care to the client as opposed to bringing the client to the care.

<u>Team and Individual Interventions (Satellite Offices / Mobile Resources / Networks)</u>	
<ul style="list-style-type: none"> • Physicians / Family Health Teams • Centres of Excellence across province which can mobilize supports to all areas. • Rehab (Terry Fox Satellite Clinics) • Specialists (Geriatric Outreach Teams, Oncology Team used in NW Ontario/Thunder Bay area) • Mobile Clinics (hearing, vision, breast screening, dialysis, etc.) • Specialized tests / labs (mobile MRI) • Networks (Stroke Strategy, End of Life) 	
Lead contact person	
Name: Dale Lowe Title: Manager Telephone: 905-885-5700 ext 233	Organization: Saint Elizabeth Health Care e-mail address: dlowe@saintelizabeth.com

High Level Action Plan

#	Description of the Tasks / Actions
1.	Network with other providers / Create communities of learning / Share best practices / Establish a rural health network.
2.	Establish an inventory of what exists – look at what is needed - Identify the gaps – how can it be linked to urban areas?
3.	Create mobile resources / teams supported by specialists.
4.	Make changes to funding / have the dollars follow patient. This will help reduce some of the barriers to service because of boundaries and transportation issues.
5.	Recognize that rural care is more expensive due to travel and time.
6.	Increase flexibility of boundaries within the LHIN i.e. similar to present hospital system so if someone wanted to attend a day program they were not restricted by boundaries.
7.	Recognize the potential for what can be done in the home setting using technology i.e. specialized wound care, tele-monitoring (right person-right service-right time).
8.	Remove barriers through the use of a common health record.
9.	Address inequities re wages (community vs. institution).
10.	Compensate providers differently - other than per visit when providing support i.e. tele-monitoring etc.
11.	Remove gatekeeper rule of physician – easier and simplified access.
12.	Compensate and provide funding for education and networking sessions for providers.
13.	Establish mandatory rural placement and training as part of professional education.
14.	Reduce competition so service providers can share resources i.e. staff training and best practices.
15.	Integrate systems i.e. hospital MIS system used by CCAC (meditech).
16.	Utilize resources and skills to the max i.e. nurse practitioners – make better use in combination with MDs. This will also help address the shortage of family physicians in the Central East LHIN.
17.	Educate re scope of practice e.g. registered staff not always required can use Personal Support Workers for delegated acts, use of rehab assistants.
18.	Break down silos: how can we make it more fluid? i.e. allow experts to move around.
19.	Need to establish a link with an Academic Health Science Centre (AHSC) that can provide support to this region. Central East does not have an AHSC within the region.

20.	Look at funding (population based funding vs. rural based funding). Need to modify funding formulas so they include a rurality factor similar to the new funding formula used by the CCAC.
21.	Look at potential barriers to new innovations i.e. dial up vs. high speed in some areas, incompatibility of systems / inability to interface.
22.	Improve viability of hospitals by spreading out their resources.
23.	Provide incentives for innovations that meet the needs of the rural population.
24.	Need faster dissemination of innovations in one area of the province to all areas of the province.
25.	Need to change funding so that innovations in care are rewarded i.e. compensate specialist who provides consult via teleconference.
26.	Provide flexibility in service delivery i.e. evenings, weekends so family is available to provide support.
27.	Link web-based information.
28.	Enable clients in self mastery supported by technology.

B. ADMINISTRATION INTEGRATION INITIATIVES

This section includes the five reports as requested in Taking Stock: Setting Integration Priorities document. Reports provide a description of each administration support service integration.

The reports are:

1. Common Health Record and Electronic Exchange of Information
2. Population Needs-Based, Multi-Year Funding Formula that Recognizes Demographic and Geographic Differences
3. Integrated Services (Acute & Community) – Ageing in Place
4. Public Education and Community Engagement
5. Development of an HR plan that maximizes HR potential through integration and innovation

Title of initiative:		Type of integration
<i>Common Health Record and Electronic Exchange of Information</i>		<input checked="" type="checkbox"/> Horizontal <input checked="" type="checkbox"/> Vertical <input checked="" type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe: The approach would allow all providers within the patients circle of care the opportunity to view an electronic health record
Existing or new initiative?	List of Partners involved	
<input checked="" type="checkbox"/> Initiated / existing integration activity* <input checked="" type="checkbox"/> New integration opportunity	Include the list of participants from the workshop as well any others who contributed to developing the integration opportunity Community Agencies, Hospitals, CCACs, Long Term Care Facilities.	
Brief description of the initiative		
<ul style="list-style-type: none"> Building on existing infrastructure, provincial initiatives and the numerous local initiatives in place within the LHIN, in our CCAC's Community agencies, and hospitals; we will begin to develop and implement a common virtual health record for residents of the Central East LHIN. The record will be built on a standards based common health record which will form the basis for the electronic health record and the exchange of information. This Common Standards Based Electronic Health Record (CEHR) will evolve in a manner that builds on provincial initiatives (CRIM, SSHA-Secure email, provider registry) as they are implemented by the province. Grounded in a vision and project plan developed through a planning group with broad representation across the LHIN, the CEHR would initially be shared through the secure portal. Longer term, as new/replacement systems are brought online and the infrastructure components become more robust additional functionality such as order entry will be incorporated into the solution. The basis and the approach will be to build a solution focused on patient needs not technology. Using a broad based inclusive approach across the LHIN we will build a virtual patient record initially focused on Patient Identification, essential medical information and a history of encounters. The content will vary from agency to agency depending on existing electronic records, but the standards based approach to the health record will facilitate adding in additional agencies and their information as it becomes available. This approach could serve as a model for other LHIN's as the development process and tools are easily duplicated across the province. The approach is designed so that there is the potential to quickly realize some benefit by leveraging the existing systems, but allows for longer term gains as the standards are developed and an increasing number of agencies are able to collaborate with us. 		
Current Status		Outcomes / lessons learned
<ul style="list-style-type: none"> The Central East LHIN has a history of cooperative initiatives within and across the different health sectors in the Region. The hospitals in Durham region began to consolidate their information system in 1995, with an agreement between Oshawa and Uxbridge to share financial systems. This grew into an agreement between all acute hospitals to share a single clinical information system. This system is still in existence with the principle partners being Lakeridge Health (major sites at Oshawa, Bowmanville, Whitby and Port Perry) and Ajax Pickering site of Rouge Valley Health. There is also a shared IT system between Peterborough Regional, 		Experience gained in the partnerships developed in the CE-LHIN can be generalized to the proposed effort to develop a CEHR. <ol style="list-style-type: none"> Get a clear consensus on the reasons for moving forward. <ul style="list-style-type: none"> One of the critical success factors for the previous project was the development and acceptance of a clear vision for the project. In their case it was the development of a "common clinical front end". This vision provided a clear backdrop to decision making, and served as a reference point in difficult times. This was a critical component in the development of this proposal with the working group. Make technical decisions later in the process

<p>Campbellford General and Northumberland Health Care. Additionally 2 CCAC's and 3 Hospitals (Durham Access to Care, Lakeridge Health, Rouge Valley, Scarborough CCAC, and The Scarborough Hospital) have hired a joint CIO and are developing a regional approach to IT planning.</p> <ul style="list-style-type: none"> • The CCAC's in the LHIN have a long history of involvement in integration activities including participation in common information systems, and the development of common standards for assessments. We believe that the proposed inventory of services will identify other integration efforts that will serve as a platform for a LHIN based approach. 	<p>rather than sooner.</p> <ul style="list-style-type: none"> • One of the divisive issues quickly brought to the table was the choice of systems. By the agreement of the group this was delayed while we developed vision, purpose, principles, consensus on governance etc. Then we agreed on an RFP process to identify vendors that could meet the requirements. The technological choice was driven by a cost benefit comparison of what the technology could do and the cost of acquiring that technology. • The working group focused on the vision of the initiative and agreed that making technical decision now would delay the development of the proposal. <ol style="list-style-type: none"> 3. Take the time to get group consensus and build trusted relationships. <ul style="list-style-type: none"> • The process for making the final decision takes a significant amount of process time to build a trust relationship and ensure that all agencies and parties have time to build internal consensus. The actual decision making process was delayed while consensus was built on principles etc. 4. Approach the process with an openness to change. <ul style="list-style-type: none"> • Previous attempts to develop partnerships had been done as an attempt to extend an existing solution to prospective partners. Success was achieved when all potential partners entered into discussions with the idea that everything was on the table and all were committed to finding the best solution for the groups. • The focus of the working group was outcome oriented, and focused on achieving positive results for the residents of the Central East LHIN.
Lead contact person	
<p>Name: George Ryan / Janet Harris Telephone: 905-263-2237 ext.111 / 905-430-3308 ext. 3501</p>	<p>Organization: Grandview / Durham Access To Care e-mail address: gryan@graconsult.com / janet.harris@durham.ccac-ont.ca</p>

Key assumptions

The process as outlined depends on the use of provincial and federal standards with respect to electronic health records, the transmission and sharing of information and the use of the Smart Systems for Agency as a hosting and connectivity partner.

High Level Action Plan

#		Description of the Tasks / Actions
	Key Priorities and High level Action Plan	<p>The following six priorities and the necessary high level action plan for each priority were developed by the task group responsible for the development of this initiative. These priorities are not ranked by importance or chronology. E.g. all of them are important and it is likely that there would be significant overlap in their development.</p> <p>Project Tasks and Milestones are summarized in Appendix A.</p>
1.	Develop an Inclusive Planning Committee that represents the Central East LHIN	<p>The development of a “Common Health Record and Electronic Exchange of Information” will require the consensus of the agencies within the Central East LHIN. One of the essential first steps in this process is the development of a planning forum that will guide the development of the project. Membership in the planning committee should include LHIN leadership as well as broad representation of stakeholders across the LHIN. Initially community membership could be drawn from two groups who have demonstrated interest in this topic and represent a broad spectrum of stakeholders across the LHIN. The first group consists of individuals from the CE-LHIN community planning session who have identified this project as a priority. This group represents a diverse cross section of the agencies and the geography of the LHIN. A subset of that group further developed this initiative when it became the #1 priority for the LHIN.</p> <p>The second group to consult with is the E-health Working Group formed at the E-health Session for the CE LHIN. Although these groups will form the basis of the planning group, it is not intended that the planning be exclusive to that group.</p> <p>The planning group will be responsible for the following tasks:</p> <p>Project Charter: One of the key first steps is the development of a project charter. This may be developed by the planning group or by the LHIN. The working group that developed this initiative have suggested the following as a starting point for discussions on the charter.</p> <p>"Facilitate the development of a Common Health Record and Electronic Health Record for Agencies and residents of the CE-LHIN"</p> <p>If the process for the development is initiated and developed by the planning group, it is assumed that the involvement of LHIN staff and eventual approval of the LHIN at an executive level will be a significant component of the development process.</p> <p>If the development of the charter is initiated at the LHIN level there will be a need for a mechanism to ensure stakeholder input. There are a variety of different methods that the LHIN may wish to use to obtain input, but the stakeholders identified in both the Community LHIN workshop and the CE LHIN E-health workshop would be excellent starting points.</p>

		<p>Selection of a Project Steering Committee: The broad based approach to involvement in the planning process makes the process of managing the development of this initiative difficult. In order to ensure that the initiative is proceeding quickly it is suggested that a representative group of members from the planning committee function as an executive or steering committee for the project and if necessary report to the LHIN. The steering committee should be drawn from the stakeholders in a manner that reflects both the range of agencies in the CE-LHIN and the geographic distribution of those stakeholders. The steering committee’s mandate would come from both the LHIN and the stakeholder group. Their mandate would be to oversee the development of the initiative, ensure communication with the stakeholders and LHIN are properly maintained, and ensure that the work plan is followed to the satisfaction of the planning group and the LHIN.</p> <p>Vision and Work Plan: The final element of responsibility for the Planning group is the development of an E-Health vision statement for the CE-LHIN and the development of a detailed implementation strategy to achieve that vision. Ideally the vision should be developed to support the LHIN vision for the provision of services for the CE-LHIN community. There will also need to be broad consultation with stakeholders to ensure that the community needs will be met, so as to begin building consensus for the project. Additionally there will need to be a technology consultation to ensure that the vision is both feasible, and advisable. It is important that the driving force behind the creation of the vision must be the provision of services to the residents of the LHIN, not the technology.</p> <p>Upon the completion and acceptance of the vision by the LHIN and stakeholders, the vision will become the focal point for development of a detailed strategy for the CEHR.</p> <p>A significant component of the Vision should be the development of essential data elements in the CEHR. This will be built on the work being done by the province in its e-health initiative, but at a local level, it may be necessary to develop a prioritized list of essential information to build the CEHR in a phased approach that captures the essential elements in a prioritized manner.</p> <p>Conceptually this strategic plan will view the development of an electronic health record as an evolutionary one. Initially this evolution may begin with the development of a web portal viewer that would allow providers within the patient’s circle of care to have access to a basic level of information. This might include demographics, other essential information such as allergies, chronic disease, and a history of encounters with agencies within the LHIN.</p> <p>The work plan should be developed in a manner that leverages provincial initiatives such as the Smart Systems for Health (SSHA) network, and when available the Secure Email, the registry of providers, and the Client Registry and Information Management (CRIM) project which will provide a system for ensuring a unique identifier for all patients.</p> <p>Where possible the work plan should leverage the existing infrastructure and partnerships within the CE-LHIN.</p>
2.	Inventory of Information Services.	The development of a comprehensive readiness assessment is a critical first step in the process of developing a CEHR for the LHIN. This readiness assessment should be done in a comprehensive manner that is focused on a

		<p>number of factors.</p> <p>The Technology Base; This survey would focus on the technology infrastructure for each agency in the LHIN. It would detail the type of network, the operating systems in use for the network, the existing server systems, and the number and type of peripherals used with that network. Where the level of infrastructure is not as advanced, the inventory may be limited to the number of PC's and Printers. The report would also include an assessment of the regional network infrastructure that will be required to support an extensive system connecting the agencies across the CE-LHIN</p> <p>Non-clinical applications: This portion of the survey would detail the use of applications that are not patient related. This is necessary in order to understand the bandwidth and other requirements of each agency. This also serves as a starting point for any work on back office transformation that may be undertaken by the LHIN. In addition, the normal office applications may be necessary to support the development of the CEHR.</p> <p>Clinical Applications: This is a critical component of the survey and will detail the patient related applications that generate data to be shared on the electronic health record. The survey should focus on what data could be made available to the electronic health record if the application data were shared in the LHIN. It would identify the format, and any mechanisms the agency currently uses, to export or share that data with other agencies.</p> <p>Work/ Business process: The survey should begin the process of collecting the business processes required in the creation of key data elements. For example, at the basic level, an understanding of the business processes required to identify patients and collect demographic information is necessary in order to assist in the development of the business case to support the strategic plan.</p>
3.	Patient/Provider Identification Methodologies.	<p>A critical component of any electronic health record is the development of a robust and trusted system of uniquely identifying patients across multiple locations. While it is clear that the provincial CRIM solution will provide the ultimate solution, the strategy and work plan should consider how this issue can be resolved in the short term for the initial phases of the CEHR. If a web based portal approach is taken as a starting point, basic information such as a unique identifier for LHIN patients, patient demographics, essential health information and a history of recent encounters could be embedded within the portal. The core issue with generating the history of encounters is the recognition that there is currently no method of uniquely identifying a patient within Ontario. In order to maximize the value of the CEHR it may be necessary to proceed with a LHIN based solution that will easily migrate to the CRIM solution once available. There appears to be two options that could be considered</p> <p>LHIN Wide Single patient Registry: If this model is chosen in the strategic planning process all agencies within the LHIN would use a single registry system. This registry system would become the front end for the CEHR and would provide a LHIN specific unique identifier for all patients seen within the LHIN. The registry would include a provision for the unique patient</p>

		<p>identifier provided by the province (CRIM) when that information becomes available. Thus patient information could be shared provincially once the CRIM system is in place. Until that time, the single patient registry would serve as a method to uniquely identify CE-LHIN patients. The unique identifier would serve as an input to the Portal and or CEHR.</p> <p>Parallel the CRIM methodology at the LHIN: Under this model the unique identifier would be generated at the portal level. The process for generating the identifier would follow the CRIM process but could be undertaken more quickly than a provincial wide rollout. At the portal level visit history information for patients would be matched based on a number of criteria. A probability of correctness is assigned based on the match.</p> <p>The two approaches will need to be evaluated as a part of the strategic planning processes.</p>
4.	Privacy and Confidentiality	<p>Solving the issue of privacy and confidentiality will be a significant priority for the LHIN as it develops its approach to many of the initiatives recommended by the planning groups. The methodology recommended by the group responsible for developing this initiative is the development of common approach and perhaps common consent processes and forms. This would be supplemented by a common set of policies on privacy and confidentiality. These policies would include a mechanism for tracking and auditing any access to a patient's records, along with a disciplinary process accepted by all members. There would need to be a process for 1) developing consensus on the guiding principles of the policies with respect to Privacy and Confidentiality. 2) Approval of these principles at the agency level, 3) development of common set of policies and forms at the LHIN level and 4) subsequent approval of #3 at the individual agencies. To a large extent the first four priorities can proceed simultaneously. However the development of a detailed solution will depend significantly on the work being done in the first four steps outlined above.</p>
5.	Development of a solution	<p>Although the group recommends the use of a portal system as an initial first step in the development of an electronic health record, it recognizes that this will likely not be the ultimate solution.</p> <p>The technological solution should be approached as a series of steps in the journey towards an electronic health record. The pace of technological change and the ongoing resource limitations of the health care system make a measured approach prudent. There needs to be a clear plan that builds the CEHR in a staged approach that recognizes the priorities identified in the development of the vision.</p>
6	Evaluation of Results	<p>The LHIN, with assistance from the Steering committee will monitor and evaluate the effectiveness of this initiative. The steering committee will, as a part of the development process, recommend to the LHIN a set of focused measures that will become the basis for ongoing evaluation. These measures will be divided between process measures, (Success in achieving timelines, participants, acceptance of the methodologies etc) and outcome measures (changes in waiting times, reduction in duplication, % of population for whom records are shared vs. not shared etc).</p>

Title of initiative:		Type of integration
<i>Population Needs-Based, Multi-Year Funding Formula that Recognizes Demographic and Geographic Differences</i>		<input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input checked="" type="checkbox"/> Other: Planning Approach
Existing or new initiative?	List of Partners involved	
<input type="checkbox"/> Initiated / existing integration activity* <input checked="" type="checkbox"/> New integration opportunity	Art Elliot, York-Durham Aphasia Institute, Brock Hall, Ron Shenfield & David Montgomery, Toronto Grace, Candy Williams, United Survivors Support, Daniela Catello, VON, Dave Sinclair, Rouge Valley Health, Doris Brick, Peterborough Regional Health, Fred Parrott, Jennifer Churchill, York Health Services Dept., Judy Eddy & Leeanne Hadley, Streamway Villa, Katherine Jackson, Regency LTC, Lorne Zon Markham Stouffville Hospital, Lynn Lawson, Provincial LTC, Maria Milanetti, Toronto DHC, Nicole Zwiers, Lakeridge Health, Pat Sparling, S. Township, Tariq Asmi, GTA/905 Alliance, Soo Ching Kikuta, Yee Hong Centre, Lynda Hessey, Durham HKPR District Health Council	
Brief description of the initiative		
What is the idea? <ul style="list-style-type: none"> • Use of a population health, needs based funding formula to allocate funding to the LHINs – based on population growth, age income, rurality, remoteness, and other social demographic characteristics. • To ensure provision of care as close to home as possible. • Will allow LHIN to better prioritize needs and plan future health care services over the entire region • The important sorts of data sources to look at in the short-term are the comparisons of CCAC levels of funding in the province and JPPC data. In these comparisons both Scarborough and Durham Region are funded the lowest cost per capita for the populations they serve both in 2001 and in 2004 • In highly populated areas of the Central East LHIN we are dealing with historical under funding problems as we enter into a new era of LHIN development. Fair funding to fund anticipated growth at the start seems an excellent place to start this planning process as a result. • The Central East LHIN has a very distinct split between urban and rural populations. Approximately 1.2 million people are located in an urban area and 327,500 are located in a rural area. There is also a large seasonal population in cottage areas such as Haliburton and Port Perry. • There is a higher percentage of youth 0-19 years the urban area than in the rest of Ontario. • And a higher percentage of seniors 65+ years in Haliburton, Marmora, Northumberland, Peterborough County, and Kawartha Lakes, than in Ontario. Durham, Scarborough and Markham are below the provincial average, however their relative numbers and rate of growth is high (50,000 and growing fast). • Factors such as low income, ethnic diversity, immigration and rates of GP's per population (covered in section D of this report) are also factors to consider in the population health of the region. • Finally, the resources to care for young adults with disabilities, those who need supportive housing, for childrens' treatment services, and for LTC spaces for the behaviourally difficult or clinically complex elderly (psycho geriatric and stroke patients, dialysis and tube feeding patients) are severely limited within this LHIN and throughout the Province. 		

Why is this important?

- The Central East LHIN is currently significantly under funded compared to other similar areas of the province particularly in Scarborough and in Durham Region where population growth and the accompanying health related needs have exceeded funding.
- There is a need in this LHIN to address the unique needs of communities within the LHIN i.e. cottage country (seasonal population) vs. 416 (urban) vs. 905 / 705 (suburban, rural and remote) populations.
- A population based, needs based funding formula will help to create a sustainable local health care system – reflecting the needs of its increasing number of residents and critical population of aging and young residents.
- The Central East LHIN has high areas of growth within it. Traditional funding formulae are retrospective and do not recognize the growth factor. This is critical in Scarborough and Durham as we move forward to attempt to deliver adequate service to the population.
- Compared to communities like Peterborough, these areas are quite far behind in building proper health and social service infrastructure.
- Development in certain parts of the Region is advancing quickly. There is an influx of 5,000 to Port Perry all at once. Seaton in Durham (just south of the 407) is estimating an addition of 70,000 additional residents. Commensurate growth is also forecasted to take place in North Oshawa, Clarington, Cobourg and Port Hope between 2006 and 2010. In Durham overall, there is a 12% rate of growth.
- Factors such as the completion of highway 407 in Durham to connect it with 35/115 as well as a proposed airport in Pickering and the further development of the University of Ontario Institute of Technology (UOIT) will also drive further growth in corresponding areas in the region.
- Scarborough is under serviced given its proportion of immigration and resettlement and the growth in need for services in this area. Scarborough already has 20% low income housing and not enough support services to deal with this population.

Key enablers

A LHIN Steering Committee which is dedicated to fundamental integration early.
 This LHIN like others could break its population into quadrants of 905, 416, Cottage Country and Other more homogeneous populations to allow a focus to be put on each areas specific and unique needs.

Key Barriers

Cross-Border Issues of Service, particularly between this LHIN area and York Region and the City of Toronto, not to mention Kingston.

Current Status	Outcomes / lessons learned
<p>Population Health Statistics—Central East LHIN In the Central East LHIN, those between 20-44 years old represent the highest percentage of the population, followed by a high proportion of children aged 5-14 years old. Persons older than 65 years and older represent a lower percentage of the population, but the growth in these age cohorts is among the highest growth in the province.</p> <ul style="list-style-type: none"> • Within the Central East LHIN, Haliburton County, for instance, has a significantly higher proportion of seniors (23.9%) than Ontario as a whole (12.7%). • A significant proportion of people within the 	<p>Outcomes</p> <p>An approach that will allow the LHIN a proactive start at dealing with the many challenges faced in this region, in a constructive way.</p> <p>An opportunity to start fresh to shift historical funding patterns to something that better meets population health needs.</p> <p>A population health approach could be an integrating factor to off-set silo thinking and funding.</p>

<p>Central East LHIN reported multiple ethnic origins.</p> <ul style="list-style-type: none"> • Ischemic heart disease is one of the leading causes of death for both males and females. • For men, other leading causes of death include lung cancer and cardiovascular disease. Cardiovascular disease is another leading cause of death among women. • The leading cause of hospitalization for males was circulatory disease. • The leading causes of hospitalization for females were pregnancy and complications. • There has been a decrease in the rate of teenage pregnancies • A higher proportion of females than males reported they needed health care or advice in the past year but did not receive it. • Population in Scarborough (2001): 593,297 • Top visible minority groups reported in Scarborough: Chinese (18%), South Asian (18%), and Black (10%) • Population in the Durham/Haliburton/Pine Ridge region (2003): 851,001 • In Durham Region, approximately 51% reported a single ethnic origin other than Canadian or English (i.e. Scottish, Irish, Italian, East Indian and Jamaican). • In the City of Kawartha Lakes and the Counties of Peterborough, Haliburton, and Northumberland, approximately 32% reported an ethnic origin other than Canadian or English (i.e. Scottish, Irish, Dutch, German and French) 	<p>Lessons Learned</p> <p>There seems to be a higher incidence of respiratory illness in the East and this is an area that needs focus from a population health standpoint – perhaps with respect to environmental factors.</p> <p>There is an opportunity in some cases for the funding to follow the patient from home to a LTC facility or another similar location. This model has worked well in other jurisdictions.</p> <p>There should be lessons in population health planning from other regions in Canada and abroad and these should be taken into consideration in the LHIN planning processes for the province.</p>
<p>Lead contact person</p>	
<p>Name: Maria Milanetti / Lynda Hessey / Pat Sparling Title: Director / Executive Director / Special Advisor to Mayor Pearce, Township of Scugog. Telephone 416-222-6522 / 1-800-833-7543 / 905-985-8001</p>	<p>Organization: Toronto DHC / Durham HKPR DHC / Township of Port Perry e-mail address: mmilanetti@tdhc.org; hessey@dhc-dhkpr.org; sparling@trytel.net</p>

High Level Action Plan

#	Description of the Tasks / Actions
1.	Do a needs based, population health analysis of the population for the entire Central East LHIN looking at urban, rural and remote populations in detail with proper epidemiological and sociodemographic data.
2.	Do an inventory of existing health care services in the LHIN and compare these to the needs of the population that have been identified
3.	Compare funding levels through hospital, CCAC and community comparative data available to make the case for proper funding for this LHIN at the outset of the planning process. Focus on the current situation and the burgeoning growth to properly resource the LHIN
4.	Prioritize areas for action for first, second and third years to address identified population health issues.

Title of initiative:		Type of integration
<i>Integrated Services (Acute & Community)—Aging in Place</i>		<input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input checked="" type="checkbox"/> Intersectoral:
Existing or new initiative?	List of Partners involved	
X Initiated / existing integration activity X New integration opportunity	Representatives from Long-Term Care Facilities, Community Health Centres (CHCs), Community Care Access Centre (CCAC), Community Support Agencies, Seniors Associations, Supportive Housing & District Health Councils	
Brief description of the initiative		
<p>What is the idea</p> <p>“Aging in Place is a philosophy, based on the preferences of seniors to remain in their homes and communities, of supporting seniors by providing in-home services as their needs change and they move along the health care continuum. (Toronto District Health Council. Coordinated, <i>Accessible Community Healthcare for Elders in Toronto: The CACHET Model</i>, December 2004).”</p> <ul style="list-style-type: none"> ▪ Multiple entry points to a single point of access (not just CCAC) that has the mandate to integrate services without barriers ▪ Electronic information sharing across areas of health ▪ Integrate funding to follow the person to meet their needs ▪ Social model of care that meets all the needs, not just medical (e.g. transportation, isolation, facilitation of care to the person rather than the person to the care, cultural sensitivity) ▪ Increase use of Nurse Practitioners to supplement costly physician care-NP’s use a social model of care. ▪ Integrate needs of rural and urban. Rural is hard to serve, lack of resources-suggest that rural communities collaborate in their own integration model as their needs and challenges are different than in urban areas. ▪ A link to family health teams to support single point of access <p>Why is this important</p> <ul style="list-style-type: none"> ▪ Our system is not sustainable in its current form. <p><i>CMI funding is punitive to clients it rewards dependency rather than independence (e.g. if client is wheelchair dependent and unable to dress or feed self, more dollars than if we assist with rehab, client becomes able to walk, dress and feed self-so why make them independent?)</i></p> <ul style="list-style-type: none"> ▪ The existence of a broad array of individual and community services is not sufficient to ensure quality of care ▪ The lack of capacity and poor coordination among services contributes to accessibility challenges ▪ There is a need for a model in the ‘system’ that is designed to efficiently and effectively deliver a continuum of high quality services to seniors as they age in place. 		

High Level Action Plan

#	Description of the Tasks / Actions
1.	Examine existing care coordination models outlining benefits and challenges (e.g. CHOICE, PACE)
2.	Develop a theoretical model that is person focused (e.g. Toronto DHC CACHET Model)
3.	Create technical groups to define functions of the model
4.	Conduct a pilot
5.	Monitor & Evaluate

Title of initiative:		Type of integration
<i>Public Education and Community Engagement</i>		<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 type="checkbox"/> Initiated / existing integration activity*	<ul style="list-style-type: none"> ▪ Contacts from December 2 meeting ▪ Communicators Group, CE LHIN ▪ Planning Group, CE LHIN 	
<input checked="" type="checkbox"/> New integration opportunity		
Brief description of the initiative		
<ul style="list-style-type: none"> • At this time of change, the public and the stakeholders need information to comprehend the change and to provide input to ensure the change is successful in implementation. • The public needs to know how to access services, the changes to service delivery that have /are occurring, and awareness of self versus system responsibility for health. In addition, they need to know the LHIN structure and how to make it into a system and make it work. • The LHIN Board needs a mechanism to gather information about its communities, ideas and issues to assist in its decision-making. Community engagement ensures two-way feedback on new initiatives and the appropriateness of changes in each of these areas. The new system is developing and the LHIN will need public assistance and stakeholder aid in developing what it will look like. • A good public education and community engagement process will support system change by raising awareness and understanding of the changes both at a service delivery and system level. • Studies show that an informed public will have improved care outcomes when awareness assists in health promotion and prevention activities. Reduced duplication resulting from system integration will lead to reduced costs and/or the opportunity to increase activity levels. Improvement of system functioning is aided by appropriate allocation of resources when the system is reviewed from a patient/client flow perspective. If resources are available, reduced wait times are a further benefit. An informed public makes a better patient in terms of accessing service, reducing the reliance on the “formal” health care system and supports the appropriate allocation of scarce resources – human, financial and technological. • In terms of strategic alignment with other priorities, this initiative is fundamental to the success of LHINs and the priorities they develop and promote. It is fundamental to the success of the Ministry’s transformation agenda. Other existing networks and cooperatives must be used to support the process e.g., cardiac Care Network of Ontario, Cancer Care Ontario etc. • Alignment with the education system is key in terms of public concern and visibility. Education is also a key success factor in moving forward by pulling together and breaking down barriers. People will not engage unless and until they are aware of what is happening and the impact that changes may have on them and their families. We believe that the strategy developed is a proactive one and one that stresses a cooperative and collaborative approach. 		

Key Enablers/ Barriers

Barriers

- Diversity of LHIN will add complexity to implementation – age, ethnicity, demographics, geography, distance, service availability, access to technology
- CE LHIN area not well linked from a transportation perspective which will impede access
- Changing behaviour of both providers and the public is challenging
- The proposed change is complex and it is challenging to explain it in a simple but thorough way, how to simplify the message without losing the essence of the description
- Public does not engage unless and until they need the system
- Shortages of resources – human and financial may impede the speed at which changes can be made

Enablers

- Health care leadership has strongly supported the concept of regionalization
- The public, if it understands and supports the messages
- Technology, in terms of a communication tool as well as a diagnostic/treatment tool
- NOTE: Barriers can become enablers if resourced appropriately

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High Level Action Plan

- While the LHIN is in its formative stages constant communication between LHIN partners, organizational leaders and consumers will be extremely important to maintain. Information and knowledge will have to flow laterally, up and down organizational structures and through communities. Without it the orderly and constructive relationships required to make the LHIN successful will not remain healthy or helpful. With it, there is the potential for the creation of a dynamic, made-in-Central East LHIN, integrated health system.
- All LHIN communications should be approached with the primary objective of improving access; giving patients and their families the knowledge to make informed decisions regarding their healthcare system.
- The following steps are recommended for the formative phase of the LHIN's development, which could extend beyond the 2007-08 budget year.

Opportunities

Short Term – Raising Awareness

- Develop a strategic plan, mission, vision and values for the LHIN. This work will assess the current state, including the present road map and the road map for the future. This initiative includes orientation and education for LHIN Board members.

- Develop a plan for public education and community engagement to create awareness and initial Engagement
- Identify and work with internal staff of all organizations internal key stakeholders to increase knowledge of system and system changes so that they can be front line ambassadors
- Increase awareness of community leaders – politicians, Chambers of Commerce, professional organizations, large community employers and media (editorial Boards)
- Develop a comprehensive communications strategy

Long Term – Ongoing Engagement

- Create and implement a plan for community and agency engagement on an on going basis
- Emphasize orientation of public which would include: information that is system wide and a comprehensive web system
- Focus on integration of services and access to care
- Deals with the changing nature of health care
- Develop operational plans to achieve strategic objectives identified in the first phase that are sensitive to demographic groups, could be diagnosis related, work with minority groups
- Use of “grass roots”, existing networks to make changes through linking of patients, communities and professionals

This phasing and approach can be used across the province.

#	Description of the Tasks / Actions
Short Term – Raising Awareness	
1.	Develop a strategic plan, mission, vision and values for the LHIN. This work will assess the current state, including the present road map and the road map for the future. This initiative includes orientation and education for LHIN Board members.
2.	<ul style="list-style-type: none"> • Develop communication principles that all LHIN organizations can agree to and apply in order to deliver more consistent information to the public regardless of the source organization. • Develop a plan for public education and community engagement to create awareness and initial engagement • Increase public confidence in the system, where the public is currently presented with information that conflicts depending on the source.
3.	Identify and work with internal staff of all organizations internal key stakeholders to increase knowledge of system and system changes so that they can be front line ambassadors
4.	Increase awareness of community leaders – politicians, Chambers of Commerce, professional organizations, large community employers and media (editorial Boards)
5.	<ul style="list-style-type: none"> • Develop a comprehensive communications strategy • Position the LHIN as the central stakeholder communications hub. The LHIN should deliver key messages and information on behalf of the LHIN as a whole, while LHIN members would continue to communicate their own information within the context of the Communications Principles. • Post stories from consumers about their journey through the health care system on a website hosted by the LHIN. Stakeholder stories will serve to educate other stakeholders about process, expectations and resources. • The Central East Communicators Group should be relied upon as a support in the implementation process and can play an ongoing role in developing and sending consistent messages. This group has strong relationships with LHIN media sources. The Communicators

	<p>Group should be encouraged to expand its membership by reaching out to include other agencies and provide sector representation. This group should also be counted upon to support communication planning regarding:</p> <ul style="list-style-type: none"> ○ The LHIN itself ○ Service Delivery Changes ○ Personal Responsibility for Health
Long Term – Ongoing Engagement	
6.	Create and implement a plan for community and agency engagement on an on going basis
7.	Emphasize orientation of public which would include: information that is system wide a comprehensive web system
8.	<ul style="list-style-type: none"> ● Focus on integration of services and access to care ● Create LHIN community development roles to carry forward organization – organization integration opportunities. Community Development Officers could meet with community groups, identify community assets and networks, and help integrate consumer, CEO, and front line involvement in the formative stages of the LHIN development.
9.	Deal with the changing nature of health care
10.	Develop operational plans to achieve strategic objectives identified in the first phase that are sensitive to demographic groups, could be diagnosis related, work with minority groups
11.	<ul style="list-style-type: none"> ● Use of “grass roots”, existing networks to make changes through linking of patients, communities and professionals ● Establish LHIN-wide Client Advocates or Navigators operating within the LHINs to ensure each consumer is listened to and to ensure that his/her real needs are addressed and appropriate services are accessed. Needs currently presented by an individual are often filtered by the organization being contacted first – a neutral advocate/navigator/case manager within the LHIN would ensure the real needs are identified and addressed according to the client’s informed choice. These roles will be especially important as integration efforts may create a dynamic service environment. These navigators will provide invaluable feedback back to service providers about consumer experiences and needs.

Into the New Normal

The ongoing work of Client Navigators, the LHIN as Central Communications Hub, and Community Development Workers provide a way to support the changing nature of health care, development of operational plans identified in the first phase of LHIN development, and keep the relationships between integrated organizations vigorous and dynamic.

Title of initiative:		Type of integration
<i>Development of an HR plan that maximizes HR Potential through integration and innovation</i>		<input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical x Intersectoral
Existing or new initiative?	List of Partners involved	
X Initiated / existing integration activity* X New integration opportunity	Representatives from Long-Term Care Facilities, Community Health Centres (CHCs), Community Care Access Centre (CCAC), Community Support Agencies, Seniors Associations, Supportive Housing & District Health Councils	
Brief description of the initiative		
<p>What is the idea:</p> <ul style="list-style-type: none"> To develop a comprehensive all inclusive HR Plan that through integration and innovation maximizes the HR potential within the LHIN and beyond. It has been clearly established that the HR in health care are in a crisis situation and without significant attention to this issue, the crisis in Health Care within the LHIN and across the province will not be solved. To resolve this issue will take significant amounts of both Integration and innovation at all levels. We need not only a local strategy for our own LHIN but a provincial strategy focused on the attraction and retention of all Health Care workers in the Province of Ontario. We need to develop a highly skilled, secure base of dedicated professionals who are encouraged to practice in this LHIN and in the Province. There is much to be done within the LHIN and across the Province to ensure the level of health care necessary to meet the needs of a growing, ageing population. The signs are present that there are human resource challenges that need to be addressed. The outlook for the future suggests these challenges will become more acute as the population ages and experienced health care professionals are lost. There are not the health professionals up and coming to take their place. The Central East LHIN must not only compete with large urban centers like Toronto, but must also compete with the US and other provinces where employment opportunities are enhanced by offers of signing bonuses, higher wages, improved working conditions and benefits as well as educational opportunities. It is imperative that a robust Human Resource Plan be developed that does not allow for contracts to be won or budgets to be balanced on the backs of the front line health care workers, and ensures that there are adequate resources to meet the ever growing needs of the health care system. <p>Why is this important?</p> <ul style="list-style-type: none"> Retaining Health Care professionals in the Region is acute. Many factors contribute to retention issues. Employees have expressed feelings associated with lack of respect. Health Care professionals are stressed by workload and working conditions and are feeling undervalued and underutilized, and lack autonomy especially in the community sector. As demand for qualified Health Care professionals continues to climb, we will have to ensure that the training capacity to turn out the numbers of qualified professionals required. The full impact of “credential creep” (requirement for higher levels of education) is impacting healthcare now i.e. Nurses and technologists. We can expect the shortages to continue at least 10 years. The doctor shortages continue. Potential recruits will have to weigh the investment in time and money against the potential opportunities offered by the occupations in health care. 		

- The impact on those already in the workforce also remains to be seen as those individuals consider whether to obtain the additional education now being required or simply move to another occupation offering improved benefits, improved compensation and most significantly a better quality of life.
- Patient acuity has increased resulting in a need for more intense health care. This trend is happening at a time when the health care system is stretched to its limits and the staff/patient ratio can and does challenge patient care. Additional focus to the community sector for patient care will require significant reallocation of funds to the community to adequately meet the needs in that sector and to have the opportunity for this sector to compete for adequate resources. We will need a fair plan to ease the movement of staff from one sector to another.

Assumptions and Risks

Key enablers to a successful HR Strategy:

We require a provincial human resource plan that includes input from the government, colleges, employers, unions.

- Training and educators need involvement. {Colleges, universities}.
- Nurse practitioners to help with doctor shortage
- Much research and consultation has already been done by the local training board and by the local District Health Councils within the LHIN, the documents produced have significant research in them with excellent recommendations that could form an excellent starting place for an HR plan within this LHIN.

Reports:

- Human Resource Study of the Health Care Sector in Durham Region “A Call to Action” – Durham Haliburton Kawartha & Pine Ridge District Health Council
- Health Human Resources in Durham Region “Exploring Issues and Actions” - Durham Haliburton Kawartha & Pine Ridge District Health Council
- Durham Region Local Area Plan – Durham Region Local Training Board

Key Barriers to a successful HR Strategy:

- Transportation issues
- Inadequate funding – flawed funding formulas
- Managed competition (in its current state)
- Union collective agreements, inconsistent scheduling
- Pay equity

Current Status	Outcomes / lessons learned
Not currently in existence	
Lead contact person	
Name Gale Coburn / Patty Rout Title Manager/ Technologist Telephone 905-4306997 ext. 234 /	Organization: Saint Elizabeth Health Care / Lakeridge Health Corporation e-mail address: goburn@saintelizabeth.com / routp@hotmail.com

High Level Action Plan

#	Description of the Tasks / Actions
1.	Develop a provincial wide, comprehensive human resource plan.
2.	Ensure that training and skills upgrading is accessible to workers. Specialized programs need to be available close to home. Mentoring and coaching programs should be available.
3.	Positive profiling of healthcare professions
4.	Funding and policies in Universities and colleges to promote training of qualified human resources. Increase the number of educational spaces. Encourage accessible education programs.
5.	Involve advocacy groups, associations, professional regulators in planning and implementation
6.	Increased use of available technologies to support and augment current scopes of practice within the healthcare sector
7.	Integration of the institutional and community sector to offer a holistic approach to patient care.
8.	Community engagement and partnerships with labour, education, government, providers, private and public sector in the development of a comprehensive strategy.
9.	Maximizing scope of practice for all healthcare providers at all levels of the continuum of service provision. (greater use of nurse practitioners)
10.	Adequate funding plan in place to support and stabilize HR
11.	Thorough evaluation of the impact of managed competition on human resources within the community health care sector
12.	Incentification for the sharing of HR best practices strategies and innovations across the Sector providing cross pollination of experience across the sector and prevent poaching of resources LHIN to LHIN

C. PRIORITY SETTING OF NEW INTEGRATION OPPORTUNITIES

The methodology utilized in the original Central East LHIN Workshop gave contributors equity of voice among a disparate group of health care providers spanning geography (urban, rural, remote), distance, and demographics. The five clinical and five administrative priorities identified at that workshop are deemed important enablers to the health system transformation.

This section contains Template C which presents each priority. The original order of these priorities have been preserved i.e., priority areas are listed as they were listed in the Workshop report (December 7, 2004). For each priority, the top three recommendations for a high level action plan are presented.

1. Patient Care / Services Integration Opportunities

	Priority Opportunity	High-Level Action Plan
1.	Community Support Services	<ol style="list-style-type: none"> 1. Review the current Ministry grants and managed competition that have no "built in" cost of living allowance including yearly ones that adversely affect wage reimbursements for direct service staff on a daily basis: e.g. no referrals = no hours to staff = no wages; no increase in funding = reduction in hours = no wages; also review these grants as they do not take into consideration the yearly increase in the cost of doing business, i.e.: technology, rent, office supplies, etc. 2. Develop and implement with incentives strategies that encourage organizations to collaborate and develop new partnerships in order to integrate programs and services that address the needs of the community. 3. Pilot "integrated model" in smaller designated catchment areas (rural/urban) so that issues could be addressed before full implementation.
2.	Comprehensive & Seamless Services for Seniors	<ol style="list-style-type: none"> 1. Create a Central East Seniors Health Advisory Committee for the LHIN. <ul style="list-style-type: none"> • Given the high priority, consistent messaging from stakeholders and likelihood of immediate success with high impact, an Advisory Committee to guide local action and connect with provincial activity is essential. 2. Identify a comprehensive "basket" of health services for seniors for the Central East LHIN and a process that ensures timely, equitable and transparent decision-making that is responsive to the LHIN's needs and to its' financial circumstances. 3. Determine the most suitable seniors' integration model for the Central East LHIN building upon the work already done in the community and outcomes from successful models in existence and exploit.
3.	Transforming the Mental Health & Addictions System in Central East	<ol style="list-style-type: none"> 1. Strengthening the infrastructure by establishing a Central East Mental Health and Addictions Network 2. Expanding the current resources by ensuring that each sub-region has a core set of mental health and addictions services 3. Building new capacity through targeted investment in specific needs based initiatives

4.	Moving People Across the System	<p>Successful integration of services within the system will require the development of tools and protocols to facilitate the timely movement, particularly:</p> <ol style="list-style-type: none"> 1. Technology for sharing information. 2. Common referral protocols. 3. System-wide case management.
5.	Innovation in Rural Health Care	<p>New innovations in rural health care priorities include:</p> <ol style="list-style-type: none"> 1. Use of e-solution technology. 2. Access to primary, secondary and tertiary care. 3. Access to specialty services / link with urban areas.

2. Administrative Support Services Integration Opportunities

	Priority Opportunity	High-Level Action Plan
1.	Common Health Record & Electronic Exchange of Information	<ol style="list-style-type: none"> 1. Develop inclusive planning committee that represent the Central East LHIN. 2. Create an inventory of information services. 3. Develop a project plan.
2.	Fair Population Needs Based Funding	<ol style="list-style-type: none"> 1. Do a needs based, population health analysis of the population for the entire Central East LHIN, looking at urban, rural and remote populations. 2. Do an inventory of existing health care services in the LHIN and compare these to the needs of the populations that have been identified. 3. Compare funding levels through hospital, CCAC and community comparative data available to make the case for proper funding for this LHIN at the outset of the planning process. <ul style="list-style-type: none"> • Focus on the current situation and the burgeoning growth to properly resource the LHIN.
3.	Integrated Services – Acute and Community, Ageing in Place	<p>Key enablers include:</p> <ol style="list-style-type: none"> 1. Use of technology for information sharing across areas of health. 2. Integrated funding. 3. Maximizing the linkages among services across sectors. 4. “Aging in Place is a philosophy, based on the preferences of seniors to remain in their homes and communities, of supporting seniors by providing in-home services as their needs change and they move along the health care continuum. (Toronto District Health Council. Coordinated, <i>Accessible Community Healthcare for Elders in Toronto: The CACHET Model</i>, December 2004).”
4.	Public Education & Community Engagement	<ol style="list-style-type: none"> 1. Develop a strategic plan, mission, vision and values for the LHIN. This work will assess the current state, including the present road map and the road map for the future. This initiative includes orientation and education for LHIN Board members. 2. Develop communication principles that all LHIN organizations can agree to and apply in order to deliver more consistent information to the public regardless of the source organization. <ul style="list-style-type: none"> • Develop a plan for public education and

		<p>community engagement to create awareness and initial engagement.</p> <ul style="list-style-type: none"> • Increase public confidence in the system, where the public is currently presented with information that conflicts depending on the source. • Identify and work with internal staff of all organizations' internal key stakeholders to increase knowledge of system and system changes so that they can be front line ambassadors.
5.	<p>Maximizing HR Potential through Innovation & Integration</p>	<ol style="list-style-type: none"> 1. Develop a provincial wide, comprehensive human resource plan. 2. Increase the use of available technologies to support and augment current scopes of practice within the healthcare sector. 3. Promote community engagement and partnerships with labour, education, government, providers, private and public sector in the development of a comprehensive strategy. 4. Incentification for the sharing of HR best practices strategies and innovations across the sector, providing cross-pollination of experience across the sector and prevent poaching of resources LHIN to LHIN.

D. CAPTURING UNIQUE CHARACTERISTICS OF CENTRAL EAST LHIN

This section contains a response to the question of the role of Academic Health Science Centres (AHSCs) and voluntary networks. Unique characteristics of the Central East LHIN are also presented, including geography, population and growth (recent and projected), incidence of low income, ethnicity and data related to under serviced area designation. It is important to note that significant calculation and analysis were performed using both Dissemination Area and FSA data to produce a comprehensive Central East LHIN population profile using the borders defined by the MOHLTC during production of this report (January 2005).

Role of Academic Health Sciences Centres and Voluntary Networks in Central East LHIN

Academic Health Sciences Centres (AHSCs)

Role. There are no AHSCs located within the Central East LHIN. For residents living within the boundaries of the Central East LHIN, referrals mainly occur to AHSCs in Kingston, Toronto, and Ottawa. AHSCs also support the delivery of care locally through outreach programs and use of telehealth/distance technologies. Specifically with the Central East LHIN, there is a rural medicine program, associated with the University of Toronto, in three communities (i.e., Port Perry, Campbellford, Haliburton). The Scarborough Hospital offers a Family Medicine program in affiliation with the University of Toronto as well.

Value Add. AHSCs provide tertiary and quaternary care not available locally. With the pivotal role in education of health human resources, AHSCs also are part of longer term responses to current and projected health human resource shortages in the LHIN. The LHIN can enhance current practices by clarifying and standardizing patient referral and repatriation processes between AHSCs and community hospitals. What is being referred to here is standardized triage and initial care to maximize patient flow that is currently spread across several community hospitals. Additionally, the use of formal repatriation agreements might be established with community hospitals in the GTA so that patients who no longer require specialized acute care are repatriated in a timely manner to the appropriate level of care in a hospital that is in proximity to his or her point of origin. The LHIN can also benefit from research, education and outreach by the AHSCs to local providers e.g. to increase opportunities for local health care providers to receive training and assistance via telemedicine technology. With increasingly affordable technology and critical mass of population in the “905” areas of the CE LHIN, it would be beneficial to increase outreach programs, as local community hospitals have sufficient volume of cases to meet the demands of increased medical student enrolment and can provide a variety of environments / cultures for teaching.

Challenges. An on-going challenge is to ensure appropriate use of AHSCs for care that cannot be safely and efficiently delivered locally. Planning for evolution of the community hospital-AHSC relationship is critical to ensure best use of all available resources in the LHIN. Communication and information sharing linkages amongst all stakeholders, including the local hospitals and physicians, supported by IT infrastructure, is key.

There is an opportunity to more clearly define AHSCs role with community hospitals to strengthen linkages. Strong linkages can ensure appropriate referrals and consistent program delivery standards. This will increase access to quality health care that is appropriate, and may result in greater accountability for resource utilization.

Next Steps.

1. Create an inventory of current interfaces between Central East and AHSCs.
2. Initiate a pilot project(s) to establish a framework agreement between an AHSC and the Central East LHIN.
3. Develop a strategic plan to proactively engage with AHSCs on an ongoing basis.

*There are however, relationships with AHSCs which have evolved over many years without any regional framework or strategy.

Voluntary Networks

Role. There are a large number of alliances / networks in the Central East LHIN, reflecting the geographic expanse of the region. These voluntary networks have varied mandates and functions, ranging from communication and information sharing, planning and developing programs, decision-making on regional issues to service delivery. The development of these networks is based on historical practices of how health care providers organized themselves to share resources and achieve collective goals. There is a higher degree of integration activity within Durham HKPR communities that have a clear ‘geographic delineation’ which may result from either a more formal designation such as the Regional Municipality of Durham or County. In addition, being physically ‘isolated’ or more removed from other communities appears to increase the likelihood of higher degrees of integration; the Haliburton community is a strong example of this. At present, service providers often attend multiple forums (various networks across communities) for geographic coverage. Such meetings/forums are often the only regularly scheduled opportunity for various providers from across health care settings/sectors and dispersed communities to come together to communicate and undertake collaborative problem-solving.

Achieving integration can be viewed as a continuum of relationship development that reflects complexity of relationships between organizations involved. When examining the voluntary networks that exist in the Central East LHIN, it is useful to use a framework¹ (Figure 1) as a lens for integration activities. The mandates of local networks will fall somewhere on the continuum. Among approximately sixty “networks”², at least twenty percent can be deemed examples of true collaboration i.e., right hand side of the continuum.

¹ 2003 (November) Local Progress to Integration and Coordination in Health Services. Durham Haliburton Kawartha & Pine Ridge District Health Council.

² Some examples include GTA Child Health Network, GTA Rehabilitation Network, GTA/905 Hospital Network, Toronto East Emergency Network, Haliburton Health Service Providers Network, Durham HKPR Partners in Addiction Services, Durham Region Health Care Group.

Figure 1

Collaboration involves comprehensive communication and planning, pooled resources, shared risks and products. Authority is vested in the collaborative; not individuals. The framework in Figure 1 is included to make the point that organized networks are not static; rather those that fall lower on the continuum are likely to move through the continuum over time. Indeed, the collaborative culture and strength of relationships developed through the networks lays the foundation for integrated service delivery, and standardized approaches, e.g. tracking and monitoring of data, best practices etc.

Value Add. Many of the existing networks focus on improving patient care with the goal of streamlining how common clients move through the system and managing the interactions or ‘hand-off’ points between agencies when caring for these common clients. As well, a number of existing networks focus on the needs of specific population groups, particularly children, older adults/seniors and those with mental illness.

Challenges. There are unique factors that can be considered as networks are developed or expanded within the LHIN area. Networks which focus on improving care for high needs populations and moving high needs and mainstream clients through the system will likely be most successful. This will build on existing network capacity. Additionally, a network’s geographic ‘boundaries’ should align with natural patterns of health and community service use and recognize existing connectivity within communities. At present, the patterns of patient flow and collaboration tend to be primarily westward, toward Toronto. Scarborough is located between Durham, Haliburton, Kawartha and Pine Ridge Districts and Toronto, e.g., it currently shares a single client database and procurement practices with the other CCACs in Toronto and this should not change in the near future.

Unique Characteristics / Features of Central East LHIN that Impact Future Integrated Health Services Planning Activity

Geography

In total, the land mass of the Central East LHIN encompasses an area of 14,752.5 km².⁽¹⁾ While 93% of the Central East LHIN land mass is considered rural, as defined by Statistics Canada,⁽²⁾ the remaining 7% of the land mass is urban and represents a total population of 1,212,351.⁽³⁾ The urban areas are Scarborough, Markham, Oshawa, Whitby, Pickering, Ajax, Peterborough, Cobourg, and Lindsay. Scarborough has the largest population density with 3,100 people/ km²; Oshawa, Ajax, Peterborough, and Lindsay each have a population density of at least 1,000 people or more/ km²; and Pickering, Whitby, and Cobourg have a population density between 400 and 800 people/ km². It should be noted that there is a heavy concentration of the population along the lakeshore in the south-west corner of the Central East LHIN.

Population Characteristics

Population. The Central East LHIN has a population of approximately 1,522,924.⁽³⁾ About 70% of the population resides in Scarborough and the Regional Municipality of Durham alone. Youth aged 0-19 years constitute a higher percentage of the population in the Regional Municipality of Durham (30% or 152,670 youth), Markham (28% or 45,525 youth), and Whitchurch-Stouffville (28% or 5,015 youth) when compared to the provincial average of 26%. For seniors aged 65+ years, Haliburton (24% or 3,130 seniors), Marmora Township (22% or 870 seniors), Northumberland (18% or seniors), Peterborough County (18% or 22,755 seniors) and the City of Kawartha Lakes (19% or 12,915 seniors) all have a higher percentage of seniors than the provincial average (13%). Although the Regional Municipality of Durham, Scarborough, and Markham each have a lower percentage of seniors compared to the provincial average, the relative number of seniors is large (e.g. 50,000 seniors in Durham).

Population Growth. The time period between 1996 and 2001 was marked with significant growth. The Regional Municipality of Durham (10.5%), Markham (20%), and Whitchurch-Stouffville (11%) all experienced a higher growth rate than the provincial average (6.1%).⁽¹⁾ The expected population growth between the years of 2006 and 2011 continues to show a significantly higher growth rate in the Regional Municipality of Durham, Markham, the City of Kawartha Lakes, and Whitchurch-Stouffville than the provincial growth rate.⁽⁴⁾ Overall, the expected population growth rate between the years 2006 and 2011 in the Central East LHIN (6.9%) is higher than that of the province (5.4%). Some growth trends in the Central East LHIN that are likely to affect the growing population size include: the completion of Hwy 407 in the Regional Municipality of Durham; the development of Seaton; the establishment of the University of Ontario Institute of Technology in Oshawa; a rapid economic growth in North East Scarborough and Markham as a whole; the proposed airport in Pickering; the growing retirement population in Haliburton, the City of Kawartha Lakes, Peterborough County,

and Northumberland County; and the seasonal population, particularly evident in Haliburton County and surrounding areas.

Low Income. While the incidence of low income in the Central East LHIN varies by region, Scarborough (22%) and Marmora (19%) have a significantly higher incidence of low income when compared to the provincial average (14%).⁽¹⁾

Ethnicity. Within the Central East LHIN there is great ethnic diversity, particularly in regions in the south-western portion of the Central East LHIN.⁽¹⁾ In Scarborough and Markham, the majority of the population report having a Chinese or Asian ancestry. The diversity of ethnicities is reflected in the immigration characteristics for each region. Approximately half of Scarborough and Markham's population is foreign-born.⁽¹⁾ The other regions within the Central East LHIN are composed mainly of Canadian-born residents (approx. 80%) in comparison to foreign-born residents (approx. 20%).

Access to Primary Care

Seventeen areas in the Central East LHIN are designated as under-served for General/Family Practitioners. In total, there are 126 physician vacancies in the Central East LHIN.⁽⁵⁾ The physician vacancies are highest in the Regional Municipality of Durham (73), Peterborough County (27) and the City of Kawartha Lakes (15). The Ministry of Health and Long-Term Care uses a benchmark of one family physician for every 1,380 residents. Durham Region has a population of 1,766/family physician, the City of Kawartha Lakes has a population of 1,600/family physician, Northumberland has a population of 1,594/family physician, and York Region has a population of 1,508/family physician. In certain areas of the Regional Municipality of Durham, Northumberland County, and the City of Kawartha Lakes such shortages are exacerbated since residents must travel great distances to reach physician care.

Sources:

1. Statistics Canada, 2001 Census.
2. Statistics Canada, 2001 Census Dictionary, available at <http://www12.statcan.ca/english/census01/Products/Reference/dict/appendices/92-378-XIE02002.pdf>, pages 261-262.
3. Statistics Canada, 2001 Census, unadjusted count.
4. Ministry of Health and Long-Term Care, Provincial Health Planning Database, Ontario Population Projections.
5. Ministry of Health and Long-Term Care, LADAU Oct/Nov/Dec 2004.

E. TRANSFORMATIONAL THINKING AND PROCESS

This section contains the Central East Working Group's response to Template E. The following information is described:

- The approach and process used to complete this task.
- The key learnings that came out of this process.

Central East LHIN (CE LHIN) Working Group – Introduction

There are many definitions of transformation but, regardless of the choice, there are qualities inherent to all. In simple terms it can be seen as the process that enables a group or organization to move from an existing state to a preferred state. Therefore, transformation can be seen not so much as a “destination” but as a “journey”. To be successful, the journey leading to the transformation of the health system within the LHIN boundaries has been about looking beyond existing CE health provider structures, processes and hierarchies in an interdisciplinary manner, across organizational boundaries.

Generally, any transformation journey is difficult, prone to protection of perceived vested interests and the age-old resistance to change. For a number of organizations represented in the CE LHIN, this process is evolutionary rather than revolutionary. That is, over the years, the leadership of many CE LHIN health partners have worked together to seize on emerging possibilities to work more closely and effectively as a system.

The point of departure in this case has been the coming together of truly dedicated and involved individuals from across the hierarchical spectrum as well as the broadening of discussions both from the perspective of specialty and geography.

The CE LHIN Working Group – Coming Together

From the initial CE LHIN meeting at the “barn” in Markham, there was a clear expression of engagement on behalf of the vast majority of participants in attendance. The Open Space model established an equal playing field and encouraged full participation. This comprehensive gathering of CE health providers was predicated on equity of voice and a search for common interest, not on ownership or organizational size.

This more grassroots type approach, as opposed to the more usual formal approaches, helped to break down barriers and traditional ways of thought. Based more on ideas than problem solving, it also led to the formation of a dedicated working group, self motivated to help lead system transformation. Moreover, it meant the coming together of individuals who represent not only a wide variety of health interests but also the broad spectrums of distance, geography (urban, rural and remote) and demographics (e.g. ethnicity, age).

The CE LHIN Working Group – The Process

The CE LHIN working group seized upon the tasks at hand in a spirit of collaboration. This spirit carried over to the work of the individuals charged with leading the 5 clinical and 5 administrative initiatives. In fact, for many of these sub-groups, discussions transcended the normal boundaries of traditional partners. It also included gathering input and advice from individuals, networks and organizations beyond those usually consulted – even those beyond the CE LHIN borders, such as those in other parts of the province.

The CE LHIN Working Group – The Thinking

Thinking outside the box in a true collaboration were guiding principles employed by the working group and those charged with leading the individual initiatives. From the start the group made sure that individual or organizational “agendas” were kept at the door. In addition, there was explicit understanding that outcomes would not be pre-determined but would come about as a result of thorough explorations to determine optimal solutions.

Additionally, as the MOHLTC and the Health Transformation Team initiated this process, the CE LHIN working group is of the understanding that the Ministry will be a full partner in transformation. This is important in that to be truly successful, the process of transformation must also include the roles, functions and relationship of the Ministry as they pertain to health providers and the system they are part of. As such, it is presumed that MOHLTC support – be it funding, policy, regulatory and/or legislative – will facilitate and enable change as we collectively engage on this journey.

The CE LHIN Working Group – Our Commitment to Continue as Ambassadors to Change

Through this process the working group has increasingly come to think of this empowering exercise as the beginning of a process for cultural change and not just a step or end in and of itself. As a group, those involved have:

- ✓ Accepted accountability and have produced reports as asked within the deadlines requested;
- ✓ Shown a commitment to the transformation process and to system integration; and
- ✓ Demonstrated the capacity, responsibility and motivation to provide leadership as the transformation process moves forward.

Therefore the CE LHIN working group represents an ideal body to continue as change agents or ambassadors for change. Additionally, the group is committed to continuing as a local resource for the new CEO and Board of the CE LHIN.

The CE LHIN Working Group – Continuing to Meet

The group has met on three occasions formally, while the initiative based groups have consulted and met on many more occasions. The next scheduled meeting will take place on February 28th, 2005. As with past meetings, the agenda will be full – from revisiting the other priorities identified at the Markham meeting (but not included in the list of 10 initiatives) to communication and stakeholder issues.

The CE LHIN Working Group – Summary: Process and Thinking

- ✓ Transformation is not so much a “destination” but a “journey”
- ✓ Process looked beyond existing CE health provider structures, processes and hierarchies in an interdisciplinary manner, across organizational boundaries
- ✓ For many in the CE LHIN working group, this process is evolutionary rather than revolutionary
- ✓ Based more on ideas than problem solving, the equity of voice based approach led to a dedicated working group, self motivated eager to help lead system transformation
- ✓ Collaborative working group approach transcended the normal boundaries of consultation with traditional partners
- ✓ It is presumed that MOHLTC support – be it funding, policy, regulatory and/or legislative – will facilitate and enable change as we collectively engage on this journey
- ✓ Working group is committed to continue to act as an ambassador for change and as a local resource for the new CE LHIN Board and its CEO
- ✓ The CE LHIN working group also committed to continue its work – next meeting February 28, 2005 to consider other priorities (among other topics)

Key Learnings or Successes

The Model

The engagement model, which gave contributors equity of voice across a wide variety of interests and concerns:

- ✓ Opened up the “thinking” and “idea generation” processes; and
- ✓ Led to the development and empowerment of a group of self-motivated and committed individuals – ideally preparing them to become ambassadors for cultural and system change.

The Process

The strengths of the process:

- ✓ Exposed the great depth of knowledge possessed by the team that can be further built upon (e.g. skill levels, clients reached, etc.);
- ✓ Illustrated the commitment to transformation and system integration present within the CE LHIN health partners;
- ✓ Showed the importance of learning from, and building upon, our past successes which made this an evolutionary rather than a revolutionary process for most;
- ✓ Opened up the doors to expand collaboration; and
- ✓ Highlighted the high level of commonality with respect to the issues and problems faced throughout the system – and the potential for joint action and/or solutions.

The Outcomes

The working group gained a much-improved understanding of the opportunities and barriers facing providers and their clients across the CE LHIN, such as those associated with the differences and similarities caused by issues such as:

- ✓ Demographic;
- ✓ Geographic;
- ✓ Access; and
- ✓ Etc.

The work of the initiative based sub-groups also showed:

- ✓ The interconnectivity between initiatives; and
- ✓ The breadth and scope of the knowledge and skills available to be explored for solutions.

The working group also found the need to maintain and build upon equity and accountability commitments, such as:

- ✓ The continued need for partner commitment and goodwill;

- ✓ The necessity of the MOHLTC to work in partnership and provide the appropriate support (e.g. financial, policy, etc.) to ensure transformational success; and
- ✓ The need to resolve certain larger issues at the Provincial and/or Federal level for local priorities to be successfully met.

Additionally, the group came to believe:

- ✓ There is a need to keep the working group going;
- ✓ In the importance of not losing the cultural change momentum already building;
- ✓ That the spirit of collaboration and empowerment created must be maintained to ensure ultimate success;
- ✓ There are other areas yet to be tackled (e.g. other priorities raised at Markham, but not considered among the top 10 priorities); and
- ✓ The importance of providing ongoing support for the new CE LHIN Board and its CEO.