

letter of transmittal

Ms. Gail Paech
Lead of System Integration
Ministry of Health and Long-Term Care
Health Results Team - System Integration
415 Yonge Street, 10th floor
Toronto, ON M5B 2E7

February 21, 2005

Dear Ms. Paech,

The members of the Champlain Local Health Integration Network Workbook Planning Group are pleased to share with you the attached workbook submission. The workbook includes each of the priority integration opportunities that were identified at the December 6th workshop and further developed through a multi-channel consultation approach that sought input from hundreds of Champlain stakeholders (A & B Templates). Planning Group members also took the opportunity to reflect on the individual priorities and identified a number of crosscutting themes that link the priorities. These have been documented in the foreword. The workbook includes high-level action plans for each priority (C Templates).

In Template E, Planning Group members identified their learnings from the process. It was recognized that although there was a fixed time frame, many individuals participated in the consultation and development process above and beyond their normal commitments. A great deal of work was accomplished in a short amount of time. A wide variety of e-mail and web-based consultation approaches were implemented however the richest dialogue remained rooted in pre-existing relationships and networks and in the face-to-face meetings of the Planning Group. Development and planning for the Champlain Local Health Integration Network will require a continuous and evolving engagement. Complementary approaches need to be implemented to enhance stakeholder engagement inclusive of the citizens of Champlain. It is recommended that ongoing and dedicated support to this process needs to be secured. A leader, who is dedicated to facilitating the dialogue and change process, needs to be identified as quickly as possible so that momentum is maintained. Additionally it is recommended that the Ministry of Health and Long Term Care translate this workbook to enhance access to the process in both official languages.

Thank you for the opportunity to be engaged.

Sincerely



Kevin Barclay
Planning Group Facilitator

On behalf of the Planning Group members

The following individuals were selected by their fellow stakeholders at the December 6th, 2004 Community Workshop, hosted by the Ministry of Health and Long Term care, to develop the priority identified ideas further. All participants made a significant contribution to the workbook. At the final meeting members acknowledged, in particular, the leadership and support of Kevin Barclay as the facilitator.

***The health care system will benefit
from their wisdom and leadership***

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3. Workbook section D “unique characteristics of the district”

Name	Organization	Contact Information
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Foreword

Hundreds of stakeholders from across Champlain have participated in the dialogue that has led to the thoughts articulated herein. E-mail groups, on-line open forums, meetings and teleconferences were utilized to connect as many stakeholders as possible. This multi-channel approach provided the opportunity for a wide range of diverse perspectives. Through the power of dialogue a number of common themes emerged regardless of where or how opportunities for integration were explored. These common themes are:

Build on existing networks

The Champlain LHIN has an opportunity to build upon the successes of pre-existing Networks within the Champlain District¹. Relationships are the foundation of successful networks. These relationships are in place and offer the potential for further integration.

Accountability is important to all priorities

All integration opportunities that were explored identified accountability as a key component of successful integration. Accountability to the community served was seen as paramount. Furthermore accountability must be implemented through agreement mechanisms that create real incentives for integration and for improving or protecting the health of the Champlain population.

Performance measurement is important to all priorities

For integration to evolve a comprehensive set of indicators that monitor impact are required. The measures must be focused on real change with demonstrable benefits to the people of Champlain.

Citizen involvement/engagement is important to all priorities

All priorities identified that meaningful ongoing engagement of citizens is essential for the system to respond to peoples needs. To establish a person-centred system, the people need to be actively involved in establishing direction and monitoring change.

Inter-ministry approach

Although neither health promotion nor population health was identified as a separate integration priority it appears as a crosscutting theme in all priorities. To operationalize gains in population health the health system will need to further integrate with other human services systems to ensure synergy towards improved health outcomes. Some of our greatest gains in health will be realized through the concerted actions across all human service ministries.

Person-focused approaches such as navigation functions will create links across services and possibly Ministries

Person-centred integration must be realized in the way people experience the health care system. One way to achieve this is through a clear navigation role for the system, ensuring that the person has ready access to all supports required to realize optimal health. The system should respond to the needs and opportunities of the person not limited to the scope of the health care system.

Human resources are important to all priorities

Ultimately health care is about people providing support to other people with care, compassion and commitment. Quality depends heavily on a culture of support and enrichment for health care workers. A mechanistic approach to this precious resource can undermine the very spirit of compassionate care. Any change in the system must embrace the people who work in the system and enable them to succeed at their calling to serve others.

¹ <http://www.champlainhealth.ca/documents/CHIN-e.pdf>

1.1.1 Develop a person centered rural health strategy in Champlain to ensure access and equity for all.

<p>Title of patient care/service initiative:</p> <p>Develop a person centered rural health strategy in Champlain to ensure access and equity for all.</p>	<p>Type of integration (more than one box can be checked)</p> <p><input checked="" type="checkbox"/> Horizontal <input checked="" type="checkbox"/> Vertical</p> <p><input type="checkbox"/> Other, describe:</p>
<p>Existing or new initiative?</p> <p><input checked="" type="checkbox"/> Initiated/existing integration activity</p> <p><input checked="" type="checkbox"/> New integration opportunity</p>	<p>List of partners involved:</p> <p>List of Participants for Report #3</p> <p>NAME ORGANIZATION</p> <p>Bill Smirle Winchester District Memorial Hospital</p> <p>Carol Halstead Township of Osgoode Home Support</p> <p>Carolyn Zacharuk Deep River and District Hospital</p> <p>Catherine Swift Western Ottawa Community Resource Ctr.</p> <p>Chris Fleming Country Roads CHC Portland</p> <p>Darlene Sernoskie St. Francis Memorial Hosp.</p> <p>Don Marsh Merrickville District CHC</p> <p>Donna Crogie Bonnechere Manor</p> <p>Heather Arthur Cornwall Community Hosp.</p> <p>Heather Stewart Ont. Hosp. Assoc.</p> <p>Jill Alguire Dundas Manor LTC</p> <p>John Carlile P. Community Home Support</p> <p>John Jordan Lanark Health Centre</p> <p>Judith Gilchrist Bonnechere Manor</p> <p>Ken Bennett Carleton Place Mem. Hosp.</p> <p>Kurt Pristanski, Hopital Glengarry Memorial Hospital</p> <p>Linda Shulist Valley Manor</p> <p>Louise Heslop Almonte General Hospital</p> <p>Lynne Budgell Kemptville Distr. Hosp.</p> <p>Marc Bisson Centre de sante communautaire de l'Estrie</p> <p>Margaret Dunn VON</p> <p>Michael Lloyd CMHA SD and G</p> <p>Michel Gervais Centre Services communautaires Vanier</p> <p>Mike Blackmore Miramichi Lodge</p> <p>Mike Poulin Lanark County Mental Hlth</p> <p>Nellie Kingsbury. Bonnechere Manor Seniors</p> <p>Ann Aikens, North Renfrew Long-Term Care Centre</p> <p>Wynn Turner County of Lanark Long Term Care</p> <p>Rachel Stamplicoski Valley Manor</p> <p>Rosemary Connelly Bayfield Manor</p> <p>Sheila Cooper Dundas Manor LTC</p> <p>Shelley Sheedy Miramichi Lodge</p> <p>Stephanie Smart Bayshore Home Health</p> <p>Stephen Maloney (J. Jordan) Lanark Health Centre</p> <p>Susan Foran Renfrew CCAC</p>
<p>Please briefly describe the initiative.</p> <p>To develop a person-centered rural health strategy for the delivery of health care recognizing the importance of:</p> <ol style="list-style-type: none"> 1) The strategic development of Outreach/Satellite Service systems bringing more services closer to home. 2) An integrated primary care model linking health, wellness and social services in the context of smaller communities and the unique resources they offer, 3) A rural funding formula across Ontario which recognizes the additional costs in rural vs. urban delivery systems 4) The need for francophone services in the rural areas of the Champlain LHIN. 5) Professional education/practicums offered in rural areas to ensure professional staff are familiar with rural health needs and systems. 6) Building on existing experience in rural communities to integrate/partner to optimize services. 7) Developing the capability to respond to growing multi-cultural service needs in rural areas, 8) The LHIN Board having balanced representation from all geographic areas of the Champlain LHIN. 	

<p><i>If this is an initiative/existing activity....</i> What is the current status?</p>	<p>What are the outcomes/lessons learned (if any)?</p> <ol style="list-style-type: none"> 1) There are viable and working models in Champlain and elsewhere in the province that can be further developed or adapted to the new Champlain LHIN to improve access to health services for rural people. 2) Solutions to transportation issues are critical to successful integration. 3) Expansion of technology to service rural communities e.g. telehealth, and video-conferencing capability. 4) Expansion of Community Health Centre (CHC) programs in conjunction with existing CHC programs in Champlain. 5) Increase opportunities for primary and secondary health care programs in rural hospitals e.g. - day surgery, chemotherapy, dialysis. 6) Municipalities must be involved in the development of an effective ambulance and non-urgent transportation strategy. 7) Expansion of supported/supportive housing options to reduce over-reliance on hospital/alternative level care and long-term care.
<p>Lead contact persons: Wynn Turner Director of Long-Term Care County of Lanark 613-267-4225 ext.237 e-mail: wturner@county.lanark.on.ca</p>	<p>Ann Aikens Administrator North Renfrew Long-Term Care Services Inc. 613-584-1900 nrltcsin@magma.ca</p>

1.1.2 Action Plan - Develop a person centered rural health strategy in Champlain to ensure access and equity for all

Template C

Opportunity

Develop a person centered rural health strategy in Champlain to ensure access and equity for all.

High-Level Action Plan

Development of a person centered rural health strategy in Champlain to ensure access and equity which:

- Builds on existing Champlain best practices of providing care as close to home as possible.

e.g.

- Outreach dialysis
- Outreach cancer treatment
- Outreach geriatric mental health services
- Outreach specialized geriatric services
- Pain and symptom management program
- Telehealth
- Outreach/satellite mental health and addictions
- Outreach/satellite programs and services for children
- Rehabilitation networks and outreach programs
- Expands existing Community Health Centres to other rural areas (Lanark-Renfrew model).
- Respects the LHIN principle of “a partnership of equals” by ensuring that some Board members live and access health care outside of large urban areas.
- Defines a funding model that reflects the significant human and financial costs related to accessing health care in urban centres far from home.
- Ensures solutions to the significant transportation issues, critical to successful integration.
- Recognizes the need for francophone services in rural areas
- Responds to emerging multicultural needs in rural areas.
- Respects the unique social structures and supports in isolated rural communities that may influence access to health care.
- Is equally accountable to rural and urban persons in Champlain.

1.2.1 The organized delivery of seniors' health care

Title of patient care/service initiative: The organized delivery of seniors' health care		Type of integration (more than one box can be checked) <input checked="" type="checkbox"/> Horizontal <input checked="" type="checkbox"/> Vertical <input type="checkbox"/> Other, describe:
Existing or new initiative? <input checked="" type="checkbox"/> Initiated/existing integration activity <input checked="" type="checkbox"/> New integration opportunity	List of partners involved: More than 150 seniors and health service providers from across the continuum of care contributed to these recommendations. Most are affiliated with the Regional Geriatric Advisory Committee or one of two Rural Geriatric Networks. Representation includes consumers, community support, retirement and long term care homes, family physicians, specialized geriatric services (geriatric medicine and psychiatry) from hospital to home; acute and complex continuing care hospitals; community health centres, Public Health, private health care providers	
Please briefly describe the initiative. It is recommended that the LHIN identify the Regional Geriatric Advisory Committee as their seniors' health advisory committee, and that they be mandated to develop a business plan and agenda for investing in senior's health, as a component of a comprehensive service plan. Given the strength of existing partnerships and networks associated with the RGAC across Champlain District, this would ensure we build on existing expertise and seniors' health integration initiatives in the district- e.g.: Rural geriatric networks, Regional Geriatric Advisory Committee', Psycho-Geriatric education program', Supportive Care & Resource Integration for Seniors in the Community (RISC), Geriatric Mental Health Outreach Teams and PRC, Dementia Network, OANHSS, OLTCA, OCSA, and many others. It is recognized rural and consumer representation should be augmented to ensure a fully representative committee.		
Key principles and strategies should be integrated into the business plan to ensure optimal value for our investment:		
<ul style="list-style-type: none"> • <u>Health Promotion</u>: Develop a health promotion strategy addressing seniors' health needs, as well as public education related to the true health potential of seniors; • <u>Choice</u>: Ensure that resources are available to respect seniors' choice to stay at home as long as possible; and have access to appropriate care and treatment when it is required. • <u>Quality Long Term Care</u>: Provide residents in LTC homes access to the same quality and range of services as seniors in the community. This should include options for community integration and incentives to improve senior's independence. • <u>Senior Friendly Hospitals</u>: Strategies to improve the effectiveness of acute care for older persons should be identified and implemented; • <u>Information & Referral</u>: Build coordinated information referral mechanisms to assist in system navigation by seniors and their caregivers; • <u>Human Resources</u>: Develop a human resource strategy to recruit and retain qualified service providers to serve seniors. This should include increased emphasis on high quality care and work environments, rather than minimum standards; • <u>Evidence-based Practice</u>: Promote educational and knowledge translation processes to ensure seniors health services and service providers apply best practices in care and support; • <u>Innovation Fund</u>: An innovation fund should be established to support new service delivery models. 		
The business plan, and the performance of the regional health system should be evaluated against system performance measures that integrate senior-sensitive indicators and outcomes.		
The plan should acknowledge resource linkages with sectors outside the mandate of the LHIN, including public health and primary care, which influence broad determinants of health.		
Why is it a priority <input type="checkbox"/> Currently, 43% of all health care resources in Ontario are being used by seniors. This investment is not seen as fully achieving the necessary health outcomes for seniors in Ontario, with only limited recognition of seniors' true health potential. Public policy has viewed seniors' health services as a cost to be limited and constrained,		

rather than an investment. A public perception of aging as a 'disease' or condition of dependency has promoted a strategy of investing 'too little too late', and has limited funding for resources that can prevent illness, reverse and restore seniors' health. As examples, the singular focus on long term care homes, and the removal of secondary health promotion for seniors as a core public health service. There is strong evidence of significant and immediate 'payoffs' for investing in seniors' health promotion, community support, specialized geriatric services, and integrated models of service delivery.

- ❑ Population aging will increase the public burden of care of the elderly to threaten sustainability. The Conference Board of Canada predicts expenditures for seniors 75 years of age or more to grow from \$8 to \$15.5B over the next 10 years in Ontario, **unless** we change our approach to seniors' health.
- ❑ Seniors have unique health needs that are not always well-served by the current health system;
- ❑ There is increasing evidence of interventions that will lead to improved health outcomes that need to be incorporated into local and provincial planning. Everyone benefits from investing in seniors' health- caregivers, seniors, care providers and the system performs better/more efficiently.
- ❑ While the majority of seniors are healthy and well served by regular health services, 25% require some level of support and 10-15% of seniors have multiple and complex needs requiring support from multiple organizations and agencies. This significant minority of the population (3%) account for 30% of health expenditures. This is the target population for specialized interventions.
- ❑ Seniors, who have built the fabric and foundation of our region, deserve timely, high quality, age-appropriate care requiring the clinical leadership/input of geriatric specialists from all disciplines. It is never too late to promote health (AGEISM). Seniors can improve their health at any age and deserve access to information and support to do so. Seniors also need access to a broad range of services and supports that recognize their diversity (cultural, physical, financial).

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

There is a long history of coordinated planning and partnership in our region. The Regional Geriatric Advisory Committee has existed since early 1980s to plan and coordinate geriatric services across the region. Its members include representatives from across the continuum of care and Champlain district. Well-established strategic planning and program evaluation have supported integrated coordinated planning.

However, there has been little opportunity to link local plans with funding priorities

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

We have the knowledge and expertise to do it, and much can be done either within the limits of existing resources, and/ or with targeted investments.

Many local **programs** and projects have been developed, largely with existing resources, and become models for the rest of Ontario. (e.g. Dementia Networks, Regional Geriatric Programs, recent supportive care bed project, etc.) These have improved the health outcomes of those they serve, while realizing significant clinical efficiencies.

However, evidence of major opportunities for improving service delivery, including high rates of readmission to ERs (43%) and hospitalization (34%), reduced choice to stay at home, and increased rates of ALC, indicate the need for comprehensive strategies at the level of the regional health **system**.

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1.2.1 Action Plan - The organized delivery of seniors' health care

Template C Integration Opportunity

Opportunity

The organized delivery of seniors' health care

High-level Action Plan

- 1 **Seniors Health Advisory Committee:** designate the Regional Geriatric Advisory Committee as the Seniors Health Advisory Committee, and mandate it to plan and coordinate seniors' health services across the region, including the development of a business plan.
- 2 **Business Plan for Investing in Seniors Health:** Develop a business plan and agenda to invest in seniors' health, as a component of an overall service plan
 - Include system performance measures which integrate age-sensitive indicators and health outcomes
 - An innovation fund should be established to support new service delivery models;
 - Senior Friendly Hospital Strategies should be enhanced to improve the effectiveness of acute care for older persons;
 - Acknowledge important resource linkages with sectors outside the mandate of LHINs, including public health and primary care, which influence broad determinants of health.
- 3 **Integrate seniors' health strategies and principles into the Business Plan:**
 - **Build on Existing Networks:** Build on existing health integration initiatives that affect seniors and promote functional integration in the region; e.g.
 - Rural Geriatric Networks
 - Regional Geriatric Advisory Committee
 - Psycho-geriatric Education program
 - Supportive Care
 - Resource Integration for Seniors in the Community (RISC)
 - Geriatric Mental Health Outreach Teams and PRCs
 - Dementia Network
 - OANHSS /OLTCA
 - OCSA
 - Regional Geriatric Assessment Program
 - Regional Geriatric Psychiatry Programs
 - **Seniors' True Health Potential:** Develop a health promotion strategy addressing seniors' health needs, including the education of service providers and family members and community about the true health potential of seniors.
 - **The choice to stay at home:** Ensure that resource are available to allow seniors to stay in their own homes as long as possible, and have access to the appropriate care when it is required;
 - **Quality Long Term Care:** Provide residents in Long Term Care Homes access to the same quality and range of services as seniors in the community, This should includes options for community integration and incentives to improve their level of independence.
 - **Information and Referral:** Build coordinated information and referral mechanisms to assist in system navigation by seniors and their caregivers
 - **Human Resource Strategy:** Develop a human resource strategy to recruit and retain health service providers to serve seniors. This should include an enhanced focus on high quality care and work environments, rather than minimum standards.
- 4 **Best Practice:** Evidence-based Practice: promote educational and knowledge translation processes to ensure seniors health service providers apply 'best practices', and allocate resources to support commitment to quality.

1.3.1 Potential Impact of Community Support Services on Acute and Primary Care

Title of patient care/service initiative: Potential Impact of Community Support Services on Acute and Primary Care		Type of integration (more than one box can be checked) <input checked="" type="checkbox"/> Horizontal <input checked="" type="checkbox"/> Vertical <input type="checkbox"/> Other, describe:																		
Existing or new initiative? <input checked="" type="checkbox"/> Initiated/existing integration activity <input checked="" type="checkbox"/> New integration opportunity	List of partners involved: Community Support Services, Physicians, Hospitals, CCAC's, Long Term Care Homes, Community Provider Agencies, Mental Health Agencies, Consumers, Community Resource Centres, various Health Organizations, and Health Care Planners.																			
Please briefly describe the initiative. This initiative involves both building upon existing integration efforts between agencies and creating new opportunities that would enhance the current value that Community Support Services (CSS) add to the health care system. It recognizes that CSS are currently an untapped, under-funded 'pearl' in the current health care system, uniquely positioned at the local level to often identify population health risks before they become acute care issues, and have been historically established throughout the province within a broader 'population health' framework designed to enable people to be empowered to manage their own care and remain within their own homes and communities as long as possible. As such, CSS's could be better utilized in the system if there were streamlined referral and communication processes between acute/primary care providers (e.g., physicians, hospitals, CCAC's, family health networks) and community support services. Ideas that surfaced in group discussions relative to this topic on December 6, 2004: Existing resources in the system can be better utilized by: - Streamlining information flow (an electronic health record/secure email for health, as well as, activating an information and referral data base that is user friendly for both providers and clients). - Redirecting resources to support community support services to provide more of what they do now, to assist people in receipt of both acute and chronic care services. - Providing universal, consistent training and education for all parties involved to understand each other's role in the care of the client. - Clarifying "case management", as currently, everyone in the system seems to do this (client/patient, family/caregiver, CCAC, each provider = too much duplication). Community Support Services are often the "eyes and ears" of the health care system as they see clients/patients more frequently, identifying risks earlier than many other providers. CSSs have potential to (some already do) work with clients and families as an advocate/system navigator/care manager. - Developing a common care plan and consent. - Developing opportunities between Family Health Networks/Centres and CSS's. Why is this an important initiative? Evidence demonstrates that community support services are a cost effective approach to enhancing and preserving health. Resource allocation up front to community support services will reduce costly treatment interventions later on. For example: Dr. Marcus J. Hollander: "The emerging evidence in Canada seems to support the potential for long-term home care, including home support, to increase the overall cost-effectiveness of the Canadian Health care system" <i>Unfinished Business: The Case for Chronic Home Care Services, a Policy Paper</i> , August 2003.																				
<table style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="3">Average costs/day of care:</td> </tr> <tr> <td style="width: 60%;">Hospital:</td> <td style="width: 20%;"></td> <td style="width: 20%; text-align: right;">\$812.</td> </tr> <tr> <td>Complex Continuing Care</td> <td></td> <td style="text-align: right;">\$494.</td> </tr> <tr> <td>Nursing Home:</td> <td></td> <td style="text-align: right;">\$117.</td> </tr> <tr> <td>Home Care:</td> <td></td> <td style="text-align: right;">\$ 44.</td> </tr> <tr> <td>Community Support Services</td> <td style="text-align: right;">\$ 5. - 25.</td> <td></td> </tr> </table>			Average costs/day of care:			Hospital:		\$812.	Complex Continuing Care		\$494.	Nursing Home:		\$117.	Home Care:		\$ 44.	Community Support Services	\$ 5. - 25.	
Average costs/day of care:																				
Hospital:		\$812.																		
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Nursing Home:		\$117.																		
Home Care:		\$ 44.																		
Community Support Services	\$ 5. - 25.																			
Community Support Services can provide care for as little as \$5/day depending on the service needed. Some people just need a meal delivered each day to maintain their independence and stay in their home. Hollander's works suggests that 1\$ spent on community support services will save \$4 in later treatment interventions.																				

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

What is the current status?

Some efforts are currently underway to support this initiative either between specific agencies that are collaborating to simplify the processes involved when a client must access both agencies for different services, or,

Through integrative efforts being explored by various Networks or Coalitions to enhance communication amongst various providers across the CSS sector and/or providers across the many health sectors involved in providing health care services (LTC Facilities, Provider Agencies, CCAC's, Hospitals, CSS's, Mental Health Services, etc.) depending upon the breadth of each network.

Work is needed to extend such efforts to the 'broader health care community' and establish more linkages with those involved in primary/acute care.

What is needed to do so?

- An electronic health record that flows or moves with the client.
- Clients empowered with information and support through a 'care manager/system' navigator.
- A change in the culture at hospitals and in the community, to support more integrative efforts.
- Resources need to be redirected to CSS to enhance local community supports bringing service closer to home.
- Downloading onto CSS's just because they tend to be a less expensive service must stop, as well as, downloading on families/caregivers.
- Salary/wage parity is a must for CSS staff to maintain needed HR resources, including staff that manage and coordinate volunteers.
- Adequate I.T. funding (especially training) to enable all service providers to use technology available effectively.

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

Increased linkages between acute care/primary care services and community support services will streamline existing resources, maximize the use of monies available, and enhance continuity of care by:

- Providing more direct care.
- Allowing people to remain at home longer, where they say they want to be.
- Reducing waitlists, by redistributing resources more effectively.
- Assisting people with transition from hospital to home, and reducing hospital stays/visits.
- acknowledging the vital "frontline" role played by community support services in local communities and the need to more effectively value and evaluate the use of these services in the health care continuum.
- providing a more "holistic" approach based on the determinants of health rather than the traditional "medical" model of response to health needs.
- putting the patient/client (for lack of a better term) at the centre in managing their own care, with advocacy/navigational support, as needed.
- eliminating previously perceived "agency ownership" re: clients/patients.
- recognizing that all services are critical links in serving the client well.
- developing a model of true "shared care" amongst providers and those who require service.
- resourcing community support services more appropriately to enhance their capacity within the continuum of care.

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1.3.2 Action Plan - Potential Impact of Community Support Services on Acute and Primary Care

Template C Integration Opportunity

Opportunity

Potential Impact of Community Support Services on Acute and Primary Care – Action Plan

High-level Action Plan

- To support the development of simple referral paths from acute and primary care service providers (e.g., hospitals, physicians, community health centres, CCAC) to community support services.
- To support service providers who are already skilled in assisting people to navigate the system, to become advocates/care managers who can play a vital role in advocating at the local level for those who require assistance to access available health care services.
- To support the activation of existing "information and referral" data bases that would allow ready access to both service providers throughout the health system and the public at large to an up-to-date inventory of health and community services.
- To support current efforts underway to develop a secure email messaging system to enhance communication amongst service providers to benefit the public served.
- To support initiatives that streamline client access to the services they need, resulting in a more timely response; i.e., work to reduce/avoid putting processes in place that require people to complete a multitude of forms or give information in excess of what their current need requires.

1.4.1 Mental health and addiction services as core components of the Champlain health care system

Title of patient care/service initiative: Mental health and addiction services as core components of the Champlain health care system	Type of integration (more than one box can be checked) <input checked="" type="checkbox"/> Horizontal <input checked="" type="checkbox"/> Vertical <input checked="" type="checkbox"/> Intersectoral
Existing or new initiative? <input checked="" type="checkbox"/> Existing & <input checked="" type="checkbox"/> New integration opportunity	List of partners involved: Consumers and their families, consumer and family networks, Champlain Addiction Coordinating Body, Champlain Mental Health Network, all mental health and addiction services in the Champlain District, providers of other health and human services that impact on or are impacted by mental health and/or addiction issues and any services publicly funded or otherwise with which there are cross-sectoral needs and issues (criminal justice, child protection, housing, social assistance), municipalities
<p>Please briefly describe the initiative</p> <p>It is proposed that Mental Health and Addiction Services be integrated horizontally and vertically and further integrated intersectorally with the primary health care system as core components of the health care system in the Champlain LHIN area.</p> <p>Mental health and addiction problems (including problem gambling) affect a significant proportion of Ontario's population. They represent a tremendous burden for those who are directly affected by them, their families, employers, the larger community and result in a substantial financial impact due to eventual demands on secondary and tertiary health care services, other human social services as a whole. Mental health and addiction problems do not exist in isolation from other health problems: they can and do impact on the incidence and treatment outcomes for many physical health problems, and consequently the costs incurred by those other areas. A high percentage of clients with addictions have concurrent mental health disorders; similarly a high number of mental health disorders exhibit substance abuse and dependence problems that hamper conventional mental health approaches. Further, the negative costs to other areas of the health care system as well as to other social/economic systems (education, employment, criminal justice, etc.) are significant.</p> <p>Existing functional integration between addiction agencies in Champlain has demonstrated benefits for the clients and their families. Functional integration of mental health and addiction, while still evolving, has clearly demonstrated benefits for those with addiction problems and concurrent mental health disorders. Yet, despite ample evidence of health and economic benefits from the early investment and timely delivery of adequate resources, mental health and addiction services have historically been marginalized within the health care system. Comprehensive integration should continue within the sectors, be encouraged to expand between the two sectors and be implemented cross sectorally with other points of entry into the health care system and address the unique cultural and linguistic needs of the region.</p> <p>The integration should occur along a variety of continuum i.e. sectors, levels of service (health promotion, acute and chronic illness prevention, treatment, support), client age, geography and other services. This will result in: (a) better understanding of mental health and addiction issues throughout the health care system, early detection at primary health care level and improved capacity to identify those with problems and those at risk, (b) decreased stigma and discrimination throughout the system, and (c) timely, effective and coordinated response (referrals and service coordination) for those with mental health and addiction problems and those at risk.</p> <p>Rationale</p> <p>1. The prevalence of addiction and mental health problems</p> <p>a. Canadian Health Network states that 10% of adult Canadians report current problems with their drinking and 50% report problems with someone else's drinking (Ontario Federation of Community Mental Health and Addiction Programs)</p> <p>b. 20% of Canadians will experience a mental illness in their lifetime. (Health Canada Report, 2002)</p> <p>c. Over 1.5 million Canadians now experience clinical depression, a disorder that affects 10-15% of Canadians at some point in their lives. (CAMH)</p> <p>d. Research reveals a high rate of co-occurring addiction and mental health problems and shows that people who have such concurrent disorders experience poor treatment outcomes, high rates of relapse, suicide and homelessness</p> <p>2. Prevention, early detection and early intervention</p> <p>a. Effective public health policies and programs can be implemented which will lead to a significant reduction in the overall burden related to substance use (WHO 2004 report on Neuroscience)</p> <p>b. Mental health disorders which are biologically based frequently evolve into chronic problems requiring life long support</p>	

but the impact of these personal and economic costs can often be decreased by early detection and intervention - the longer psychotic symptoms are left untreated, the worse the prognosis, cognitive impairment is decreased, and there is greater evidence of brain damage in persons who experience long, untreated psychotic episodes than in those who experienced shorter, more efficiently treated episodes (Kirby 2004)

c. Most addiction problems, while behaviorally based, are driven by bio-psycho-social factors which also benefit from early intervention and prevention which address risk factors to abuse and dependence - 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 (Federation 2003)

3. The impact of mental illness and addiction on other health issues

a. A review of 62 research studies conducted from 1980 to 2003 has found that depression increases the risk of mortality for people with coronary heart disease. (Psychosomatic Medicine)

b. Depression is frequently a predictor of disease and research has found that people with serious mental illness have higher rates of grave medical illness and premature death than the general population (CMHA Ontario)

c. Depression occurs in 30% of people who suffer a stroke while patients with bipolar disorders have obesity rates two times higher than the general population (Chen 1990)

4. The economic and social costs of mental health and addiction problems are well documented:

a. 90% of suicide victims have a diagnosable mental illness or substance use disorder (Kirby 2004)

b. Mental illnesses were second only to cardiovascular disease in terms of direct health care costs alone (Kirby 2004)

c. "Alcohol dependence syndrome" accounted for the largest number of live hospital separations (discharge of patient) by "most responsible diagnosis" and "all other diagnoses", in 2000-01, there were an estimated 56,161 adult hospital separations, both live and dead, attributable to alcohol and drug use as the most responsible diagnoses in Canada and a further 137,429 hospital separations where alcohol and drug use were responsible to some extent (CCSA 2002).

d. The relationship between mental illness/addiction and work can be characterized as bi-directional. The workplace is a critical environment for the promotion of mental health and the early detection of mental illness and addiction. A healthy workplace will benefit not only the individual and the employer but also society as a whole by enhancing productivity and reducing the overall economic burden. (Kirby 2004)

e. In acknowledging that in contrast to other illnesses the indirect costs of mental disorders appear to be higher than the associated direct health care costs, the Nov 2004 Senate report (Kirby) reports that lost productivity due to illness and premature death is substantial (\$24.9 billion for addiction and \$8.1 billion for mental health - the aggregate corresponding to 19% of the combined corporate profits of all Canadian companies), direct health care costs are significant (\$2.1 billion for addiction and \$6.3 billion for mental health with \$3.9 billion of the latter figure being for direct hospital care), and law enforcement costs associated with addiction is \$1.7 billion

5. Investment in effective interventions can substantially lower costs

a. Each dollar spent on the treatment of addictions results in a saving to the taxpayer of \$5.60 (Ontario Auditor'1999)

b. Early mental health interventions can prevent substance use disorders of a secondary nature from becoming primary health problems

c. Alcohol related problems account for 10% to 30% of all ER hospital visits (Federation 2004)

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

Integration within the addiction field is well underway - Champlain area addiction agencies have been working collaboratively for the past four years under the umbrella of the Champlain Addiction Coordinating Body. The recent formation of the Champlain Mental Health Network has allowed inter sectoral collaboration in areas of staff training, treatment referrals and best practice based treatment programs.

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

a. A formalized collaboration (horizontal & vertical integration) between mental health and addiction services in Prescott Russell has resulted in a uniform referral system allowing more rapid interventions for those in crisis, more efficient long term treatment plans because of appropriate treatment approaches (parallel, integrated or sequential) monitored via common clinical conferences, and better outcomes due to more rapid collaboration and ongoing support between professionals.

b. Building on existing systems such as peer support networks, common databases (Catalyst) and province wide referral systems (DART) should not be compromised by divergent local systems.

School based prevention, early intervention and treatment programs in addiction and mental health result in more cost effective outcomes and lower morbidity (Health Canada - Best Practices in Youth Prevention - 2001)

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1.4.3 Action Plan Mental health and addiction services as core components of the Champlain health care system

Template C Integration Opportunity

Opportunity

Mental health and addiction services as core components of the Champlain health care system

High-level Action Plan

- 1 Establish a Central Role for Citizens
 - Integrate citizens in all planning and evaluation processes across the continuum of care at both the macro and local level with a recovery focus.
 - Dedicated resources to support and facilitate involvement of citizens and providers.
 - Champlain LHIN evaluated on this dimension as part of the LHIN scorecard.
 - Establish and fund a central role for citizens.
- 2 Champlain LHIN ensures a continuum of care
 - Accessible, effective, adequately resources MH&A services.
 - Across life span.
 - Diversity, culturally specific and sensitive to gender and age.
 - Health promotion, early intervention, primary care, acute care, specialized services, rehabilitation, tertiary care services all included.
 - Standardized screening for MH&A issues across continuum and in all health-related sectors.
- 3 Create Infrastructure in Champlain LHIN to Support the Action Plan
 - Assign a senior executive to oversee the exclusive portfolio of MH&A
 - Existing networks are key planning bodies for MH&A, linked with other LHIN advisory bodies with direct link to the LHIN CEO and Board.
 - Resource existing networks for planning and LHIN advisory roles.
- 4 Link Academic & Research Resources
 - Disseminate best practices services within all aspects of the service system continuum.
 - Advocate for increased research funding for MH&A.
- 5 Education of Health Care Stakeholders
 - Core competencies in MH&A included in academic and education at all levels of healthcare stakeholders.
 - Specific focus on MH&A education for ALL health care professionals developed and implemented.
 - Budgeted and protected funds for training.
- 6 Dedicated Funding:
 - Needs-based sustainable, indexed, equitable funding.
 - Multiyear funding implemented.
 - MH&A envelope protected and increased.
 - Identification of regional needs and funding to reflect both urban and rural accessibility issues.
- 7 Strategic Human Resource Planning to Build System Capacity
 - Implementation of shared care approach amongst family physicians and MH&A professionals through Family Health Teams and other mechanisms.
 - Focus on development of strategic HR plan for the 6-patient/client care priorities of the Champlain LHIN.
 - Flexible funding to address changing demand and needs is important. An inventory of current programs and capacity is essential. Fiscal resources must be dedicated to these five priorities.
- 8 Scorecard to Measure Performance
 - MH&A indicators and metrics reflected in LHIN scorecard.
 - Performance contextualized within both provincial and national benchmarks.
 - Bi-directional accountability and transparency.
- 9 Building on existing strengths and system /district initiatives and work
 - Supporting policy frameworks, “Making It Happen” and Setting the Course”
 - Utilizing prior planning and implementation priorities that are currently relevant for the district
 - Review and build upon the existing integration experience within the district.
- 10 Consistent Screening, Admission and Discharge for MH&A
 - Develop and implement consistent criteria for intake and discharge, protocols and evaluation criteria that are associated with best practice and evidence-based research.
 - The LHIN mandates and funds the development of standardized tools and evaluation systems
 - Screening and service access at ALL entry points across the continuum

1.5.1 Coordinated service and planning links between health and other sectors that impact health

<p>Title of patient care/service initiative:</p> <p>Coordinated service and planning links between health and other sectors that impact health status</p>	<p>Type of integration (more than one box can be checked)</p> <p><input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input checked="" type="checkbox"/> Intersectoral</p> <p><input type="checkbox"/> Other, describe:</p>
<p>Existing or new initiative?</p> <p>✓Initiated/existing integration activity* ✓New integration opportunity** *Cross-sectoral links exist within the Champlain LHIN connecting a variety of services that impact health status; the new LHIN can contribute to supporting these networks and can facilitate their collaboration.</p> <p>** Coordinated health policy will require new and strengthened initiatives which more formally link provincial ministries; this is especially important for the healthy development of children and youth</p>	<p>List of partners involved:</p> <p>Funders, service providers, consumers, and family members (especially the parents/caregivers of children and youth) from all the sectors which impact health status including: education, housing, public health, family and children's services, transportation, income, recreation, labour, community services, employment, land use, justice and provincial health services.</p>
<p>Please briefly describe the initiative.</p> <p>This initiative:</p> <p>1) aims to ensure that the LHIN formally recognizes and acknowledges the full range of factors that impacts and influences the health status of the people of Champlain region. These determinants of health include services that are complemented by the province's public policies. Improving and maintaining population health, and individual health within the broader community, requires integration across key provincial ministries and service sectors. A co-ordinated approach to public policy between these ministries, service sectors and the various levels of government is a critical component to effective planning in and for a health system. Services for children and youth and their families are particularly fragmented and uncoordinated. Improving the health of children and youth specifically requires coordination of services and systems across provincial Ministries and their integration with MOHLTC funded services.</p> <p>2) is anchored in a philosophy which accepts and promotes both social and physical determinants of health including education, housing, adequate income, nutrition, family/community supports, early childhood services, and emotional/psychological well-being. As a result, effective planning must be cross-sectoral and public policy must be coordinated.</p> <p>For children and youth there are key elements and influencing factors which reflect these cross-sectoral determinants. With minor revision, one can see their applicability to all populations. A summary is provided below and a key document, <i>Middle Childhood Matters: A Framework to Promote Healthy Development of Children 6 to 12</i>, may be found at www.child-youth-health.net under 'Research and Publications'.</p> <p>SAFE & CARING ENVIRONMENTS: safe places to place; family-friendly workplaces; community supports to vulnerable families; adults take responsibility for children; freedom from harm and neglect; clean and healthy environment; positive school climate.</p> <p>MEETING FUNDAMENTAL NEEDS: nutrition and food security; stable and secure housing; access and opportunity to health care and mental health services; sleep.</p> <p>OPPORTUNITY TO DEVELOP COMPETENCIES: engaged in learning; recreation, leisure, arts and culture; supports to foster social skills; positive peer relationships; opportunities to develop and explore sense of self.</p>	

STABLE & NUTURING RELATIONSHIPS: at least one caring adult in a child's life; school-aged child care; supports and services to the family and the parenting role; school attachment; participation in neighbourhood, school and community

3) is based upon a vision of intersecting networks within communities, with permeable boundaries between the health care system and :schools, social and community services, immigrant services, public health, service clubs, pharmacies, faith organizations, housing, children's services, employment, recreation, transportation etc.. (The increased application of electronic technology would allow for timely, transparent and accurate communication amongst all stakeholders.)

4) supports the identification of existing cross-sectoral networks and building on their integrating capacity. Where gaps exist, (i.e. children moving from hospital to home care to school; pharmacies not having access to patients' medication profile), the LHIN could facilitate increased coordination, broaden existing mandates and/or initiate new structures and mechanisms.

Implementation strategies may include:

- identification and review of existing integrating/coordinating cross-sectoral mechanisms (both planning and service models)
- identification of health related services/sectors that need to be involved
- developing innovative and effective cross-sectoral pilots (i.e. portable, individualized funding support for those with multiple and complex needs which cross Ministries)
- support for multi-disciplinary service organization models which can support satellites, mobile outreach and provide services as close to the community as possible (I,e, the 'community health centre' is an effective and existing model)
- review of roles and responsibilities of different organizations to facilitate cross-sectoral integration
- establish an interministerial pilot project to facilitate cross-sectoral collaboration and the co-ordination of services and policies (especially those impacting the health of children and youth)
- promote the standardization of planning boundaries within all ministries so that they coincide with the new provincial LHINS
- support a legislative framework for inter-ministerial co-operation as key to the development of a supportive and seamless health (care) system; the distinction between 'health' and 'social services' needs to be less rigid.

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

The Champlain LHIN catchment includes the region covered by the Champlain District Health Council as well as parts of the counties of Lanark and Leeds and Grenville that were previously part of the Southeastern Ontario DHC. In each of these areas, cross--sectoral planning/service bodies exist. They need to be identified and incorporated into planning initiatives undertaken by the new Champlain LHIN.

Examples of coordinated networks for public policy, planning and broad health services exist which can be built upon. Some of these cross-sectoral examples are:

- a) Child and Youth Health Network for Eastern Ontario (facilitated through Children's Hospital of Eastern Ontario)
- b) Integrated Services for Northern Children
- c) Cross-sectoral Committees for Section 20 programs (education and mental health)
- d) Every Kid in Our Community (Leeds, Grenville)

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

Cross-sectoral and cross-Ministerial collaboration and networks exist and are shown to work. They need to be legislated, promoted, used and enhanced.

Goals in the health care sector (MOHLTC), including cost containment and reduction, cannot be met if other Ministries, critical to the equation, are not considered. "Down-loading" costs from one Ministry to another and from a Ministry to a municipality (i.e. from MOHLTC to MCSS) does not save money nor improve health. While true for all ages, this is particularly significant for children and youth.

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1.5.2 Action Plan - Coordinated service and planning links between health and other sectors that impact health

Template C Integration Opportunity

Opportunity

Coordinated service and planning links between health and other sectors that impact health

High-level Action Plan

1. Identify existing networks which have a cross-sectoral, cross-ministerial health mandate
2. Identify where new such networks are required
3. Support their work and integration into the mandate of the Champlain LHIN
4. Take a leadership role in supporting and contributing to “healthy public policy” for the Champlain District
5. While cross-sectoral integration (both vertical and horizontal) is not part of the new Champlain LHIN's initial mandate, we urge our LHIN to take a leadership role and use the resources of existing cross-sectoral/cross-ministerial networks to enhance the health status of children, youth and adults in Champlain and to strengthen the health care system

1.6.1 Accessibility to the continuum of care that is close to home

<p>Title of patient care/service initiative:</p> <p>Accessibility to the continuum of care which is close to home and which is defined in terms of: a) networks of community-based services, i.e., community, primary and acute-tertiary; and b) other criteria, i.e., geographic urban-rural locations, language & culture, health needs disease & population based.</p>	<p>Type of integration (more than one box can be checked)</p> <p><input checked="" type="checkbox"/> Horizontal <input checked="" type="checkbox"/> Vertical <input checked="" type="checkbox"/> Intersectoral</p> <p><input type="checkbox"/> Other, describe:</p>
<p>Existing or new initiative?</p> <p><input checked="" type="checkbox"/> Initiated/existing integration activity</p> <p><input checked="" type="checkbox"/> New integration opportunity</p>	<p>List of partners involved:</p> <p>Lois Hall, VON Lanark; Simone Thibault; OverbrookeForbes CRC; Ivan Emmerth, Deep River Hospital; Linda Assad, La Cite Collegiate; Michael Godden, Cumberland Home Support; James Simpson & Penny Pepin, Ottawa Hospital; Karen Roosen, Renfrew CCAC Terri White Lobsinger, Carleton University; Lesley Larson & Mary Anne Fish, St. ElizabethHealth Care Helen McGuire; Lise.Richard; Michel Gervais; Nicole Lafrenier-Davis; Michael Birmingham; Carole Halstead; Cheryl English; Marg Stephenson; David F. Walls; Wanda MacDonald</p>
<p>Please briefly describe the initiative. This initiative:</p> <ul style="list-style-type: none"> - Describes/represents key high-level principles that ought to underscore the operations of all health services and programs accessed by both rural and urban populations alike, in an equitable manner, within the Champlain LHIN. These principles are enshrined within the Canada Health Act and have recently been affirmed and communicated to all governments in Canada through the Romanow Commission. - Acknowledges the existence of networks of community-based care (see DHC document-“Network of Networks”), which, when integrated more fully, would represent a continuum of: community services, primary health care and acute-tertiary care. - Represents an opportunity to more fully integrate each of clinical, administrative, governance and accountability systems within the Champlain LHIN and, between the LHIN and the Ministry so that citizens’ health needs are met and addressed as close to home as possible by the highest quality care as possible. These need to take place in a timely, equitable and efficient manner. - These integration opportunities would encompass, for example: a) need-based planning (defined more than by population based averages), b) capital planning, c) HR planning, d) budgeting and expenditure allocations, e) delivery of preventive, community and allopathic health care services, and f) evaluation and accountability to the citizens of the Champlain LHIN by both the LHIN Board and the Ministry. The establishment of a standard and provincially regulated E-health system and the sustained integration of the Champlain LHIN’s administrative systems, e.g., HR planning and agreements and accountability frameworks which are directed to the community, would improve system navigation for both citizen-patients and their families and for evaluation exercises. - Recommends defining, documenting and validating the specific health needs of the citizens of the Champlain LHIN in terms of primary and preventive services, health promotion services, morbidity and mortality patterns as represented by data other than population averages. It would include current data as well as population projections for both social and economic criteria. Hence, socio-economic variability of language and culture, age and sex breakdowns, employment and income, education, urban-rural patterns and so forth would be acknowledged and included. - Recommends that accessibility be broadly defined to include securing good quality and affordable preventive and allopathic care as close to home as possible, in a timely manner and, in terms of individual socio-economic characteristics. Thus, besides geographic location, i.e., rural-urban, accessibility to networks of preventive and curative care would incorporate one’s income and/or employment status, education, gender, age, culture, degree and availability of family supports, caregiver requirements, and so forth. Accessibility, defined in this broad manner would maximize not only citizen-patient and family comfort but it would also secure financial efficiencies. Community-based services provided with family supports, when possible, are good methods to lower costs. <p>This initiative is a priority because:</p> <ul style="list-style-type: none"> - A standard system of supports available within the Champlain LHIN for its local communities (broadly defined) is required. - Interdisciplinary teams are central and important to the delivery of community health services; hence, they must be valued and supported. - Health services ought to be accessed as close to home as possible. - It acknowledges and builds upon the capacity of local communities. - It acknowledges the need to promote not only curative/allopathic health needs but also health promotion and prevention 	

as equally important needs.

- The communities within the Champlain LHIN need to know that a viably integrated system is available to them when they need to access tertiary and other types of acute care and that when these care needs are addressed, an equally important network of good quality, local and community care is also available to them. People wish to secure health care as close to home as possible, i.e., the most appropriate care at the most appropriate level.

The following steps represent the new integration opportunity:

- Developing funding mechanisms that support community-based care.
- Providing 100% funding from the province with no requirements for cost-sharing arrangements with other sources as this leads to inequities.
- Developing HR strategies for recruitment and retention as well as capacity building within community-based services.
- Undertaking, at the 'local' level, community planning within the context of the Champlain LHIN which recognizes that 'Communities' (broadly defined) often have unique needs. Planning needs to include identification of need both in terms of services-allopathic, preventive and health promotion, and in terms of the system's overall operations.
- Developing evaluation mechanisms that are built into the system so that outcomes (preventive, promotive and curative) and best practices can be identified and shared. These would improve accountability to citizens by each of providers, institutions, the Champlain LHIN Board of Directors and the province.
- Educating partners to facilitate, improve and make available and share professional training opportunities that are accessible across a spectrum of community-based settings. Encourage the development of integrated-professional training.
- Ensuring government commitment to, and use of citizen-patient-family centred planning models. Government's commitment must be clear, transparent and loud.
- Developing public education strategies to promote clarity and understanding to the citizens of the Champlain LHIN about all aspects of the integrated network. These would include current and future changes to the system as well as issues related to communicating how individuals access services within the system.
- Promoting stability. Health care is a provincial responsibility and ought to be 100% funded. Stability is needed in the planning, delivery, coordination and evaluation of services. It is imperative that organizations undertake their service mandates through multi-year funding arrangements. This would promote effective and efficient planning and delivery of services and facilitate vertical and horizontal integration among and between partners/providers, where possible. The latter needs to be strengthened.
- Recognizing and supporting the broad determinants of health. Community-level funding is needed to focus on health promotion (broadly defined) and disease prevention. Local community services are well placed for and experienced in illness-disease prevention and health promotion. These promote and improve the quality of life and health for all citizens within the Champlain LHIN. They also represent opportunities to secure longer-term savings for the system.

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

What is the current status?

This is both an existing activity and a new opportunity. The opportunity is in integrating existing systems and activities and their focus. More work is required to place the citizen-patient-family at the center and all provider/stakeholder interests, i.e., professional and institutional, at the periphery.

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

Currently, the emphasis or focus, within the Champlain LHIN, is too greatly directed at provider and stakeholder interests-their wants, needs and wishes. This will continue to be a challenge and changing this focus (including how it affects decisions and funding) will require a long-term sustained effort and will be by all leaders and champions within the Champlain LHIN. There is insufficient attention to the needs, wants and aspirations of the citizens of the Champlain LHIN. There is too great an emphasis on curative-allopathic care at the expense of preventive and promotional care. Insufficient attention is devoted to the needs, wants and access to care by rural citizens. Greater attention is required to secure improved mental health and addition services and to improve the coordination of seniors' care. Greater integration is needed between community support services, acute and primary care. Improved links are needed between Ministries, programs and educational facilities. Integrating and improving administrative functions would also improve overall access to and the development of integrated networks of clinical care. It would promote access as close to home as possible.

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1.6.2 Accessibility to the continuum of care that is close to home

Template C

Opportunity: Accessibility to the continuum of care which is close to home and which is defined in terms of: a) networks of community-based services, i.e., community, primary and acute-tertiary; and b) other criteria, i.e., geographic urban-rural locations, language & culture, health needs disease & population based.

High-Level Action Plan

- Use community based planning processes to support current and future community based service needs.
- Begin planning process by: a) developing guiding principles to govern all LHIN operations using citizen input; b) not restricting data to population averages of morbidity and mortality; and c) using social/cultural determinants of health.
- Develop measureable goals and objectives in the planning process using: a) principals supporting vertical and horizontal integration of health promotion and prevention, curative, and long term care; and b) cultural and geographic criteria.
- Balance between community, provincial and hospital interests in governance and, recognize physicians as key players (physicians will be socialized into the network through incentives).
- Balance between care types, citizen representation (i.e., advisory council reps) and administration so that capture of the Board by powerful lobby groups (e.g., OHA, physicians) is minimal.
- Maximize public involvement: a) in governance and planning; b) when making future changes like, for example, delisting services; and, c) in ongoing service provision.
- Use training and public education to overcome resistance to change at all levels: a) the Board; b) professionals; c) organizations; and d) the community.
- Establish patient-ombudsman positions within each LHIN.
- Ensure and protect stable, 100%, and multi-year provincial funding (no cost sharing) for all services, (as per the Canada Health Act and citizens' views that health care is an important public good), so that integrated program models of preventive, acute, community and long-term care will develop and be supported to meet a continuum of citizen-patient needs, close to home.
- Expand existing levels/standards of service and respond to public demands for improved community care and pharmacare.
- Reject copayments for standard health services; accept private insurance for supplementary coverage.
- Establish HR recruitment/retention strategies for community-based care.
- Undertake organizational inventories (not necessarily those on contract) which encompass capacity, staffing and, history of care quality and, use this information in short and long-term planning, funding and training processes.
- Incorporate into the HR strategy: a) inventory of current/future staffing and scope of practice of all providers; b) principles which ensure the "most appropriate provider for the most appropriate service" and which avoid gaps; c) FTEs defined for all community-based health needs; d) standardized recruitment with compensation that is equitable with hospital counterparts; e) technology to reduce face-to-face care while ensuring appropriate family supports; f) wellness rather than medical models; g) optimal use of nurse practitioners; h) a continuum of training/education, also closer to home (e.g., training in community-based settings) and, which is sensitive to urban-rural and other criteria like language and culture; and i) distance education, local trainer of trainers and satellite academic hubs to facilitate training closer to home.
- With geography, language, culture, and health needs/disease as a basis, use monitoring and evaluation to: a) identify outcomes, best practices and vertical and horizontal integration of care; b) encourage citizen-patient and family engagement; c) promote transparency; d) continuously update and improve health care services and outcomes; and e) maximize access to care as close to home as possible.
- Ensure that evaluation criteria are flexible and adaptable to changing health needs.
- Consider funding efficiencies to be the last measure of the health of the Champlain LHIN health system.
- Include citizens in evaluation exercises of: a) provincially established global budgets; b) definition of needs and priorities; c) governance; and d) leadership and vision.
- Feature on LHIN web site: a) evaluation outcomes; b) best practices; and c) other data on the full network of care.
- Include in vertical evaluation: a) board operations; b) community consultation; c) high level planning, budgeting and networks of care (tertiary, primary, community, preventive); d) patient-citizen outcomes and satisfaction.
- Include in horizontal evaluation: a) delivery of and, access to a network/continuum of care to/for patient-citizens and their families; and b) preventive care.
- Maintain government commitment to a patient-citizen centred planned and delivered health system through effective integration.
- Make visible government commitment through: a) open and transparent communication; b) multi-year funding arrangements based upon a variety of criteria, broader than population averages; c) equitable funding of

networks of high quality, measurable care, accessed close to home and which reflect the determinants of health and health promotion; c) citizen ombudsman positions within each LHIN; d) open board meetings with citizen representation; and e) leadership which ensures that all care types receive equal attention in the planning and funding cycle.

- Establish broad-based public education on: a) citizen-patient service programs; and b) how to negotiate the system of community based services close to home.
- Use consistent messages and, clear and transparent information in all communications to citizen-patients and their families and to specific interest groups.
- Use health forums and community activities as venues for public education.

vi. Work to support rural and community based services through these linkages and collaborations, in order to keep patients closer to home and away from the urban facilities as much as possible.

Eastern Ontario is uniquely positioned to have its LHIN start up with a functioning eHealth strategy and well established collaborative groups.

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

What is the current status?

The Regional EMPI project is currently in the pilot phase (4 hospitals) with 3 further roll out phases planned over the next 10 months.

The IM/IT (CIO Working Group and Regional Health Records/Admitting Working Groups are established and working on the EMPI project as well as developing other regional issues for standards development and projects of a regional nature.

The IM/IT (CIO) Working Group is establishing an inventory of systems and initiatives and collaborating with SSHA on secure email development.

The Regional IT Executive Committee is now in deliberations as to how to expand the membership to the non-hospital sector as well as the creation of a Regional CIO position to provide leadership for all healthcare agencies.

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

True regional collaboration and cooperation must have the explicit agreement of the CEOs first. As long as there is consensus to a vision and/or direction, the working groups will be able to connect to the CEO vision.

All projects must have agreements, at the CEO level, for the required resource commitments. In addition, there must be an agreement, up front, as to ongoing support and maintenance costs before the project commences.

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2.1.2 Action Plan - eHealth – sharing information and building linkages amongst providers and organizations (“one patient, one record”).

Template C Integration opportunity

Opportunity

eHealth – sharing information and building linkages amongst providers and organizations (“one patient, one record”).

High-level Action Plan

Building from successes and collaboration.

Linkage of patient information throughout the region will facilitate the goals and mandates of all health service agencies. Further, it will support patient care in all aspects and promote more efficient use of health system resources.

The first building block will be to grow the membership in the Regional EMPI Project currently in its pilot phase. While funding restrictions precluded organizations other than hospitals from participating at this early stage, it will be important for Ministry and/or LHIN investment in expanding the install and implementation base for the EMPI across agencies in the Champlain LHIN geography. The development of standards for Registration and Records will go a long way to improve the interoperability of systems and sharing of information in the region. The EMPI is the building block for that linkage.

After the linkage mechanisms have been developed through the OACIS EMPI product, it will then be important to work on the propagation of all information into a regional repository for sharing. This will involve all regional healthcare partners from individual to group family physician practices, specialist offices, through the CCAC's, Community Health Centres, Community Mental Health and Addiction Agencies, up to the hospitals.

A regional linkage approach for bringing together the various partners is already in place in Eastern Ontario. We have a Regional IT Executive to facilitate the actions and directions taken across organizations. We want to work with the existing, working structure to ensure it has broad membership from across the region and then build on the successes thus far. Membership in this Regional IT Executive will include non-hospital sector agencies to ensure we are promoting and pursuing a systems linkage approach. This will ensure regional IT governance that is inclusive of all partners to promote integration and sharing across the continuum. A further opportunity will be to create a regional CIO position that will provide leadership and direction for all agencies and promote linkage and sharing across the partners.

As a further regional consideration, the Capital Health Alliance, through the EMPI Project and IM/IT (CIO) Working Group, is taking steps to harmonize and facilitate compliance with PHIPA through cooperation on Policies and Procedures for the EMPI and eventual regional repository.

With the creation of a true systems linkage, we see the regional IT structure facilitating the efforts of the LHIN to move the system forwards. The IT investments and collaboration will enable LHIN efforts for system improvements in areas such as:

- Reduction of duplicate tests
 - Improvements to patient safety
 - More efficient use of resources
- Improved access to patient information for providers
 - Improved and more timely patient care
 - Less repetition of background information by patients
 - More integrated care plans and care supported closer to home
- Improved quality of care initiatives at a regional level
 - Shared approaches to Quality and Quality Improvement
 - Access to and use of evidence based management and care practices
 - More consistent monitoring and access to patient care tools and, ideally, patient access to their own personal “portlet” of health information for improved self-awareness and health management.
- Leveraging successes and investments at larger organizations to facilitate access and opportunities for smaller organizations to participate.

EHealth initiatives have the potential for significant positive impact to patient care and service throughout the region and for bringing care providers and partners closer together. The potential is to link providers from the primary level through community care, rural and community hospital and all the way to regional and tertiary facilities. In other words, vertical and horizontal integration of providers along the continuum of care to improve patient care.

Ehealth initiatives are positioned well to enable the LHINs to move forward on other linking activities. The current action plan and projects have already established successes, partnerships and cooperation within the region that the LHIN can and will build from.

The explicit agreement amongst all regional hospital CEOs lays the foundation that this particular initiative is seen as extremely important for building the future. Successes will be built through the existing EMPI project but then will rapidly need to be extended to the missing, regional hospitals, CCACs, CHCs, Community service agencies, and family and specialty physician offices in order to continue the linkages.

The model and strategy being employed in Eastern Ontario's Champlain LHIN region is one that builds on what organizations have already invested in. It does not require a "rip and replace" mentality but allows for an interface to bridge into the respective systems already in existence. Therefore, this model could very well be built on elsewhere within the province to link organizations and providers together.

2.2.1 The Champlain LHIN's Accountability to the Community and Consumer & An Accountability Framework that aligns health investments to health outcomes

Title of patient care/service initiative: The Champlain LHIN's Accountability to the Community and Consumer & An Accountability Framework that aligns health investments to health outcomes		Type of integration (more than one box can be checked) <input checked="" type="checkbox"/> Horizontal <input checked="" type="checkbox"/> Vertical <input type="checkbox"/> Other, describe:																																
Existing or new initiative? <input checked="" type="checkbox"/> Initiated/existing integration activity* <input type="checkbox"/> New integration opportunity**	List of partners involved: <table border="0"> <tr> <td>Alex Cullen</td> <td>Ken Johnson</td> </tr> <tr> <td>Ann Alsaffar</td> <td>Kevin Barclay</td> </tr> <tr> <td>Bob Miller</td> <td>Lloyd Koch</td> </tr> <tr> <td>Brigitte Gagnon</td> <td>Moira Toomey</td> </tr> <tr> <td>Carolyn Zacharuk</td> <td>Norma Strachan</td> </tr> <tr> <td>Colin Sangster</td> <td>Peggy Taillon</td> </tr> <tr> <td>Colin Stuart</td> <td>Remy Beaudoin</td> </tr> <tr> <td>David Marshall</td> <td>Riek van den Berg</td> </tr> <tr> <td>Diane Lavallee</td> <td>Sharon Ann Kearns</td> </tr> <tr> <td>Edward Timoffee</td> <td>Susan Foran</td> </tr> <tr> <td>Ellis Westwood</td> <td>Susanne Bowen</td> </tr> <tr> <td>Heather Caloren</td> <td>Tim Plumptre</td> </tr> <tr> <td>Hugh Armstrong</td> <td>Virginia McNaughton</td> </tr> <tr> <td>Jack McCarthy</td> <td>Wes Libbey</td> </tr> <tr> <td>James McCaffrey</td> <td>Yvonne Bateman</td> </tr> <tr> <td>Cindy Harrison</td> <td>Mary-Ellen Schaafsma</td> </tr> </table>		Alex Cullen	Ken Johnson	Ann Alsaffar	Kevin Barclay	Bob Miller	Lloyd Koch	Brigitte Gagnon	Moira Toomey	Carolyn Zacharuk	Norma Strachan	Colin Sangster	Peggy Taillon	Colin Stuart	Remy Beaudoin	David Marshall	Riek van den Berg	Diane Lavallee	Sharon Ann Kearns	Edward Timoffee	Susan Foran	Ellis Westwood	Susanne Bowen	Heather Caloren	Tim Plumptre	Hugh Armstrong	Virginia McNaughton	Jack McCarthy	Wes Libbey	James McCaffrey	Yvonne Bateman	Cindy Harrison	Mary-Ellen Schaafsma
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Please briefly describe the initiative. <p>This initiative outlines specific principles for a framework that will establish mutual accountabilities between the Ministry of Health, the LHIN Board and CEO, and the service providers, as we work together to achieve wellness for the communities in the Champlain District.</p> <p>Accountability is:</p> <ul style="list-style-type: none"> • About outcomes, it is <i>not</i> about process; • About clarity in roles and responsibilities, it is <i>not</i> about rules and regulations; • About alignment to the shared Mission and Vision, it is <i>not</i> about competing interests; • About creating the conditions and incentives for success; it is <i>not</i> about blame and finger-pointing; • About a combined loyalty to the health of the citizens of our region, it is <i>not</i> about loyalty to the Ministry or to an individual organization. <p>What we propose here are the principles to build a framework and a process by which to achieve all the things that accountability is. By aligning ourselves and integrating our services we will achieve our purpose – that of improved health and wellness of the citizens of Champlain. The only way that a complex system of services can be aligned to support a common Vision and Mission is if those services share a standard framework defining their contribution to that Vision and Mission. They must develop mutually agreed upon outcomes that they wish to achieve, and determine and acquire the tools and level of flexibility by which to achieve them.</p> <p>An Accountability Framework is a tool to assist the LHIN, and those within it. It will:</p> <ul style="list-style-type: none"> • Establish the responsibilities of the LHIN and the service providers clarifying how they interact with each other; • Ensure a focus on health outcomes, not processes; and • Contain a high degree of transparency that builds trust between all involved, both within the LHIN and with its community; • Ensure alignment of all services to the Mission and Vision of the Champlain LHIN; and, • Rely on rigorous and systematic evaluation of services and health facilities and agencies in the decision-making process. 																																		

Accountability is **not** a simple two-way responsibility, **nor** should there be multiple accountabilities for one body (e.g. LHIN CEO to both the Ministry and the LHIN Board). It is more than accountability between the Ministry (via the LHIN) and service providers, but involves mutual accountability between:

- The Ministry and the LHIN Board;
- The LHIN Board and the Service Provider Boards;
- The LHIN Board and its CEO;
- The Boards of organizations, among each other;
- Organization Boards and their CEOs; and,
- The LHIN and its communities.

A key element in accountability is clear communication that is two-way and transparent on all levels of the health system, the LHIN, and the government to the citizens and communities we serve. To be citizen-centred means that all citizens, as health system users, have a voice and are actively and meaningfully engaged in the accountability process. There are multiple opportunities for input into the development of an accountability framework and there should be a mechanism built into the Accountability Framework that ensures the citizen's voice is always heard and used. Because health outcomes are complex, the collective wisdom of the community and stakeholders must be harnessed to define the outcomes most desired, in a bottom up and top down dialogue for decision-making.

An Accountability Framework must be system focused and inclusive of the entire continuum of care. It is recognized that the system is complex and organic and that any accountability framework would be multi-dimensional. A Balanced Scorecard approach may be the best mechanism to achieve this. While accountability is not about process, we recommend that in order to see accountability consistently woven throughout our LHIN, that a framework, and process to implement it, be developed.

Links:

Strengthening Accountability: Involving Patients and the Public (UK experience)

<http://www.dh.gov.uk/assetRoot/04/09/38/65/04093865.pdf>

Regionalization: Making Sense of the Canadian Experience

<http://www.longwoods.com/hp/5-1Regionalization/HP51lewis.html>

Commission on Healthcare in Canada (Romanow Reports): Practical Strategies for Facilitating Meaningful Citizen Involvement in Health Planning

<http://www.hc-sc.gc.ca/english/care/romanow/hcc0495.html>

Regionalization Literature

http://www.regionalization.org/Regionalization/Reg_Literature.html

The Balanced Scorecard Institute

<http://www.balancedscorecard.org/>

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

What is the current status?

There is no accountability framework in place, as described here. See 2.2.2 for a high level action plan to achieve this.

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

Anticipated outcomes:

- Improved Access
- Effectiveness of care
- Appropriateness of care based on evidence
- Knowledge-based decision making
- Consumer Satisfaction
- Increased Service Availability
- Efficiency and Cost/Benefit
- Productivity
- Fairness & Transparency in Funding
- Population Health Outcomes
- Financial Health/Clinical Pathways
- Responsiveness to Diversity
- Transparency in Communication
- Transparency in Decision Making
- Continuity of Care
- Accountability for French Language Health Services

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2.2.2 Action Plan - The Champlain LHIN's Accountability to the Community and Consumer & An Accountability Framework that aligns health investments to health outcomes

Template C Action Plan

The Champlain LHIN's Accountability to the Community and Consumer & An Accountability Framework that aligns health investments to health outcomes

High-level Action Plan

1. A System of Accountability, supported by these 7 Principles:

- Developing alignment with a shared Mission and Vision at macro- and micro-levels;
- Mutuality: constructive negotiation to reach agreement upon outcomes;
- Outcome based, not process based;
- HEALTH, not healthCARE (taking into account health human resources, rural vs. urban health, diversity, and special populations);
- Transparency and community engagement;
- A citizen-based system or process (not patients only, because all people are part of this system); and
- Organization to organization accountability.

2. Key Success Factors:

- A common understanding, or Mission and Vision, for the LHIN;
- An agreed upon approach/tool for the implementation of an accountability framework (supported by an Accountability Template to move system towards alignment);
- A Balanced Scorecard approach to defining outcomes (i.e. develop more than finance-based outcomes) (<http://www.balancedscorecard.org/>);
- A focus on wellness and productivity (a population health approach);
- Clarity around the role and expectations with the LHIN, for the system;
- Accountability for French Language Health Services;
- Transparency, citizen engagement and community consultation;
 - Communications training for LHIN Boards,
 - Open Board meetings, held at different locations throughout the region,
 - Ensuring meaningful mechanisms to gain a thorough understanding of what the citizens' health goals are (community-centred rather than provider-centred and ensuring chosen organizational models have roots in the community),
 - Health Information Protection Act, Freedom of Information and Protection of Privacy Act and Personal Information Protection Electronic Documents Act are integral.

3. Accountabilities:

Accountability is best done when it is dually mutual, versus multiple. We are talking about more than just accountability between the Ministry (via the LHIN) and service providers, but the mutual accountability between a variety of partners, for agreed upon outcomes:

- The Ministry and the LHIN Board;
- The LHIN Board and the Service Provider Boards;
- The LHIN Board and its CEO;
- The Boards of Organizations to each other;
- Organization Boards to their CEOs; and,
- The LHIN to its communities.
 - There needs to be a partnership in delivering news (good and bad) to the community, not negative optics for the LHIN and positive for the Ministry (or vice versa);
 - There needs to be recognition of the informal health/human services support system: Grassroots volunteerism, support from families and networks, support to caregivers, and other human/social services that contribute to the health system.

5. "Red Flags": Consider and address the necessary fit of these into an Accountability Framework for a successful LHIN:

- Primary Health Care and the Family Health Teams
- Public Health and Municipalities
- Pharmaceuticals
- Urgent and non-urgent transportation
- Links with other sectors/human services/volunteers/caregivers
- Private healthcare providers
- WSIB
- Procurement
- LHIN to LHIN relations

2.3.1 Navigating the System

<p>Title of patient care/service initiative:</p> <p>Navigating the System</p>	<p>Type of integration (more than one box can be checked)</p> <p><input checked="" type="checkbox"/> Horizontal <input type="checkbox"/> Vertical</p> <p><input type="checkbox"/> Other, describe:</p>
<p>Existing or new initiative?</p> <p><input checked="" type="checkbox"/> Initiated/existing integration activity*</p> <p><input checked="" type="checkbox"/> New integration opportunity**</p>	<p>List of partners involved:</p> <p>Carolyn Green Eganville and District Seniors Chris Cobus Renfrew and Area Senior's Home Sppt. Delores Woodley Ont. Case Mgmt. Assoc. Diane O'Donohue North Star Seniors Support Centre Jo-Ann Trottier Glen Gary Inter. Agency Group Inc. Oris Retallack Unitarian House Terry Dube Community Lifecare Terry Kirkpatrick Mills Community Sppt Corp. Marion Williams ALS Society Jocelyne Contant SCOHS Kathryn Desai Ottawa CCAC Stephen Arbuckle ROH Gillian Price Ottawa Hosp Sue Appelt, Ottawa Burn Survivor Support Group Carolyn Green Carmel Desormeau Ont Arthritis Society Suzie Joannis Cancer Care Ont</p>
<p>Please briefly describe the initiative.</p> <ul style="list-style-type: none"> • Bring together all existing information about services, accessibility & type as well as health care information in one central area for public access (public kiosk) for the purpose of empowering all residents of Champlain to manage their own access, question providers etc. – this is a technology issues, approach which needs to be decentralized and propagated throughout the district –demystification of system Information should include clinical, provider information, service access, requirements as well as costs of procedures, contacts etc.. • For people who have complex needs or who cannot interpret information available, the system should provide a navigator, care manager dedicated to the client / family • Service & health information are available in various formats & in different locations that need to be incorporated electronically in a central local location • Access to information must be in a public kiosk manner & broadly disseminated throughout the district • Information must be made available in non-electronic format for non-internet users • Information available in English and French as well as in a many other language based on population need. • Information must be sensitive to multi-cultural issues. • Education of health care professionals to accept the resulting empowerment of their clients. • Education in the school system to encourage and foster popular empowerment. • Case / care management must be provided to individuals who cannot understand or interpret the information or who live with complex health situations or whose needs cross ministerial boundaries e.g. dual diagnosis • Review and consolidate existing care / case management roles to redefine this service provision. The sources of existing resources include CCACs but also many other providers who have incorporated nurse navigators & coordinators into their operations. • In Champlain, this opportunity must be developed in consideration of the needs of the francophone community. • Lessons learned from existing case management services must be considered. • Information must include non-medical approaches. • Access to the system may thus be simplified. <p>Why is it a priority / Pourquoi est-ce une priorité ?</p> <ul style="list-style-type: none"> - More empowered individuals will access services in a more efficient manner. - More self-care is required to reduce duplication & make less costly choices about care. - Current resources for case / care management should focus on individuals with complex needs which they cannot independently manage. The system should support & organize that most people can be empowered. - Individuals with needs that cross-ministerial boundaries & those without family / personal support are of particular concern. - Individuals who need access to sparsely available services e.g. French language and other multicultural 	

- services.
- Individuals with language and hearing barriers.
 - Health care professionals, in particular physicians control information to public and clients creating a dependency that is costly and inefficient. Education of health care providers does not focus on self-care or on considering the client as the decision-maker about care. This requires a significant paradigm shift for family physicians that the system still considers to be the gatekeeper.
 - The public's expectations about care are not presently managed.
 - Growing number of new Canadians with different health care experiences & needs.
 - The increasing burden of chronic illness and conditions necessitates more effective and efficient client involvement. This self-care approach must be effectively supported, developed with the client and involve the entire continuum of care.
 - There is a need to integrate throughout Champlain and to better link the better-resourced Ottawa with the east and west.
 - The lack of client empowerment and of system navigation when required, results in inappropriate / unnecessary service, expensive duplication & even iatrogenic illness that at times can be deadly.

<p><i>If this is an initiative/existing activity...</i></p> <p>What is the current status?</p> <p>Currently CCACs have a scope of practice that includes access to information and referral to home based services and access to long term care facilities. Many other community agencies have smaller scopes of practice but no agency has a scope of practice that truly facilitates navigation through the system. An increase in scope of practice that includes admission to and from acute care hospitals and links with the family practitioner would increase the ability of this care coordination function to influence the health care market. This will ensure that the right person is in the right place at the right time.</p>	<p>What are the outcomes/lessons learned (if any)?</p> <p>Case management services have been tied to entitlements and financial resources. This has been a problem and people have fallen through the cracks because they do not have any entitlement to these specific services.</p>
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2.3.2 Action Plan - Navigating the System

Template C Integration Opportunity

Opportunity Navigating the System

High-level Action Plan

Health services navigator

- This resource would ensure that clients do not fall through the cracks because they are supported in the most efficient and effective manner. This would have the potential result of less duplication and decreased costs related to more expensive options such as admissions to long term care and acute care facilities. The navigator could develop an education program for the public about how to access the health system and the information services related to health care.
- The role of facilitator/navigator within the health care system would impact all sectors of health services. Bilingual or multicultural information could be shared through virtual care plans or decision-making tools.
- There are already resources within the system that can be used. The present CCAC case manager role provides professionals with appropriate qualifications in overall system navigation and this role could be expanded beyond the CCAC, which has its limitations. Clients would receive the right care at the right time by the right provider with a navigator. Links with accessibility and integrated links
- A fair and equitable assessment process would ensure that all populations receive appropriate health service delivery and links with other resources.
- There are measurable outcomes based on health care indicators in various disciplines and in holistic health care.
- The standardized model can be replicated across the province.

Access to health care system through other health care providers.

- This will help to address the shortage of health care professionals.
- The primary care physician should be the point of access for the client and the system navigator would provide a natural extension of primary care and a link to secondary and tertiary care. The system should be driven by the concept of wellness rather than the medical model. Access to services or gatekeeping needs to be shared by a team of health professionals linked to the client by the most appropriate professional depending on the client's needs.
- The team approach based on client needs will help to address the territorial issues within the health care system.
- Links with HR and ADM may mean seamless HR and infrastructure support for virtual health providers
- Can be evaluated and monitored through client and provider satisfaction surveys, client and provider focus groups. Indicators can be developed to monitor the costs of delivering the care by the appropriate provider.
- This can be replicated across the province

Health service kiosk

- Provide current information about the health services available within the area. This would result in better use of valuable resources in the community and would also promote appropriate self-care.
- It would provide bilingual information of all of the resources within the health community. It could provide copies of standardized care plans to provide basic information about diseases and empower the client to seek resources related to their health condition. It would target all populations across the continuum of care.
- Kiosks are already being used for licensing and other government services. These have been successful.
- Information should be accessible via electronic means and to all socio-economic groups of the population Links with rural health, accessibility, integrated links
- Client satisfaction surveys on the web could provide feedback about this service. Health care providers could survey clients to determine the use of kiosks.
- Easy to place a network of kiosks across the province in key public areas.
- This service could be linked with the 211 initiative across the province.

2.5.1 Human Resources Planning & Agreements

Title of patient care/service initiative: Integrated Human Resources Strategy		Type of integration ✓Horizontal ✓ Vertical ✓Intersectoral
Existing or new initiative? New integration opportunity	List of partners involved: Representatives of acute care, LTC facilities, community agencies, consumer advocacy groups and others.	
<p>Please briefly describe the initiative.</p> <p>An ever-increasing scarcity of human resources has precipitated a crisis in the health care sector. Workers consistently report feeling undervalued and overworked. Negative media stories, shortage of full time employment, burn-out, lack of wage parity and an aging workforce all contribute to a growing destabilization. This crisis will reach epic proportions within the next five to ten years as a significant share of professional health care workers reach retirement age and leave the system. The resultant struggle to meet growing demands with a paucity of resources (workers and expertise) will inevitably result in rapidly declining quality of care and ultimate erosion of the system itself.</p> <p>Currently, the lack of employment security in the health care sector results in a continual shift of workers across the continuum and an exodus of workers either from the country or from the health care field entirely. This instability is compounded by the negative culture within the system (causing workers to leave) and the rejection of health care as a possible career choice by those outside the sector (including elementary and high school students and university applicants). The <i>CPRN – Ekos Changing Employment Relationships Benchmarking Survey</i> revealed that health care professionals had the lowest scores on four employment relationship indicators - trust in their employer, commitment to their employer, workplace communications and influence on workplace decisions. The 2000 Statistics Canada Labour Force Survey reported that nursing, technical and support staff in the health care sector had the highest number of days lost due to personal illness or injury of any occupation (at least double the national average). Additionally, those newly entering the workforce from academia are often unprepared to meet the challenges of applying theory to practice in the toxic work environment of our current system. New graduates rapidly become discouraged from unmanageable workloads and the lack of mentoring. The current and potential shortages in healthcare human resources are recurrent media topics and have also garnered the attention and concern of various other interest groups (<i>Best Practice Balanced Scorecards - A Powerful Tool & Process for Mobilizing & Aligning Human Effort, Bruce Harber & Ted Ball; Council on Aging of Ottawa, Initial Reactions to the Minister of Health & LTC on the LHINS Initiative</i>).</p> <p>High turnover of staff has significant negative impact – increased turnover results in increased costs, decreased staff satisfaction and decreased patient/client satisfaction. The system is losing expertise at a time of dramatically increasing complexities of care and technological interventions. The reality is that patient care suffers to the point of increased errors, increased lengths of stay and increased mortality. (<i>Shaping the Future of Patient Care Delivery: The Business Case for Workforce Stability, VHA CNO Network</i>).</p> <p>At the present time, human resource disparities exist across the continuum (e.g. urban versus rural, acute care versus chronic care) and between distinct populations (e.g. Anglophone versus Francophone). Such disparities in human resources lead to inequities in service provision as geography or language of choice rather than health needs dictate service levels. This maldistribution of resources creates an inherent imbalance in the system. (<i>From Practice to Policy – Report of the Health Human Resources Capacity & Utilization Project 2003</i>)</p> <p>During the consultation process, multiple factors were identified as impacting on the capacity of healthcare organizations to both recruit new staff and to retain those already in their employ. Seminal ideas for the development of a regional (and provincial) human resources strategy reflected those factors and included:</p> <p>Worklife</p> <ul style="list-style-type: none"> ➤ Support the transfer of staff within the system through such initiatives as transfer of benefits and seniority ➤ Implement regional plans/agreements for all care providers including doctors to enhance stability of the workforce ➤ Change the negative healthcare culture; recognize and support the diverse needs of the current workforce (e.g. 'club sandwich generation' versus new graduates); support a work/life balance; recognize and value all levels of provider ➤ Implement alternative educational models and opportunities reflective of HR gaps and challenges (e.g. distance education, mentoring) ➤ Support foreign trained health care professionals to enable them to work in Ontario. Investigate 'return of service' contracts ➤ Identify, define and value all roles (including volunteers) and realign skill sets where necessary to support the 		

most efficient use of resources (including self-care). Investigate the expansion of scopes of practice in partnership with academia and regulatory bodies

- Provide mentoring and support to current employees and those newly entering the field. Ensure middle management and training are available to support transition from the academic setting to the workplace
- Address the negative media stories with the inherent contradictions (e.g. front page tells of shortages, burn-outs, layoffs, etc. while small recruitment ads are in the classified section of the same paper)

Structure

- Identify provincial/regional/local responsibilities and formal links with the ADM for HR in Ministry of Health
- Create a centralized best practice and HR inventory; centralized repository of HR expertise to support smaller organizations
- Identify recruitment needs across the region (equity in HR supports equity of service)
- Implement HR accountabilities for all constituent organizations
- Develop and implement comprehensive, enforceable, provincial employment security agreements that address such components as wage & benefit parity
- Maximize capacity of technology for education, telehealth, mentoring, etc.

French Language Services

- Recognize that the lack of Francophone health care professionals in Eastern Ontario has a direct impact on access to services in French and the ability of health care facilities and agencies to provide services in French
- Address the challenges in recruitment, training and retention of health care professionals that are able to work in French
- Address the gaps in training for francophone health care professionals, especially in several one-of-a-kind health care services
- Recognize and address the significant challenges in recruitment of professors and in finding bilingual or francophone environments for clinical training/placements
- Address the lack of regional mechanisms for francophone health care professionals to create a knowledge-based network to sustain best practices

French Language Health Services in Eastern Ontario: Training Needs in Health Care Professions (April 2000); French Language Health Services in Eastern Ontario: Programmes postsecondaires en santé offerts en français en Ontario : mise à jour des données (2003)

Rural Services

- Address rural recruitment issues to ensure equity of service across the region (and the province) including the financial support necessary to support those initiatives. In rural and remote areas, staffing issues (recruitment & retention) assume even greater challenges than are experienced in urban centers. (*Northwestern Ontario Health Human Resource Study: Final Report 2002*).
- Address the lack of educational opportunities in rural areas

Funding

- Initiate multiyear funding
- Recognize that stabilized funding equals non-competitive wages and loss of workforce. Organizations are then obligated to spend a disproportionate amount of time and dollars on recruiting, interviewing and training new staff.
- Encourage and reward innovation

Addressing this human resources crisis in our health care system necessitates an approach that is both regional and provincial in scope. An integrated human resources strategy is imperative to ensure that the necessary human resources are identified, recruited and retained.

What is the current status?

While there are no HR initiatives currently in place that integrate the entire Champlain LHIN district, there are local and regional integration initiatives that have the potential for expansion and inclusion across the continuum.

Current initiatives include:
 * Collaborative sharing of HR resources/staff between 4 area organizations (Arnprior Hospital/Arnprior

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

Current initiatives recognize common benefits:
 * sharing of expertise
 * economies of scale
 * pivotal role of technology
 * minimizing or eliminating duplication
 * maximizing available HR

There is a seminal capacity within current initiatives to create a comprehensive and integrated human resources strategy reflective of the continuum both within the Champlain LHIN and provincially.

<p>Nursing Home,Queensway Carleton Hospital and Kemptville Hospital) *OHA Region 2 HR Committee (comprised of the leads in HR for Region 2 hospitals) *Recruitment & Retention Committee (Ottawa & region) (specific to technologists, health records) Physician Recruitment Initiative (Renfrew and adjacent municipalities) (community-based) EORL Project (Eastern Ontario Regional Laboratory)</p>			
<p>Lead contact persons:</p> <table border="0"> <tr> <td data-bbox="152 537 669 680"> <p>Name: Tami MacDonald Title: President, OPSEU, Local 464 Telephone: 613-739-9100 Organization: OPSEU/The Ottawa Hospital Email address: tamimacdonald@bellnet.ca</p> </td> <td data-bbox="669 537 1510 680"> <p>Name: Gwen Brown Title: Quality Advisor Telephone: 613-732-2862 Ext. 254 Organization: Renfrew County CCAC Email address: gwen.brown@renfrew.ccac-ont.ca</p> </td> </tr> </table>		<p>Name: Tami MacDonald Title: President, OPSEU, Local 464 Telephone: 613-739-9100 Organization: OPSEU/The Ottawa Hospital Email address: tamimacdonald@bellnet.ca</p>	<p>Name: Gwen Brown Title: Quality Advisor Telephone: 613-732-2862 Ext. 254 Organization: Renfrew County CCAC Email address: gwen.brown@renfrew.ccac-ont.ca</p>
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2.5.2 Human Resources Planning & Agreements – Action Plan

Template C Integration Opportunity

Opportunity

Integrated Human Resources Strategy

High-level Action Plan

Implement a Human Resources Strategic Planning Committee

- inclusive of all principal stakeholders/partners (including clients, caregivers, health care workers, volunteers, unions and relevant universities/colleges) and reflective of the continuum of care (acute care, long term care and community). Equity in representation will support equity in recruitment and retention and, by extension, equity in the delivery of care.
- establish formal links with the ADM of Human Resources for the Ministry of Health. This link will ensure that a provincial strategy is developed in congruence with regional needs. Formulating a more global strategy will avoid cross-regional competition for human resources and support a cohesive recruitment effort.
- establish formal links with the Ministries of Labour & Education
- build on current HR partnerships and existing expertise
- research HR needs and best practices

Funding

- multiyear funding to support stabilization of the current workforce and to encourage entry into practice of professional and para-professional workers

Maximize Technology

- create a central inventory of best practices and a registry of resources (workers and skills)

French Language Services

- address inequities in university and continuing education opportunities for Francophone health care workers
- address challenges of providing health services in French resulting from recruitment & retention issues
- capitalize on the expertise and knowledge of the Réseau. Mandate of the French Language Health Services Network of Eastern Ontario is to ensure access in French to the complete range of health care services in the region.

Rural Services

- address inequities in university and continuing education opportunities for health care workers in rural areas
- address unique recruitment & retention challenges in rural areas

Human Resources Adjustment Plan or Employment Security Agreements

- consider the creation and implementation of binding Provincial Agreement(s) signed by government, employers and employee associations / unions
- support employment security (comparable position, training if applicable, same pay, working conditions and within a reasonable commuting distance)
- use a standard provincial approach and application
- establish a central training and job registry
- provide funding for voluntary exit options, early retirements and separation allowances.
- consider enforceable and mandatory participation of all stakeholder groups
- provide transition funding
- provide government funded facilitators including mediators and arbitrators if required
- establish a clearly defined time frame
- adapt legislation as required

D. Unique Characteristics of the District

What role does the Academic Health Sciences Centre and voluntary networks play with the Champlain LHIN?

The University of Ottawa Academic Health Sciences Centre (AHSC, medicine, nursing, allied health professions) along with Algonquin College (nursing, health care workers), La cité Collégiale (nursing, gerontology social work) and Carleton University (social work) are enablers and drivers of the Champlain health system. Academic, research, training and service delivery priorities can align to create an integrated system that anticipates changes in service needs, human resources and technology; and adapts accordingly. AHSC partnerships with tertiary hospitals are visible and vibrant, with other components of the health system, less so. The diversity of needs across Champlain suggest that enhanced partnerships between Academic/research and service delivery across the district and across the continuum are an opportunity for better-integrated service delivery. Particular opportunities exist with the Institute of Population Health to align the system along broad health outcomes.

Substantive voluntary networks exist across the Champlain District². Many share information towards the goal of creating a common understanding of needs and gaps. Some collaborate on issues of common interest towards the goal of joint problem solving. Some have created partnerships that offer greater efficiency in service delivery. A few have collaborated to create mechanisms that enhance person-centred continuity of care. The existing networks represent an important resource for the Champlain LHIN to access. Networks depend upon a developmental process of relationship building. Significant investments have been made by partners towards developing the successful networks. The benefits of these networks will accrue to the Champlain Health Integration Network if purposes are aligned.

A few examples of the more than 40 networks:

- The French Language Health Services Network: Developing a consistent approach to French language service delivery across designated Champlain communities
- The Regional Geriatric Advisory Committee: capacity building, education and coordination through district wide networks
- The Perinatal Partnership of Eastern and South Eastern Ontario: Capacity building towards the goal of an integrated system of best practice perinatal care
- The Child and Youth Network of Eastern Ontario: capacity building to support collaborative learning and advocacy related to broad Child and Youth health determinants
- The Ottawa Hospital/ Champlain hospitals/ Capital Health Alliance E-health initiative: creating a common patient index towards the goal of an integrated patient record.
- The Eastern Ontario Regional Lab Associates: creating a single system of laboratory services for the District.

More information on all networks in Champlain can be found at

<http://www.champlainhealth.ca/documents/CHIN-e.pdf>.

Describe any unique characteristics/features of the Champlain LHIN that impact this process and or future integrated health services planning activity

At over 20,000 square kilometers and over one million people, the Champlain district represents an association of diverse communities with diverse needs. While the vast majority of Champlain residents will receive all their health care from within Champlain, the resident's needs and opportunities vary significantly on demographics, health status, language and location.

Urban and rural diversity

Eighty percent of Champlain residents live within only 20% of the Champlain land mass. Champlain needs to be examined at a local level to understand the diverse needs of communities. Rural realities in Champlain include:

- Long distances to travel, by providers or clients, to receive services, and the resulting treatment choices made (see radiation therapy access, regional cancer plan).
- Limited local care options
- Limited local social and housing support options
- Lower health status indicators than urban populations
- Lower status of health determinants such as income and education
- Employment circumstances, independent of incomes, that do not provide the same level of secondary health care options available in urban employment

² <http://www.champlainhealth.ca/documents/CHIN-e.pdf>

Examining Champlain as a whole distorts the reality that the Ottawa population presents with better than provincial average on many health indicators while rural Champlain presents with worse than provincial average on many health indicators. Integrated services planning needs to avoid this distortion by examining the needs of communities within the Champlain community.

Ontario's Largest and most concentrated Francophone population

Recognizing that Champlain is a community of communities is also very important in considering the unique characteristics of Champlain's Francophone population. The counties of Renfrew, Prescott Russell, Stormont Dundas and Glengarry and the city of Ottawa are or have within their borders, communities designated under the French Language Services Act. As a whole, Champlain's population is identified as 17.3% French mother tongue. It is just as important, however, to recognize that some communities, such as Alfred, have over 90% of their residents identified as French mother tongue, while others have less than 1%. Furthermore the number and concentration of Francophones in some Ottawa neighbourhoods and other communities in Prescott & Russell provide the opportunity for some parallel services to be provided in a francophone milieu. As mentioned before, the French language Health Services Network of Eastern Ontario provides a valuable resource to assist in planning health service needs of the Francophone population.

Demographic Diversity

While profiles of Champlain as a whole provide average indicators suggesting a homogenous average population, closer examination reveals significant variation within the demographic profile of Champlain communities.

Growth of the population:

- Ottawa sees a growing and aging population, relatively rapidly as compared to the rest of Champlain. In contrast Renfrew and Stormont, Dundas and Glengarry populations demonstrate negative growth
- Renfrew and Stormont, Dundas and Glengarry Counties already demonstrate high senior dependency ratios but the growth of the proportion of elderly has tapered off while Ottawa's is rising more quickly

Education

- Ottawa represents a higher than provincial average educational attainment while the rest of Champlain represents a lower than provincial average.

Proportion of persons living below the Low Income Cut Off benchmark (LICO)

- Ottawa has a higher proportion of persons living below LICO than the rest of Champlain.

Ethno-cultural diversity

- Similar to other urban centres, Ottawa represents a rich ethno-cultural diversity relative to the rest of Champlain. It is important to recognize the cultural roots run deep throughout the Ottawa Valley. As an example, the community of Barry's Bay has a strong Polish identity. Additional details can be found at <http://www.champlainhealth.ca/documents/cdhcmonitoringprojectreporteng.pdf>

A history of working through partnerships

As identified earlier, existing voluntary networks provide a significant asset to the Champlain LHIN. Champlain appears to have a unique capacity in this respect, possibly related to size (a critical mass large enough to support meaningful partnerships while not so large that partnerships overlap). Over 40 networks and partnerships can be identified³.

A culture of political literacy and political action at the coalition and individual level

It is recognized by some that individuals and coalitions are relatively politically literate and exercise political advocacy in relation to health services. Although this may not be a consistent characteristic across the Champlain district it is perceived by some to represent a dimension that will require consideration in further integrated planning.

³ see <http://www.champlainhealth.ca/documents/CHIN-e.pdf>

Template E

The approaches and processes used to complete the workbook submission

The approaches used to develop the submission were as follows:

- Over 400 people participated in the community workshop hosted by the Ministry of Health and Long Term Care on December 6th, 2004, in Ottawa
- A 23 member workbook Planning Group was formed at the workshop. The Planning Group met 4 times during the submission period (which represented an approximate 2 month time frame inclusive of Christmas and New Years).
- The majority of Planning Group members attended the two-day provincial workshop hosted by the Ministry of Health in January 2005.
- A website was established to post meeting outcomes, draft submission components and reference documents. Posting documents allowed any and all Champlain LHIN stakeholders a chance to provide input.
- An on-line web dialogue forum was established for each priority.
- Each priority lead established e-mail exchanges with workshop participants interested in the topic.
- A number of pre-existing networks devoted time on their agendas to further develop the relevant priorities, with some arranging special meetings and/or teleconferences to address priority issues.
- Leads consulted with other local stakeholders who were known to share an interest in the priority.

In summary, hundreds of stakeholders were engaged in the development process. Although a number of e-mail and web based approaches were implemented, these methods yielded relatively little feedback. These approaches efficiently broadcast information but do not effectively support rich dialogue. The richest dialogue was evidenced within the pre-existing networks. These pre-existing relationships are a valuable asset to be harnessed in further LHIN developments. The time frame necessitated a rapid consultation process. However true consultation requires time to reflect and re-think. Members recognized that the workbook is the initial step in an ongoing engagement process for the Champlain LHIN. It was recommended that the Champlain LHIN should build upon the work accomplished through the current process. Workbook members remain keenly interested in monitoring Champlain LHIN Developments and look forward to further engagement.

The key learnings that came out of the workbook development process

Members welcomed the opportunity to share their learning regarding the process. It was recognized that in keeping with the participative approach, learning from the process is as important as the product of the process. Members acknowledged that ongoing engagement of stakeholders is essential for the Champlain LHIN to capitalize on the energies of those who are committed to a person-centred system of care. It was also recognized that further engagement processes are required to ensure that Champlain LHIN benefits from the wisdom of all stakeholders. One of the tasks identified by the ministry was to engage the public. Additional mechanisms need to be implemented to achieve this task in a meaningful way. In general, formal planning, facilitation and engagement resources need to be established quickly so that momentum for change is not lost. It is important that resources be dedicated to this task so that relationships can be established amongst the diverse stakeholders who are committed to improving the system. The geographic, demographic and linguistic diversity of Champlain suggests the need for planning and facilitation resources that have capacity to engage all communities. Planning Group members represented a diverse group of individuals and although many had not worked together before this process they were now united in a shared purpose. An intentional approach to engagement was required to establish this unity and it was further recognized that such intentional approaches to planning and change need to be seen as a core function for the Champlain LHIN and its partners.

Further engagement will require a commitment to accessibility and inclusion for all stakeholders (including citizens). This includes:

- Accessibility in both official languages
- Access to attendant care, day care, transportation etc. as needed to enhance opportunities for citizen participation
- Incentives or formalized recognition for diversity in provider participation
- Identifying and supporting community champions from a broad cross section of civil society

Appendices:

Full workshop report of all opportunities identified in Champlain (55 in total) can be accessed at

<http://www.champlainhealth.ca/documents/chincommunityworkshopdecember2004-e.pdf>

An initial draft map of relationships amongst opportunities can be found at

<http://www.champlainhealth.ca/documents/chindraftmappingrelationships-e.pdf>

Detailed health system indicators for the former Champlain District (Renfrew County, Ottawa, Stormont, Dundas Glengarry, Prescott-Russell) can be found at

<http://www.champlainhealth.ca/documents/cdhcmonitoringprojectreporteng.pdf>

Detailed Health System Indicators that reflect Lanark, Leeds and Grenville Counties can be found at

http://www.seo-dhc.org/reports/62_SEODHC_Health_Services_Profile-EntireDocument.pdf

All planning developments related to identifying opportunities for the Champlain LHIN can be accessed at

<http://www.champlainhealth.ca/documents/CHIN-e.pdf>

<http://www.champlainhealth.ca/documents/CHIN-f.pdf>