System Integration Opportunities for LHIN 4

February 2005

**Project Steering Committee for
Local Health Integration Network 4**

**Hamilton Niagara Haldimand Norfolk Brant
(Includes Burlington)**

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Prepared by the Hamilton District Health Council

February 11, 2005

Chief Executive Officer
Local Health Integration Network 4
Hamilton Niagara Brant Haldimand Norfolk
(and Burlington)

Re: Proposed initiatives for a coordinated and integrated health system in Local Health Integration Network 4

The Project Committee for Local Health Integration Network 4 is pleased to send you our LHIN 4 Report summarizing enhancement opportunities for our local health system.

We acknowledge that our report is one important input, among many, for the LHIN 4 integration agenda. Its strength lies in its origins, that being the LHIN consultation held in November 2004, at which approximately 48 integration opportunities were identified by some 300+ persons from across our region. These in turn, have their roots in local intelligence, supported by a strong culture of collaboration at the district and regional level.

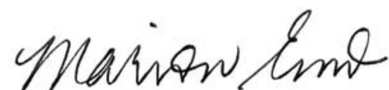
LHIN 4 is rich in assets. Health system planning and funding is informed and supported by 50+ networks, promoting collaborative solutions for health system gain. Our Academic Health Sciences Centre is key to evidence based service, and education and research for a sustained health system. The legacy of our district health councils is sound planning and stakeholder engagement practices for decision-making. And our diverse populations contribute to a rich mosaic for community living and quality of life.

LHIN 4 is not without challenges. Our report advances opportunities where there is work in progress and high readiness for continued progress and performance measurement. The report as well makes suggestions on how to continue the LHIN dialogue for sustained momentum.

We invite you to meet with our Project Steering Committee. We ask you to encourage our collaborative and forward thinking networks to continue to make gains for coordinated, integrated and effective care systems.

The Project Steering Committee for LHIN 4 looks forward to your comments on our report and how they will shape the LHIN agenda over the next few months.

Sincerely,



Marion Emo, Chair
Project Steering Committee for LHIN 4
Executive Director, Hamilton District Health Council

cc: Project Steering Committee Members

Acknowledgements

We, the Project Steering Committee for Local Health Integration Network 4, Hamilton Niagara Brant Haldimand Norfolk (and Burlington) thank:

- The Project Steering Committee partners for their leadership in identifying integration activity foci and action plans;
- Those persons and organizations who assisted us in our work;
- The Grand River, Niagara, and Hamilton District Health Councils for their assistance with planning and local communication;
- The Hamilton District Health Council for their coordination leadership; and
- Jackie Davy, Hamilton DHC, for document presentation; and
- Michelle Gold and Ron Wray, Hamilton DHC, for their writing contributions.

Finally, we thank the Ministry of Health and Long-Term care for this opportunity to advance our ideas and readiness for the LHIN 4 integration agenda on behalf of our area.

Project Steering Committee Membership

Bill Bloor,	Community Care Access Centre of Niagara
Chris Carew,	Grand River District Health Council
Diane Doherty,	CMHA Halton Region
Winnie Doyle,	St. Joseph's Healthcare Hamilton
Ingrid Fell,	Community Care Access Centre Niagara
Rita-Marie Hadley,	Grand River District Health Council
Maureen Harmer,	City of Hamilton Public Health and Community Services
David Jewell,	Regional Geriatric Program central, St. Peter's
Bala Kathiresan,	Niagara Health System Corporate Office
Cindy Kinnon,	Participation House – Hamilton & District
David Lewis	Regional Geriatric Program central, St. Peter's
Melody Miles,	Community Care Access Centre of Hamilton
Pat Morden,	Shalom Village Nursing Home
Gail Mores,	Ontario March of Dimes
Sherry Muir,	Bayshore Health Care
Jan Narduzzi,	Brain Injury Services of Hamilton
Jodi Phillips,	Saint Elizabeth Health Care Haldimand-Norfolk
Peter Szota,	St. Joseph's Healthcare
Donna Thomson	St. Peter's
Wendy Walker,	Community Support Services of the Niagara Region
Gary Zalot,	Niagara District Health Council
Marion Emo,	Committee Chair, Hamilton District Health Council

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LHIN 4
Patient Care / Services Integration Initiative

Geriatric Access and Integration Network (GAIN)

Patient Care/Services Integration Initiative
Geriatric Access and Integration Network (GAIN)

Title of patient care/service initiative	Type of integration
Geriatric Access and Integration Network (GAIN)	_X_ Horizontal _X_ Vertical _X_ Intersectoral ___ Other, describe:
Existing or new initiative?	**List of partners involved:**
_X_ Initiated/existing integration activity* _X_ New integration activity *Some integration work has already taken place. This initiative will provide the momentum to move this forward	LHIN 4 Geriatric Integration Initiative. Participant list in Section E.

Please briefly describe the initiative:

Initiative
A coordinated strategy to improve the quality of care for frail seniors.

Rational
A population health approach to inform health and human service organization should be adopted to respond to the complex requirements of our aging demographic. Seniors are living longer and presenting with more complex issues. Seniors are more educated about health care and expect better care. Access to patient and client centred support services and geriatric expertise across LHIN 4 is variable. Consumers, caregivers and providers merit increased confidence that people are receiving the right care in the right place at the right time as they age.

Objectives
- Equitable access to Specialized Geriatric Services. Clients with needs have the right to equal access to inpatient and outpatient geriatric services in LHIN 4.
- Improved coordination of services for client outcomes
- Enhanced integration of services leading to more effective utilization of resources
- Redistribution of resources based on best practice and population health needs.

Description
The GAIN initiative will focus on improved access to and integration of Specialized Geriatric Services (SGS) for improved patient care throughout LHIN 4. Access and integration enablers will include
- human resource planning
- applied best practice interventions
- common screening, referral and assessment (underway) and
- effective and continuous evaluation strategies

GAIN outcomes will include, among others, increased service alignment, sustained continuum of care, fewer inappropriate presentations/admissions to hospital, and increased consumer and provider knowledge about available resources to help maintain senior's independence "at home"

<table>
<tr><th>If this is an initiated/existing activity…
What is the current status?</th><th>What are the outcomes/lessons learned (if any)?</th></tr>
<tr><td>• A high level of readiness is evident.
• There is considerable intersectoral support from among front line clinical staff and program managers and executives across the continuum of care.
• LHIN 4 has access to key networks and coalition groups, universities and colleges.
• In addition, initiative momentum builds on existing enablers and resources: the provincial funding of 8 new Geriatric Emergency Managers (GEM) will help reduce unnecessary admissions to ER, educate staff and link with key resources (i.e., primary care) to promote improved quality of care; the dedicated Long Term Best Practice Resource Centre (Hamilton is the pilot site) improves staff access to best practice.
• Providers have considerable experience with network initiatives and collaborative, integration solutions for enhanced client outcomes and system performance, for instance in the areas of emergency health, end of life, and mental health and addictions.</td><td></td></tr>
<tr><th colspan="2">Lead contact person(s):</th></tr>
<tr><td colspan="2">Name: David Jewell
Title: Manager
Organization: Regional Geriatric Program central, St. Peter's
Telephone: 905-549-6525 x12435
Email address: djewell@stpetes.ca

Name: Pat Morden
Title: Administrator
Organization: Shalom Village Nursing Home
Telephone: 905-529-1613 x229
Email address: pat@shalomvillage.on.ca</td></tr>
</table>

Integration Activity Action Plan
Patient Care Integration Initiative

Integration Initiative:
Geriatric Access and Integration Network (GAIN)

Champions:
David Jewell, Manager, Regional Geriatric Program central, St. Peter's
Pat Morden, Administrator, Shalom Village Nursing Home

Approach
Assess opportunities for improved access to services, improved outcomes and effective resource deployment
- Conduct Specialized Geriatric Services (SGS) Inventory (in progress)
- Identify meaningful stakeholder engagement approaches within and across sectors
- SWOT analysis
- Identify range of SGS practice models and tools in existing programs, and scope of [defined] service integration (work in progress)
- Assess effectiveness of service delivery models, (this work is in progress across Ontario)
- Assess gaps in services against established benchmarks (Ontario Regional Geriatric Programs currently compiling best practice)
- Identify where existing resources can be utilized more effectively. This will also involve recommendations for redistribution of resources and areas requiring funding enhancement.
- Promote a culture of change that is action oriented, driven by patient centered values and best practice

Key Deliverables
- Identified strengths, weaknesses, opportunities, and threats for current specialized geriatric services
- Recommendations for GAIN, September 2005

Timeline
- September 05

Stakeholder Involvement
- Outside of LHIN 4, Specialized Geriatric Service Integration participants need to collaborate with other stakeholders, i.e., CCAC, Acute care, community agencies and other priority champions.
- Engage consumers at different access points; inpatient and outpatient to improve care delivery planning.

Risk Management

Assumption:
- Expect resistance to change
- A change in one part of the health system may impact service delivery

Enablers:
- Clear mandate with some resources to proceed.
- Early win(s) to build momentum for change.
- Excellent communication strategies to promote iterative dialogue
- Reasonable pace
- Need to be cognizant

LHIN 4
Patient Care / Services Integration Initiative

Integrating Mental Health and Addictions with Other Sectors

Patient Care/Services Integration Initiative
Integrating Mental Health and Addictions with Other Sectors

Title of patient care/service initiative	Type of integration
Integrating Mental Health and Addictions with Other Sectors	_X_ Horizontal _X_ Vertical _X_ Intersectoral ___ Other, describe:
Existing or new initiative?	**List of partners involved:**
_X_ Initiated/existing integration activity* _X_ New integration activity *Note: Initiated/existing activities do not need to be confined within LHIN boundaries	All mental health and addiction services/agencies in LHIN 4; providers of other health services that impact on or are impacted upon by mental health and/or addiction issues; services funded by other Ministries where there are cross-sector needs and issues (criminal justice, housing, social assistance)

Please briefly describe the initiative:

Population health needs - mental health and addictions

One in eight Canadians will be hospitalized for mental illness at least once in their lifetime; more than cancer and heart disease combined. Twenty percent of Canadians will suffer from a mental illness or addiction, and for three percent it will be persistently disabling. In 1998 Health Canada estimated the corresponding lost productivity at $8 billion a year. The cost to individuals, health care and society is severe. The opportunities for LHIN 4 are significant.

Overview of the transformation agenda

An individual's mental health is exquisitely and intricately linked to their physical health, psychological health, social and environmental conditions, and genetic inheritance. A home, adequate income, employment, and social supports are critical to recovery. To be successful the transformation agenda must address the full range of contributing factors.

The system of services for mental health and addictions in LHIN 4 is committed to supporting consumers as they strive to achieve wellness and realize their potential as citizens. The system intervenes to provide crisis management, case management, housing, employment, advocacy, consumer and family support initiatives.

Significant outcome improvements for LHIN 4, will require a greater integration of mental health and addictions services with other sectors and it is very important that we build on key strategic directions and existing strengths. Key elements of the transformation agenda are:

1. The central role the consumer and family – a "recovery based system"
2. Optimizing health outcomes and population health, through integration across sectors
3. Increasing the capacity for early detection and treatment in primary care
4. System level integration for concurrent (mental health and addictions) disorders
5. Building a system of integrated access

1. The central role the consumer and family – a "recovery based system"
Outcomes in addiction and mental health services are improved when consumers and families are empowered to make significant decisions about their own care and take responsibility for their recovery. This requires a shift from a traditional services system driven largely by professionals, to one in which consumers and families play an integral role in the planning and delivery of services; this is called a "recovery based system". Evaluation should be based on continuity of care across the full spectrum of health and social services.

2. Optimizing health outcomes and population health through integration across sectors
To optimize health outcomes and address the broader determinants of health, LHIN 4 will need a comprehensive strategy to target unemployment rates, educational attainment and the supply of affordable housing with support, for people with

mental health and addictions problems. The outcomes are dependent on quality as well as quantity and minimum acceptable standards must be identified and achieved. By facilitating productive lives and reducing the need for more intensive health services, there are significant benefits in terms of the social and economic fabric of the community, in addition to population health improvements.

3. Increasing the capacity for early detection and treatment in primary care
While 70% of Ontarians with a psychiatric disorder will receive no treatment over a one-year period, more than 80% of those Ontarians will visit their family doctor in the same period. This indicates a clear opportunity for LHIN 4 to improve outcomes through the widespread adoption of successful primary care models. Mental health services have been successfully integrated in a number of primary care settings in LHIN 4, including the nationally recognized best practice Hamilton HSO Mental Health and Nutrition Program. Such programs increase access to care for adults and children, reduce wait times, improve co-ordination of care and offer unique opportunities for early detection and intervention. They also align with primary health care reform, Family Health Teams and the Primary Health Care Transition Fund.

4. System level integration for concurent disorders (co-occurance of addiction and mental illness)
In LHIN 4 providers in both the mental health and the addictions sectors have already demonstrated leadership at the local and provincial level in implementing Health Canada Best Practices for people experiencing a combination of mental health problems with abuse of alcohol and/or psychoactive drugs. The implementation of best practices profoundly improves outcomes in terms of health, social and economic indices. A consistent and sustained approach to concurrent disorders is needed.

5. Building a system of integrated access
Access problems are a common criticism of the addictions and mental health systems. Implementation of district specific centralized information and an easy system for navigation must be developed. This initative would build on the IT strategy for LHIN 4 so that information is available across sectors and duplication avoided. Tertiary level services must ensure access is equitable and wait times (especially rural) would be essential indicators in a balanced scorecard.

If this is an initiated/existing activity… What is the current status?	**What are the outcomes/lessons learned (if any)?**
Work has been undertaken on all 5 initiatives. Progress varies significantly throughout the LHIN.	Local Networks are invaluable in priority setting and coordinating the system. Resources are essential to sustain these networks. Common data is needed for planning and evaluation. IT infrastructure is needed.

Lead contact person(s):

Name: Winnie Doyle
Title: Vice President, MH
Organization: St. Joseph's Healthcare
Telephone: 905-522-1155, ext. 6254
Email address: wdoyle@stjosham.on.ca

Integration Activity Action Plan
Patient Care Integration Initiative

Integration Initiative:
Integrating Mental Health and Addictions with Other Sectors

Champion:
Winnie Doyle, Vice President, MH, St. Joseph's Healthcare

Priority Opportunity – Integrating Mental Health & Addictions (MH & A) with other sectors

1. **Establish a Central Role for Service Users.**
   To ensure that service users are at the centre of the System, integrate consumers/families in all planning and evaluation at both the micro and macro levels of the healthcare services. LHIN resources must be dedicated to support and facilitate their participation. The level of participation would be evaluated and reported in the LHIN scorecard.
2. **Reducing the Stigma for Consumers.**
   A MH & A strategy to reduce stigma must be developed. This strategy would begin by focusing on reducing stigma in areas related to the five priorities and in public services.
3. **Create LHIN Infrastructure to Support the Action Plan.**
   Dedicate a senior executive from the LHIN to MH & A. Establish a LHIN 4 MH & A Stakeholder Committee with representation from each district. This committee would be key in informing and advising the LHIN CEO and Board.
4. **Maintain and Improve the Existing Local MH & A Network Committees.**
   These networks would be responsible for local system planning and evaluation. Resources must be provided to ensure success. These networks would be responsible for the detailed plan to implement the integration priorities in this document. The representative to the LHIN 4 MH & A Stakeholder Committee would be selected from this network.
5. **Human Resources Planning.**
   A human resources plan for MH & A must be developed. This plan must address the needs of both rural and urban centres and the role of Academic Centres. To facilitate the five priorities would be the first area of attention for HR.
6. **Education of Health Care Professionals.**
   Education of all health professionals must include core competencies in MH & A. A plan to incorporate these core competencies within educational programs will be developed and implemented.
7. **Dedicated Funding.**
   MH & A must receive dedicated, needs-based funding. The historical inequitable funding in community addiction and mental health programs must be addressed. The current funding as a minimum must be protected. 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.**
   The scorecard for the LHIN must include specific MH & A indicators that would reflect both local and LHIN 4 outcomes. Performance must be contextualized within provincial and national benchmarks.

LHIN 4
Patient Care / Services Integration Initiative

Health Promotion and Disease Prevention

Patient Care/Services Integration Initiative
Health Promotion and Disease Prevention

Title of patient care/service initiative	Type of integration
Health Promotion and Disease Prevention	X Horizontal X Vertical X Intersectoral ___ Other, describe:
Existing or new initiative?	**List of partners involved:**
X Initiated/existing integration activity* X New integration activity *Note: Initiated/existing activities do not need to be confined within LHIN boundaries.	All services/agencies in the LHIN 4 region that have a prevention and health promotion focus; services funded by other Ministries with cross-sector needs and issues (housing, social assistance. education and training).

Please briefly describe the initiative:

Initiative

A health promotion and disease prevention strategy for LHIN 4

Background Information
The goal for health promotion is to enable people to increase control over and improve their health by working within communities to create conditions for health (WHO 1986, CPHA 2001). To be effective, health promotion activities must engage communities and individuals at a population level in creating healthy public policy, building supportive environments, reorienting the health system as well as developing skills and educating on an individual level.

Objectives

To determine community needs through knowledge of epidemiology and context to determine health indicators, benchmarks, to provide surveillance activities, demographics, mortality, morbidity, data management, data analysis, community needs assessment, risk assessment and communications, monitoring of health outcomes and quality of life measures.
Changes in the health care environment

- Effective planning
- Increase in health status
- Identification of issues for planning and programming

Readiness
Currently District Health Councils, CWHPIN, Social Planning Councils, PHREDs and Health Department data analysts provide this service.

To implement strategies and address the determinants of health and involve broad community participation and extensive community partnership with other sectors and agencies.
Changes in the health care environment

- Increase accessibility
- Increase community participation
- Intersectoral cooperation and collaboration

Readiness
It is expected that implementation include intersectoral cooperation and coordination, assessment of community capacity, program planning, evaluation, policy development/analysis, data management, equity of access and negotiation and mediation. There are many examples across the LHIN 4 area of integration activities in this area - See the document Selected Integration Activities in LHIN 4 Areas prepared by the Hamilton DHC on behalf of LHIN 4 District Health Council November 23 2004. A gap exists in the area of evaluation - impact and outcome.

To focus on Health Promotion and Disease Prevention Aspects.

Changes in the health care environment

- Increased attention and allocation of funding to primary prevention health promotion activities realizing that the expected outcomes of any health promotion initiatives are long term.

Readiness

- 2004 Chief Medical Officer of Health Report is on Health Promotion Strategy for Healthy Lives
- Reports focused on Chronic Disease surveillance activities
- In Ontario, three quarters of the population have one or more risk factors for chronic disease development. To address this challenge, it is necessary to implement comprehensive, multiple risk factor strategies to reduce risks of developing disease. Knowledge of aspects of community development, social marketing, mass communication and media, health education, peer education, self management, advocacy, behaviour change education, community mobilization, creating supportive environments and developing personal skills are all aspects in improving the social and physical environment to support healthy living and prevention.
- Agencies and organizations that are focused on this mandate include public health departments which are mandated to provide prevention of disease, health promotion and health protection programs and services and work in partnership with other agencies such as Community Health Centers, Family Physicians, Pharmacists, Parish Nurses, Occupational Health, Pharmacists and NGO's.

If this is an initiated/existing activity… **What is the current status?**	**What are the outcomes/lessons learned (if any)?**
All initiatives have begun, progress varies throughout the LHIN.	• Multiple partners required • Due to complexities it is difficult to come to common ground • Different mandates, funding, legislations result in silos • Time intensive • Less incentive to work together due to different platforms • Duplications • Different health promotion frameworks/models
Lead contact person(s):	

Name: Maureen Harmer
Title: Acting Director, Healthy Lifestyles & Youth Branch
Organization: Public Health & Community Services Department, City of Hamilton
Telephone: 905-546-2424 x3589
Email address: mharmer@hamilton.ca

Name: Beatrice McDonough
Title: Public Health Nurse, Healthy Lifestyles & Youth Branch
Organization: Public Health & Community Services Department, City of Hamilton
Telephone: 905-546-2424 x3589
Email address: bmcdonou@hamilton.ca

Integration Activity Action Plan
Patient Care Integration Initiative

Integration Initiative:
Health Promotion and Disease Prevention

Champions:
Maureen Harmer, City of Hamilton, Public Health and Community Services Department
Bea McDonough, City of Hamilton, Public Health and Community Services Department

Approach

- Develop a comprehensive multi-sectoral action plan to address healthy living based on Best Practices.
- Develop a comprehensive Chronic Disease Management Strategy with community partners
- Develop a strategy to access funding support.
- Develop a targeted, strategic, well-resourced mass media campaign for the LHIN to increase awareness of the determinants of health.
- Develop policies and programs to support the determinants of health in relation to health promotion and prevention.
- Conduct ongoing LHIN wide health surveillance
- Partner with private sector and interministrial jurisdictions and other LHINs.

Key Deliverables
Because of the great diversity among the municipalities involved with LHIN 4, there will be complexities in bringing stakeholders to the table to plan for and address common and specific issues
Short term approach would be to:

- Conduct stakeholder meetings. Those invited to the table will be those groups, individuals etc. involved with the issue identified from surveillance, health status data from their particular community which can direct attention to certain local issues versus others e.g. one community 's issue could be seniors issues, or child and youth (school boards etc.), or women, etc. There will also be common areas e.g. obesity, chronic disease risk factors, determinants of health where all stakeholders involved with health promotion and primary prevention from all LHIN 4 communities can reach consensus on a plan of action.
- Develop a network and inventory of partners for each specific and common issue identified
- Increase communication and seek collaboration opportunities among communities
- Facilitate data collection and share in a timely manner, e.g. report card, surveillance data, quality of life, health status data
- Conduct quarterly/biannual meetings of stakeholders
- Establish collaborative campaign on determinants of health
- Develop a comprehensive plan to address healthy living based on best practices and determinants of health.

Timeline

- This will be an ongoing integration initiative.

Stakeholder Involvement.

- Identified stakeholders for each municipality and each issue will be involved at each stage of the development. This includes community participation.

Risk Management: Assumptions are that:

- All partners with different mandates and priorities will work together.
- There will be adequate funding to deliver identified initiatives
- Community will be involved
- Timelines are long term
- We have the capacity to carry out surveillance activities and communicate this to partners
- Social and recreational programs which promote health and well being will be at the table
- Communities can learn from one another
- There will be Provincial wide strategies and Integration and tie in with Federal level health initiatives
- Health promotion is throughout the lifespan
- LHIN will fund health promotion in balance with health care
- Definition of health is focused on health promotion as well as health care
- Enhanced coordination of community based secondary and tertiary prevention services and hospital based services would provide seamless continuity of care, enhanced quality of life and equal opportunities for all
- With a focus on health promotion and prevention health care costs will decrease

LHIN 4
Patient Care / Services Integration Initiative

Cross Sectoral Palliative Care / End of Life Care

Patient Care/Services Integration Initiative
Cross Sectoral Palliative Care / End of Life Care

Title of patient care/service initiative	Type of integration
LHIN 4 Cross Sectoral Palliative Care / End of Life Care	__ Horizontal ___ Vertical _X_ Intersectoral ___ Other, describe:
Existing or new initiative?	**List of partners involved:**
_X_ Initiated/existing integration activity* __New integration activity *Note: Initiated/existing activities do not need to be confined within LHIN boundaries.	Donna Thomson — V. P. Patient Services, St. Peter's Hospital (SPH) Carol Mckenna — Program Director, Palliative Care, SPH Ingrid Fell — CCAC Niagara Sherry Hnatyshyn — Bayshore Home Health Janet Noble — Director, Hamilton Hospice Palliative Care Network

Please briefly describe the initiative:

Initiative
LHIN 4 Regional End of Life Network to support common goals and strategies for effective end-of-life care and support.

Rational
End of Life Networks are in various stages of development in LHIN 4 planning areas. All networks are addressing requirements for effective service delivery in an environment characterized by limited resources. We recommend the creation of an over-aching End of Life Network for LHIN 4 to ensure that local networks will be formalized across the LHIN using a standard template for system design.

Common end of life system design and resource requirements for LHIN-wide expectations can be effectively and efficiently addressed through collective planning and development. The local networks would customize LHIN wide planning outcomes to meet local needs.

Objectives
- Coordinated and equitable access to palliative care services (in accordance with professional standards and government guidelines) across LHIN 4.
- Link and support existing palliative care networks in LHIN 4 by means of broad strategic planning, focusing on common palliative care program design requirements, such as,
    - Common philosophy and standards of care (CHPCA Norms of Practice) across the care continuum (interdisciplinary care models)
    - Consistent definition and criteria for access to care (coordinated entry point / system integration within continuum)
    - Best practice protocols
    - Continuous environmental scanning of End of Life support requirements in LHIN 4
    - Education – public & professional
    - System monitoring and evaluation
    - Advocacy
    - Research

Readiness
There is a readiness in LHIN 4 planning areas (Hamilton, Niagara, Brant, Haldimand, Norfolk, and Burlington) to design and implement End-of-Life care and supports. Network development is informed by local area studies, provincial and national reports, and the Provincial End of Life initiative.

<table>
<tr><th>If this is an initiated/existing activity…
What is the current status?</th><th>What are the outcomes/lessons learned (if any)?</th></tr>
<tr><td>Existing Integration Activities - LHIN 4

District Health Councils have been leading the development of EOL planning networks within each of the LHIN 4 geographic areas. The networks are at various stages of development. However, it is expected that each planning network will be established prior to the initiation of the LHIN 4 End of Life Care Network.

A brief summary of the status of the regional networks follows.

Hamilton - The Hamilton DHC conducted an environmental scan on the status of palliative care in Hamilton in 2001, and published a report in June 2002 calling for a city wide palliative care program. The Hamilton Hospice Palliative Care Network (HHPCN) was launched in June 2003 and is fully functioning.

Halton (Burlington) - A steering group is developing the Halton-Peel network model, using the previous Halton-Peel DHC plan which included an environmental scan as well as a proposed model for a Halton-Peel EOL network. The implementation timeframe is April 2005.

Grand River (Haldimand-Norfolk and Brant) – The Grand River DHC is developing two planning networks, one in Haldimand-Norfolk, the other in Brant. Steering group meetings have been held in both regions, and it is expected that the networks will be implemented in April 2005.

Niagara – The Niagara EOL Task Force is developing a network model based upon earlier planning work of the Niagara DHC. The Niagara EOL planning network will be implemented in April 2005.</td><td>A. The current state and the lessons learned to date for EOL planning are informed by a legacy of milestone documents including:

• 1990 Canadian Palliative Care Association (CPCA) established
• 1992 Funding by Ontario Ministry of Health for the Four Initiatives in Palliative Care to help improve the delivery of community-based palliative care.
• 1995 Senate Sub-Committee Report on Euthanasia and Assisted Suicide
• 2000 Senator Sharon Carstairs' report, Quality End of Life Care: the Right of Every Canadian
• 2002 Kirby and Romanow reports identified palliative care as one of the top priorities within the health care and support domain in Canada.
• 2004 First Ministers' Meeting
• 2004 MOHLTC transformation agenda-End of Life Care Strategy-to address trends of aging population as well as prevalence of chronic disease

B. Stakeholders involved in recent and current EOL planning identify several factors which contribute to the successful development and implementation of integrated networks:

• The Steering Committee membership must be comprised of senior leaders willing to commit time and resources to the development, implementation, and maintenance of the Network.
• The Network must have clearly articulated goals and objectives that reflect planning, not service delivery.
• The Network must develop its work plan early, identifying goals and tasks that are measurable and achievable.
• It is critical to the overall Network development that there be "early successes".</td></tr>
<tr><th colspan="2">Lead contact person(s):</th></tr>
<tr><td colspan="2">Name: Ingrid Fell
Title: Director of Case Management Operations
Organization: CCAC Niagara
Telephone: (905) 684 - 4811
Email address: ingrid.fell@niagara.ccac-ont.ca</td></tr>
</table>

Integration Activity Action Plan
Patient Care Integration Initiative

Integration Initiative:
LHIN 4 Cross Sectoral Palliative Care / End of Life Care

Champions:
Donna Thomson, V. P. Patient Services, St. Peter's
Carol McKenna, Program Director, Palliative Care, St. Peter's
Ingrid Fell, CCAC Niagara
Sherry Hnatyshyn, Bayshore Home Health
Janet Noble, Director, Hamilton Hospice Palliative Care Network

Approach

- Establish a plan to implement a new LHIN 4 PC/EOL Network with process steps, time frames and deliverables.
- Develop a framework / terms of reference for a LHIN 4 Palliative Care/End of Life Care (EOL) Network.

Key Deliverables

- LHIN 4-wide strategic planning for PC/EOL services / issues
- A common template for PC/EOL local system design across LHIN 4
- Integration of existing local PC / EOL networks
- Coordinated, equitable access to PC /EOL services: right care at the right time in the right place
- Evidence based PC/EOL best practice guidelines
- Integrated education and research strategies for PC/EOL
- LHIN-wide collaboration on the development of creative and innovative care delivery models

Timeline

- Framework / terms of reference = 3 months
- Establish work plan and launch new LHIN 4 PC / EOL Network = additional 3 to 6 months

Stakeholder Involvement

- Leadership of all existing PC/EOL networks in LHIN 4

Risk Management

Enablers
- LHIN wide support for common tools and practices for equitable access to PC/EOL supports.
- Local customization of service delivery models, to reflect unique realities (urban vs. rural, etc.).

LHIN 4
Patient Care / Services Integration Initiative

A Role for Community Services in Continuity of Care: Mapping Independent Living for Long-Term Care Populations in LHIN 4

Patient Care/Services Integration Initiative
A Role for Community Services in Continuity of Care:
Mapping Independent Living for Long-Term Care Populations in LHIN 4

Title of patient care/service initiative	**Type of integration**
A Role for Community Services in Continuity of Care: Mapping Independent Living for Long-Term Care Populations in LHIN 4	X Horizontal X Vertical __ Intersectoral __ Other, describe:
Existing or new initiative?	**List of partners involved:**
__ Initiated/existing integration activity* X New integration activity *There is a legacy of LTC community support planning from each DHC now incorporated in LHIN 4 as well as a variety of standing committees and service networks.	Cindy Kinnon, Participation House – Hamilton & District Wendy Walker, Community Support Services of the Niagara Region

Please briefly describe the initiative:

Initiative

Model an innovative planning approach for continuity of care for long term care populations that is inclusive of community service partners and sensitive to geography, population characteristics and need. The proposed focus is independent living requirements for long term care populations in LHIN 4. The role of community support services is integral to health system performance and citizen health gain in LHIN 4. The MOHLTC transformation agenda presents an opportunity to get on with planning approaches that are inclusive community service partners.

Rational

Local health planning has as a core focus the development of coordinated long-term care services in the community sector, often referred to as community support services. Community health includes those services and supports that enable seniors and persons with a physical disability, brain injury, or HIV/AIDS to live and function independently in the community. A well-resourced and coordinated system of community-based long-term care services can reduce hospital admissions, reduce length of stay and delay or prevent placement in a long-term care facility.

Community support services represent over 60 categories of services in the MOHLTC Planning, Funding and Accountability Policies and Procedures Manual. A recent initiative to re-organize long-term care services include the restructuring and provision of one component of community care and service - in-home nursing and other health professional and personal care - through Community Care Access Centres. Other planning and funding initiatives have taken place to strengthen the resource base and coordination of community support services, but with less success. The majority of community support re-organization initiatives have tended to adopt a system-wide perspective. However, community support services are a broad mix of services and supports serving diverse populations, with unique medical, functional and social needs, in a variety of geographic areas (e.g., rural, suburban, urban core).

Objectives

The objectives of "targeted" planning is to develop mechanisms for service design, implementation and system management to accomplish the following objectives:

- Improve client access and coordination by developing client pathways
- Enhance access by developing service and support packages
- Strengthen collaborative service planning through network development and distribution of resources based on best practice and population health needs.

Description

To enhance local health planning through LHIN 4, an initiative to a shift from system-wide planning approaches to a "targeted" planning approach is required. "Targeted" planning incorporates the mapping services and supports to design specific services mixes and client pathways according to geography, population characteristics and dimensions of need.

<table>
<tr><th>If this is an initiated/existing activity…
What is the current status?</th><th>What are the outcomes/lessons learned (if any)?</th></tr>
<tr><td>Indicate awareness of recent or existing initiative(s) that might be related to the proposed initiative. Briefly describe the recent/existing activity and its current status. How is the proposed initiative aligned with this existing and/or recent activity?

While there is no on-going initiative specific to the proposal, there is a legacy of district health council planning and local committees, coalitions and networks unique to each area in LHIN 4. Mapping the current activity levels will be necessary to appropriately engage these groups in planning (See Step 5), and to link the initiative to on-going implementation.</td><td>How does the recent or existing activity/activities
• inform the proposed priority and/or
• contribute to readiness or momentum?

A number of recent DHC long-term care planning activities that can be integrated and used to inform the proposed initiative:

• Scenario Techniques – Population Targets (Halton-Peel DHC)
• Network Analysis and Community Planning Survey (Hamilton DHC)
• LTC Census Survey (Central South DHCs)
• Service Information Framework (Niagara DHC)
• LTC Reporting Framework (Grand River DHC)

An integrated blend of these planning approaches and methods will establish an evidence-based platform for information collection and analysis to support the initiative.</td></tr>
<tr><th colspan="2">Lead contact person(s):</th></tr>
<tr><td colspan="2">Name: Cindy Kinnon
Title: Executive Director
Organization: Participation House - Hamilton & District
Telephone: 905-692-4465
Email address: cindykinnon@participationhouse.hamilton.on.ca

Name: Wendy Walker
Title: Executive Director
Organization: Community Support Services of the Niagara Region
Telephone: 905-892-7779
Email address: mowcssfonthill@on.aibn.com</td></tr>
</table>

Integration Activity Action Plan
Patient Care Integration Initiative

Integration Initiative:
A Role for Community Services in Continuity of Care:
Mapping Independent Living for Long-Term Care Populations in LHIN 4

Champions:
Cindy Kinnon, Executive Director, Participation House – Hamilton & District
Wendy Walker, Executive Director, Community Support Services of the Niagara Region

Approach and Deliverables

To enable the initiative to accomplish the objectives, the following steps are required to develop the appropriate planning and system management information:

- **Community Engagement and Consensus Building:** Establish LHIN 4 advisory committee(s) providing expertise and experience in long-term care community support service delivery to provide direction and input on implementation of the initiative.

- **Identify "Client Groups"** - Through a collaborative process of consensus building, use scenario development methods to identify client groups based on health, functional and social need.

- **Design Client Pathway Maps and Services:** Use process mapping techniques to identify appropriate client pathway and service mix for each client group

- **Assess Current Service Organization:** Through the use of network analysis assess the current mix of services and client pathways in relation to the new client service designs (See step 3).

- **Develop Service Planning Networks:** Service planning networks to be developed as required and existing networks to be strengthened for each "Client Group" to proceed with joint planning and service implementation.

LHIN 4
Administrative Support Services Integration Initiative

Integrated Information Technology / Information and Communications Technology Strategy for the LHIN

Administrative Support Services Integration Initiative
Integrated Information Technology/Information and Communications Technology Strategy for the LHIN

Title of patient care/service initiative	**Type of integration**
Integrated Information Technology/Information and Communications Technology Strategy for the LHIN	___ Horizontal ___ Vertical X Intersectoral ___ Other, describe:
Existing or new initiative?	**List of partners involved:**
__ Initiated/existing integration activity X New integration activity	Participants from the Regional eHealth Forum held January 10, 2005 (list attached).

Please briefly describe the initiative:

Initiative
Establish an Information Management Governance structure with intersectoral representation to lead the development of an information system strategic plan.

Rational
Information and Communications technology is a key enabler in the MOHLTC transformation agenda. Creation of an integrated information and communication technology strategy for Hamilton Niagara Haldimand Brant Local Health Integration Network LHIN 4 will be critical to the smooth transformation and effective and efficient function of the LHIN. Projects proposed in this submission are consistent with Canada Health Infoway's priority projects, and provincial e-Health priorities and will support the Ministry's transformation agenda.

This initiative will result in an integrated system of information and communication technology that will put infrastructure and processes in place that will support any transformation plans of the LHINs.

Objectives
Patient Care:
Provide a comprehensive and secure clinical view of patient information accessible by all authorized care providers from any location to achieve improved patient outcome/experience.

Administrative:
Integration of financial, clinical and statistical information for effective and efficient utilization of scarce resources. Facilitate population based health planning vis-à-vis health promotion/wellness and disease prevention/management.

Readiness:
The LHIN community is ready for this type of initiative. Information systems and technology initiatives have the potential for high impact advances. To improve the capacity for communication and data sharing amongst health care partners across many sectors (including connecting primary care provider offices) is a goal that will improve the efficiencies and effectiveness of many organizations.

The enabler that is in place to achieve the goal is the readiness of the sectors to start this type of initiative which builds on sector-specific initiatives currently underway. The outcomes for each specific project within the work plan will be measurable e.g. development of a unique patient identifier.

<table>
<tr><th>If this is an initiated/existing activity…
What is the current status?</th><th>What are the outcomes/lessons learned (if any)?</th></tr>
<tr><td>Intersectoral planning is new.

Sector-specific projects that have been initiated include:
• EMR in Primary Care Practices (Dr. K. Burgess)
• e-Learning/e-Health at McMaster Faculty of Health Sciences (Dr. A. Levinson)
• Ontario Criticall Program (S. Moneta)
• Online Community of Practice: for Substance Abuse Prevention Workers in Ontario (R. Valaitis)
• CCAC e-Health Initiatives (P. Creighton)
• Hamilton CCAC/Stakeholder Web Portal (D. Redfern)
• Regional Hospital e-Health Initiatives (B. Kathiresan)</td><td>The need to establish:
• a governance structure
• project charter
• a sustained focus on system benefits</td></tr>
<tr><th colspan="2">Lead contact person(s):</th></tr>
<tr><td colspan="2">Name: Bala Kathiresan
Title: Chief Information Office
Organization: Niagara Health System
Telephone: 905-323-3110
Email address: bkathiresan@niagarahealth.on.ca

Name: Melody Miles
Title: Executive Director
Organization: Hamilton CCAC
Telephone: 905-526-3610
Email address: melody.miles@hamilton.ccac-ont.ca</td></tr>
</table>

Integration Activity Action Plan
Administrative Support Services Integration Initiative

Integration Initiative:
Integrated Information Technology/Information and Communications Technology Strategy for the LHIN

Champions:
Bala Kathiresan, Chief Information Officer, Niagara Health System
Melody Miles, Executive Director, Hamilton CCAC

Approach

- Establish Terms of Reference and guiding principles for the intersectoral information Management Governance Committee
- Define and recruit membership and a working leader
- Prepare work plan
- Describe projects, including but not limited to:
    - technology/network inventory for each organization that would enable us to develop a plan in the immediate term to build on SSH initiatives and establish connectivity;
    - clinical information and collaborative portals; and
    - a Regional Master Patient Index.
- Identify project projects leaders, time lines and measurable outcomes.

Key Deliverable

- The formation of an Information Management Governance Committee that will deliver on projects to meet the goal of creating an integrated information and communication technology for the LHIN.

Timeline

- The committee will be formed immediately.
- The work plan will be developed, and specific projects will be achieved within the next 12 - 18 months.

Stakeholder Involvement

- To be determined at first meeting.
- The committee structure will also include project-specific working groups.

Risk Management
Enablers:

- A balance of communication and representation across the sectors
- Attention to inclusion of small [community-based] and large organizations
- Resource requirements.

LHIN 4
Administrative Support Services Integration Initiative

Tools and Approaches to Sustain Patient-Centred Community-Based Networks

Administrative Support Services Integration Initiative
Tools and Approaches to Sustain Patient-Centred Community-Based Networks

Title of patient care/service initiative	Type of integration
Tools and Approaches to Sustain Patient-Centred Community-Based Networks	X Horizontal X Vertical X Intersectoral ___ Other, describe:
Existing or new initiative?	**List of partners involved:**
X Initiated/existing integration activity __ New integration activity	Attachment: List of individuals and organizations that participated in the identification and development of this opportunity. The work was co-lead by Rita-Marie Hadley, Grand River DHC, Jodi Phillips, Saint Elizabeth Health Care and Bill Bloor, CCAC Niagara.

Please briefly describe the initiative:

Initiative
LHIN 4 sponsorship of best practice approaches and tools, and required resources for effective networks to advance health system performance.

Rational
Formal and informal networks are an essential mechanism to facilitate planning, continuity and coordination of broad health issues. Across LHIN 4, networks develop and sustain integrated and coordinated services for health gain and enhanced system performance. For LHIN 4 to be successful, networks will be a key mechanism to provide the LHIN 4 team with both access to broad stakeholder groups and a platform to support integration

Existing network approaches for health gain and health system improvement are important assets for LHIN 4. The extent to which identified critical success factors and best practices are shaping successful network outcomes in LHIN 4 should be evaluated and promoted for broad uptake.

Objectives
- Improve LHIN 4 networks' effectiveness and efficiencies through the use of best practice approaches.
- Enhance inclusiveness and collaboration among existing networks throughout LHIN 4, ensuring stakeholder participation from Burlington in the southeast and Blandford-Blenheim in the northwest.
- Promote feasible structure and accountability mechanisms
- Leverage funding opportunities for provincially-mandated networks

Readiness
There is a high level of readiness within LHIN 4 to sustain and further develop networks as a preferred mechanism for collaborative planning and transformation.

<table>
<tr><th>If this is an initiated/existing activity…
What is the current status?</th><th>What are the outcomes/lessons learned (if any)?</th></tr>
<tr><td>An increasing body of evidence demonstrates the effective use of networks as mechanism to support communication, collaboration and integration.

• Networks are a successful mechanism for undertaking health planning, service coordination and development activities
• Networks promote innovation.
• Networks are a successful model for capturing the leadership necessary to achieve shared goals and implement significant reform.

The effectiveness of existing networks varies widely and is largely related to the presence or absence of barriers and enablers identified in, for example, the recent report “Accountability, Continuity and Effectiveness: Health Networks in Ontario” published by The Change Foundation in November 2004.

Central South District Health Councils have preliminarily identified some 50 networks in LHIN 4. These networks provide a forum for discussion on ways of work (structures, processes and resources) that promote effective outcomes.</td><td>In its November 2004 report, “Accountability Continuity and Effectiveness: Health Networks in Ontario”, the Change Foundation identifies characteristics of the ideal network and enablers. Characteristics include: a) transparency (revealing the success, challenges, and failures); b) an environment where all participants are considered equal; and c) clarity of expectations, decision making processes and outcomes, and roles and responsibilities.

Enablers for a successful network include:
• Strong focused leadership
• A shared vision
• Innovative approaches
• Clear accountability
• Inclusive participation

Networks are most successful when:
• funding is available to support administrative/coordination functions
• key system players are actively involved
• adequate resources are available to allow agencies and individuals to fully participate
• accountability structures and mutually shared objectives are explicitly identified and defined
• all participants are considered equal and share a common vision.</td></tr>
<tr><th colspan="2">Lead contact person(s):</th></tr>
<tr><td colspan="2">Name: Bill Bloor
Title: Executive Director
Organization: CCAC Niagara
Telephone: 905-684-4811 (x400)
Email address: bill.bloor@niagara.ccac-ont.ca

Name: Rita-Marie Hadley
Title: Planning Director
Organization: Grand River District Health Council
Telephone: 519-756-1330 (x223)
Email address: rmhadley@grdhc.on.ca

Name: Jodi Phillips
Title: Manager
Organization: Haldimand Norfolk & North York SDC’s, Saint Elizabeth Health Care
Telephone: 416-498-3805 (x2272)
Email address: jphillips@saintelizabeth.com</td></tr>
</table>

Integration Activity Action Plan
Administrative Support Services Integration Initiative

Integration Initiative:
Tools and Approaches to Sustain Patient-Centred Community-Based Networks

Champions:
Bill Bloor, Executive Director, CCAC Niagara
Rita-Marie Hadley, Planning Director, Grand River District Health Council
Jodi Phillips, Manager, Haldimand Norfolk & North York SDC/s, Saint Elizabeth Health Care

Approach & Key Deliverables

- Create a sustainable data base for LHIN 4 Networks
- Promote best practices for network ways of work – processes, structure, acountablities
- Create indicators of network effectivenes
- Identify and secure resources to sustain networks, inclusive of mechanisms to support participation of smaller players and using technology to span the broad geography
- Identify criteria for local area networks and LHIN-wide networks (respecting economies of scale, natural affinities, current service flows and relationships(transportation across the LHIN as an example)
- Develop a mechanism to support comunication links among LHIN 4 networks.
- Establish a consistent LHIN-wide framework for holding networks accountable to plan for and integrate service development in local communities; address population health needs based on evolving capacities and LHIN priorities and best-practices.

Timeline

- Within a twelve month cycle.

Stakeholder Involvement

- All stakeholders would be involved at all stages of the process including the membership of all relevant Networks across the LHIN.

Risk Management

Assumptions:

- Formal and informal networks are essential mechanisms to facilitate planning, continuity and coordination of broad health issues in LHIN 4
- The role of Networks for coordination and integration is supported by LHIN 4
- LHIN 4 will promote best practice approaches for successful network processes and outcomes.

LHIN 4
Administrative Support Services Integration Initiative

Integrated Human Services Systems Planning for Population Health and Wellness in LHIN 4

Administrative Support Services Integration Initiative
Integrated Human Services Systems Planning for Population Health and Wellness in LHIN 4

Title of patient care/service initiative	Type of integration
Integrated Human Services Systems Planning for Population Health and Wellness in LHIN 4	X Horizontal X Vertical X Intersectoral ___ Other, describe:
Existing or new initiative?	**List of partners involved:**
__ Initiated/existing integration activity* X New integration activity *Note: Initiated/existing activities do not need to be confined within LHIN boundaries	Jan Narduzzi, ED, Brain Injury Services of Hamilton Mae Radford, Manager, VON Hamilton Volunteer Services Susan Roach, Program Manager, Haldimand-Norfolk Resource Centre Peggy Guiler-Delahunt, Program Assistant and Peer Specialist Coordinator Gail Mores, Regional Director, Ontario March of Dimes, South Central Region

Please briefly describe the initiative:

Initiative
A human services systems network for LHIN 4.

Rationale
Research has consistently demonstrated that the health of the population is influenced by many factors outside the health system such as housing, city design including transportation, income, education and our relationship with friends and family. These broader determinants of health lie outside the health care envelope and yet are key to health gain and healthy communities.

MOHLTC and communities continue to engage in health planning that focuses on issues and related decision makers (policy and finding) within the traditional boundaries of the health sector. Yet health services and supports are influenced by federal, provincial and/or municipal policies and funding in environments characterized by change and unpredictability, and health outcomes are influenced by the broad determinants of health in concert with access to health services. While the growth and development of inter-organizational cooperation and planning is evident, it is not necessarily coordinated and linked.

This initiative proposes to ask the question: what steps can be take to coordinate planning across various policy sectors at the local and LHIN 4 level, and what is required to sustain this approach?

Objectives
- Better informed decision makers on impacts across sectors of policy, program and funding shifts in any one sector.
- Shared goals for healthy communities among LHIN 4 human services.
- Assessment of legislative enablers at all 3 levels of government for LHIN 4 health community goals and sustained continuity of care and support.
- Proactive strategic advice to human service decision makers in LHIN 4.

Description
The MOHLTC transformation agenda can be a catalyst for addressing the full range of issues that have an impact on community health, and, influence the pace at which the MOHLTC can achieve health system performance goals. Lack of affordable housing and supporting housing options, and poorly integrated transportation services, for instance, pose barriers at the local for mental health reform, and access to services and sustained independence in the community.

The human services systems network – inclusive of, for example, decision makers from health, social and public health services, Child and Family Services, boards of education, discretionary finders (e.g. United Way, community foundations),

training and development programs, to name a few – will identify cross jurisdictional issues for problem resolve and enablers for shared policy goals in LHIN 4.

If this is an initiated/existing activity… What is the current status?	**What are the outcomes/lessons learned (if any)?**
Indicate awareness of recent or existing initiative(s) that might be related to the proposed initiative. Briefly describe the recent/existing activity and its current status. How is the proposed initiative aligned with this existing and/or recent activity? • Mental health networks across LHIN 4 include for example, housing, social service, and public health stakeholders to support alignment of enablers for the continuum of recovery based mental health services in respective jurisdictions. A human service managers group (Hamilton) meets regularly to share sector policy and program developments, strategic directions for goal alignment and effective use of resources where feasible, and identified gaps and opportunities for local system improvement.	• There is a high level of readiness among formal and informal partnerships to work together. • There are well-established relationships among local and regional initiatives and McMaster University. This platform can support research requirements for problem solving. • The value of intelligence sharing and collaborative problem solving for wide gain trumps independent functioning for limited gain.

Lead contact person(s):

Name: Gail Mores
Title: Regional Director
Organization: Ontario March of Dimes, South Central Region
Telephone: 905-528-6585
Email address: gmores@dimes.on.ca

Integration Activity Action Plan
Administrative Support Services Integration Initiative

Integration Initiative:
Integrated Human Services Systems Planning for Population Health and Wellness in LHIN 4

Champions:
Gail Mores, Executive Director, Ontario March of Dimes, Central South Region
Jan Narduzzi, Executive Director, Brain Injury Services of Hamilton

Approach and Deliverables, Year 1

Initiative approach and deliverables require a blend of a) internal processes to enable the Network to provide effective leadership; b) the acquisition and development of information; and c) the creation of goals and recommendations to guide cross sector and inter ministerial planning and coordination.

- Confirm readiness (2 months)
  Scope the range of integrated human service networks across LHIN 4, assess key success factors and seek advice on enablers for a regional network development (I progress)

- Seek input of LHIN 4 leadership – Board Chair and CEO (one month)
  Seek advice on how the Human Services System Network can be useful to the LHIN leadership

- Develop network table (2 months)
  In concert with LHIN 4 stakeholder advice and the input of LHIN leadership, identify sector champions, develop first terms of reference and ways of work.

- Network Work Plan (3 months)
  The Human Services System Network
    - consults with existing health networks and seeks advice on its role
    - assesses current hot spots for early cross sector deliberation and advice
    - identifies LHIN 4 timelines for annual/multi year priorities for alignment of Network opportunities for input
- Network Communication Plan and Framework for Network Performance Measurement (1 month)

Timeline
- Year 1: Development phase (as above) April to December 2005

Stakeholder Involvement
- Multi sector and multi level.

Risk Management
Assumption:
- Organizations, programs and groups will move beyond discrete policy and funding interests and find ways to coordinate ongoing planning and decision-making environments.

Risks:
- Adversity to shared accountability
- Increased scope of policy and decision issues given a wider lens to consider
- Creation of unmet expectations

LHIN 4
Administrative Support Services Integration Initiative

Development of a LHIN 4 Report Card for Performance Measurement

Administrative Support Services Integration Initiative
Development of a LHIN 4 Report Card for Performance Measurement

Title of administrative support service initiative:	**Type of integration**
Development of a LHIN 4 Report Card for Performance Measurement	X Horizontal X Vertical X Intersectoral __ Other, describe:

Existing or new initiative?	**List of partners involved:**
__ Initiated/existing integration activity* X New integration activity *Note: Initiated/existing activities do not need to be confined within LHIN boundaries	Adult Mental Health [Haldimand/Norfolk], Grand River District Health Council, Hamilton District Health Council, LTC-Haldimand County McMaster University, Niagara District Health, Norfolk General Hospital, Regional Geriatric Program central, Therapy Healthcare, VON [Hamilton], Ontario Osteoporosis Association, Marchese Health Care (Pharmacy), Therapy Health Care, Consumer Representative

Please briefly describe the initiative:

Initiative

A performance report card for LHIN 4 focusing on

- health care availability, access and effectiveness;
- satisfaction of patients and clients with the health care system; and,
- fairness in funding/incentives.

Rationale

Decision makers, providers and taxpayers are interested in reliable, accessible and understandable information on health needs, interventions and outcomes [both financial and quantitative]. Stakeholders want to know how their community compares to others, and if their health care system is responding adequately to local needs.

Ensuring accountability to the community was cited as a priority in more than half of all LHIN workshops Fall 2004. This interest derives from a wide range of motivations including: promoting stronger governance, better accountability, improved community understanding of health systems, enhanced consumer influence within health systems, competition between providers and services, and, quality improvement.

The significant work to date on health system performance indicator development in Ontraio and across Canada should form the basis of local health system monitoring in LHIN 4, recognizing the opportunity to incorporate additional indicators deemed relevant for particular communities.

<table>
<tr><th>If this is an initiated/existing activity…
What is the current status?</th><th>What are the outcomes/lessons learned (if any)?</th></tr>
<tr><td>There is a significant amount of health system monitoring development and reporting in various sectors. This good work needs to be integrated with LHIN 4 performance monitoring activities. Steps must be taken to incorporate public health and primary health care monitoring for improved integration of the health care system.

Existing initiatives include:

• District Health Councils in Ontario conduct local health system monitoring and report health status and health system performance utilizing a standardized set of indicators
• District Health Councils have recently prepared a technical document recommending indicators to monitor integration and accessibility; other work has been prepared by various DHCs considering various approaches to measuring health equity
• Central South District Health Councils have initiated a census based approach to examine long-term care services provided to clients
• Ontario Mental Health Implementation Task Force reports recommend indicators to monitor mental health performance
• Ontario Hospital Association/ University of Toronto Hospital Reports. This performance measurement framework involves 4 quadrants: clinical utilization, patient satisfaction, financial performance, and system integration and change.
• The Institute for Clinical Evaluative Sciences (ICES) has proposed framework for public health performance monitoring.
• Various organizations have proposed indicators to monitor home care.

It is essential to note that LHIN 4 boundaries do not align with existing data resources and this issue must be addressed with both the Ministry and data sources such as Statistics Canada, Canadian Institute for Health Information, Institute for Clinical Evaluative Sciences.</td><td>Experience in performance monitoring has demonstrated that community-based services in Ontario currently require enhanced information technology (IT) resources and experience to contribute data and information to health system monitoring. It is critical that this work begin early.

Expected outcomes:

• Improved transparency and demonstration of accountability from LHINs to the public
• Development of Guiding Principles should eliminate duplication of performance monitoring initiatives across the 14 LHINs
• Should support identification of best practice among LHINs
• Improved health system performance and better integration
• Information that can assist policy makers to identify trends and patterns, inform decision making and support evaluation
• This reporting system would emphasize patient outcomes (such as health status, health utilities, and clinically significant change), which are acknowledged to be the weakest elements of existing frameworks.</td></tr>
<tr><th colspan="2">Lead contact person(s):</th></tr>
<tr><td colspan="2">Name: Chris Carew
Title: Executive Director
Organization: Grand River District Health Council
Telephone: 519-756-1330
Email address: ccarew@grdhc.on.ca

Name: David Lewis
Title: Director, Research and Evaluation
Organization: Regional Geriatric Program central & McMaster University
Telephone: 905-777-3837 x12436
Email address: lewisd@mcmaster.ca</td></tr>
</table>

Integration Activity Action Plan
Administrative Support Services Integration Initiative

Initiative Name:
Development of a LHIN 4 Repot Card for Performance Measurement

Initiative Champions:
Chris Carew, Executive Director, Grand River District Health Council
David Lewis, Director, Research & Evaluation, Regional Geriatric Program central & McMaster University

Approach, Deliverables, Timelines

At LHIN launch

- Inform organizations governed by LHIN 4 of the project and its purpose as outlined herein. Inform the public likewise.

1-6 months

- Inventory existing performance indicator/ balanced report card strategies in health services across LHIN 4. Most include clinical utilization, outcomes, patient satisfaction, financial performance, and perhaps system integration.

- Assess potential for adoption of outcomes, service utilization, and other performance indicators in use by CIHI, ICES, Health Authorities or equivalents in British Columbia, Quebec and across Canada. It is recognized that many of these will be negative outcomes (such as mortality, adverse events, readmissions, and loss of independence).

- Assess use of such indicators in other OECD countries, notably the US and UK. Some likely candidates for outcomes indicators are the EuroQOL and the SF-12.

1-3 months

- Obtain majority agreement across like services (e.g. community mental health, acute care, etc.) about appropriate indicators. Obtain public input, using existing mechanisms, the press and other media, and the Internet.

- Obtain funding, possibly through a set-aside of 1-5% of organization budgets

1 month

- Determine sample sizes and study intervals.

12 months

- Implement, Report, Review results and reformat as needed

Annual

- Repeat cycle on annual basis

LHIN 4
Administrative Support Services Integration Initiative

Continuing the LHIN 4 Dialogue: Next Steps

Administrative Support Services Integration Initiative
Continuing the LHIN Dialogue

Title of patient care/service initiative	Type of integration
Continuing the LHIN 4 Dialogue: Next Steps	_X_ Horizontal __ Vertical _X_ Intersectoral ___ Other, describe:
Existing or new initiative?	**List of partners involved:**
_X_ Initiated/existing integration activity __ New integration activity	Marion Emo, Executive Director, Hamilton District Health Council Gary Zalot, Executive Director, Niagara District Health Council

Please briefly describe the initiative:

Initiative

Roundtable forums to identify requirements and tools for ongoing dialogue between the LHIN and its natural "communities" that support agenda setting and evidence-based planning.

Background

The principles guiding the LHINs emphasize people-centred, community-focused care that respond to local population health needs. Accountability between providers, government, communities, and citizens will be shared. To successfully achieve these ends, the LHINs must embody a strong and independent mechanism, capable of carrying out dialogue for evidence-based community health planning – a critical component of health system development.

LHINs are understandably large with respect to both geography and population. They represent a multitude of diverse circumstances and needs that impact on the planning and delivery of health care services. A planning approach and mechanism that will enable LHINs to "drill down" to appropriate community levels, and ensure local input, will be essential.

The community-based planning component of the LHINs must feature salient ingredients in sufficient volume, and with sufficient quality, to make community-based planning and dialogue relevant and useful to the other tasks that LHINs and their partners must carry out.

Objective

- Timely, visible and credible dialogue processes and approaches that support LHIN agenda setting and evidence-based planning.

Description

LHIN 4 stakeholders support the stated role of Local Health Integration Networks: LHINs will engage communities in health system transformation by enhancing and supporting local capacity to plan, coordinate, integrate and fund the delivery of health care services at the community level. Of necessity is the need to engage communities on the tools and practices to support this dialogue and sustain momentum for transformation. There is high readiness for this dialogue: stakeholders are keen to work with LHIN leadership, and DHCs have developed tools to set the stage for ways of work (evidence-based decision making, ethical stakeholder engagement, etc.) The Project Steering Committee for LHIN 4 as well endorses performance measurement approaches to monitor effectiveness of tools and practices.

<table>
<tr><th>If this is an initiated/existing activity…
What is the current status?</th><th>What are the outcomes/lessons learned (if any)?</th></tr>
<tr><td>Indicate awareness of recent or existing initiative(s) that might be related to the proposed initiative. Briefly describe the recent/existing activity and its current status. How is the proposed initiative aligned with this existing and/or recent activity?

• District Health Councils of Ontario have collectively advanced requirements to support the importance of community-based planning in a paper developed by Peter Deane, Northern Shores DHC. The Importance of Community Based Planning in the Development of Health Integration Networks. 2004.

• The Hamilton DHC has advanced best practice tools to support evidence-based planning. “Ethical Stakeholder Engagement” guides the ways in which initiatives can engage stakeholder dialogue in meaningful and relevant ways.</td><td>• The existing tools and approaches serve as a departure point for shared dialogue – LHIN leadership and natural communities – to identify ways of work to support relationship building for mutual agenda setting.</td></tr>
<tr><th colspan="2">Lead contact person(s):</th></tr>
<tr><td colspan="2">Name: Marion Emo
Title: Executive Director
Organization: Hamilton District Health Council
Telephone: 905-570-0354 x125
Email address: emomari@hdhc.ca

Name: Gary Zalot
Title: Executive Director
Organization: Niagara District Health Council
Telephone: 905-682-7000 x15
Email address: gzalot@niagaradhc.on.ca</td></tr>
</table>

Integration Activity Action Plan
Administrative Support Services Integration Initiative

Integration Initiative:
Continuing the LHIN 4 Dialogue: Next Steps

Champions:
Marion Emo, Executive Director, Hamilton DHC
Gary Zalot, Executive Director, Niagara DHC

Approach and Key Deliverables
Identify natural communities for feasible dialogue on "continuing the dialogue".
- Inclusions might be; Project Steering Committee for LHIN 4, LHIN 4 districts, existing integration networks by sector, program, patient/client service group

Develop a framework for dialogue, considering the following elements
- Models for stakeholder input
- Elements of procedural fairness
- Flexible approaches to systems planning
- Meaningful and manageable planning units
- Local connectivity to decision makers

Evaluate feedback on open space concept experience in the LHIN consultations and assess opportunity for replication

Identify preferred and evidence based approaches to continuing the dialogue in literature and consultation

Model a framework for feedback.

Identify pilot approaches for application and evaluation.

Timeline
- 9 months (April-December 2005)

Stakeholder Involvement
- LHIN 4 leadership – Board and CEO
- LHIN 4 Project Steering Committee
- Natural "communities" as defined above

Risk Management
Assumptions
- Best practice should guide tools and approaches for continuing the dialogue
- Stakeholders are ready to build a relationship with LHIN leadership and functions and contribute to the transformation agenda.

Risks
- Expectations of the LHIN functions are high, including those for community engagement to support local decision-making.

Priority Setting of Proposed Integration Activities

Priority Setting of Proposed Integration Activities

The Project Steering Committee for Local Health Integration Network 4 unanimously determined at its meeting on January 17th, 2005, that the already identified ten (10) integration initiatives would not be prioritized or ranked.

Principle reasons include:

a) The ten (10) initiatives represent already prioritized integration activities among some 48 ideas presented and discussed at the LHIN 4 workshop in November 2004.

b) LHIN 4 integration champions acknowledged that most if not all of the initiatives are consistent with recent and current MOHLTC priorities for a safe, accessible and effective health system.

c) Emerging factors that would enable or preclude a priority moving forward for example the MOHLTC Corporate Business Plan, are unpredictable.

d) There is increasing appetite among stakeholders to carry on with integration activity, where feasible, that moves the yardstick for all integration activities described.

The Role of Academic Health Sciences Centres in LHIN 4

The Role of Academic Health Sciences Centres in LHIN 4

Academic Health Science Centres (AHSCs)

AHSCs are characterized by their tripartite mission of clinical service (tertiary and quaternary), education and research[1]. They also typically provide hospital services (primary and secondary) to the population in their immediate vicinity. The activities of each AHSC is closely integrated with one of Ontario's six medical schools. LHIN 4 contains two (AHCSs), namely, Hamilton Health Sciences and St. Joseph's Healthcare Hamilton; both are affiliated with McMaster University. These centres have the capacity to champion service integration and coordination, support planning processes and provide a focal point for world-class research. It is important that the expertise within the AHSCs be available to increase capacity across the LHIN.

Planning Implications for LHIN 4

The role of AHCS has been recognized in a number of Federal and Provincial Reports (including Romanow and Kirby) and is typically described in terms of the following impacts on health services:

Tertiary and quaternary services have regional responsibilities. The design and management of the health system in LHIN 4 will have an impact on equity of access, clinically effectiveness, and efficient use of resources. The academic component of these programs (education and research) is critical to the recruitment and retention of clinicians and the quality (best practice standards) of the service provided. The coordination of these services with associated secondary and primary care services across the region offers the potential of improved outcomes and efficiency. With the inception of the LHIN it will be very important for the AHSCs to build on existing work to improve access and outreach throughout the LHIN.

The training of health care professionals is vital to the overall functioning of the system and the availability of health services personnel is critical to the capacity of clinical services, education and research in LHIN 4. The presence of McMaster University and teaching institutions provides an opportunity to secure future new health services personnel by recruiting learners as they graduate to the LHIN 4 health care providers in which they trained.

Health research has been termed "the lifeblood of medical discovery and innovation"[2], a role that provides benefits regionally, nationally and internationally. Health research and teaching also increase the speed of adoption of new techniques, technologies and best practice standards and provide the intellectual capacity to do so. Health research is also an important component of recruitment and teaching, and is essential to achieve the specialized clinical skills required for specialized clinical programs in AHSCs. The research conducted at the AHSCs in Hamilton includes internationally recognized research in the areas of clinical epidemiology, primary care services, population health and health technology assessment. The expertise in these and other areas provide an opportunity for knowledge transfer within the LHIN 4 to significantly enhance planning, service delivery, and outcomes measurement.

Provincial, national and international opportunities are provided by the AHSCs in LHIN 4. AHSC and their services are not limited to LHIN boundaries. AHSCs frequently play a role in provincial, national and international arenas and this needs to be considered in LHIN planning processes.

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[1] AHSC are listed in the Public Hospitals Act as teaching hospitals.
[2] Association of Canadian Academic Health Organizations (ACAHO)

Voluntary Networks' Role in LHIN 4

Voluntary Networks' Role in LHIN 4

Formal and informal networks are an essential mechanism to facilitate planning, continuity and coordination of broad health issues. Across LHIN 4, networks develop and sustain integrated and coordinated services for health gain and enhanced system performance. For LHIN 4 to be successful, networks will be a key mechanism to provide the LHIN 4 team with both access to broad stakeholder groups and a platform to support integration.

Interest in networks as a mechanism to promote innovation, coordination and effectiveness in services delivery[1] is evident in the groundswell of networks across LHIN 4.; our area networks effectively engage disparate participants across sectors and geography. Approximately fifty active networks have been identified as contributing to healthy communities, with origins ranging from provincial mandates to needs identified by stakeholders across communities, regions and issues.[2] These are referenced in the attached examples of LHIN 4 networks and the appendix elaborating on Niagara Region networks.

Promoting Coordination and Integration
LHIN 4 stakeholders participate in both government and broader regional and provincial networks. Networks merge expertise and capacity across a range of autonomous organizations, serve as forums for information sharing, and apply evidence based planning outcomes to solutions for enhanced coordination and integration.

Government-mandated networks across Ontario, including LHIN 4, address for example, Emergency Services, Rural and Northern Health, Dementia, and Palliative Care (End-of-Life supports). Other network examples have as their focus addictions and mental health and specialised geriatrics, and broad human services e.g. social housing and community supportive care, among others. These networks develop and improve a system approach around an identified condition or need. Networks also focus stakeholder efforts on infrastructure, as in the case of those addressing broad health human resources planning. Networks apply planning frameworks that incorporate health services research, health information data and best practices guidelines, where available.

Promoting Inter- and Intra-Sectoral Relationships
Networks incorporate a systematic and negotiated balance between diverse types of expertise, resources and organizations.[3] Shared accountability mechanisms, while variable, promote a common agenda among diverse and pluralistic services.[4].

Enablers for Success
Existing network approaches for health gain and health system improvement are important assets for LHIN 4. The extent to which identified critical success factors and best practices are shaping successful network outcomes in LHIN 4 should be evaluated and promoted for broad uptake.

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[1] Pedler, M. **Networked Organizations – An Overview**, Health Development Agency, United Kingdom, October 2001
[2] See the LHIN 4 priority re: structure, processes and resources within the LHIN to build on, integrate and support the development of patient-centre community-based networks focused on client outcomes.
[3] Provan, K. and Milward, B. "Do Networks Really Work? A Framework for Evaluating Public Sector Organizational Networks", **Public Administration Review**, 61, 2001.
[4] The Change Foundation, **Accountability, Continuity and Effectiveness: Health Networks in Ontario**, November 2004.

Notable Characteristics of LHIN 4

Notable Characteristics of LHIN 4

The new LHIN 4 has the second largest population of all LHIN regions in Ontario. It encompasses the areas of Brant, Burlington, Haldimand, Hamilton, Niagara and Norfolk, which each have a rich history of local identification and sense of community, despite the fact that there are been numerous boundary changes over the past three decades. The Regional Municipality of Niagara encompasses 12 municipalities, the new City of Hamilton incorporates 6 former municipalities and the Counties of Haldimand and Norfolk were united in 1974 and then separated again in 2001. Brant area, which includes both the City of Brantford and surrounding County of Brant underwent additional boundary revisions in 2005. Burlington, part of the Regional Municipality of Halton, is considered part of the Greater Toronto Area (GTA). One of the greatest concerns in our area is that the new LHIN regional structure appreciate the natural communities within LHIN 4 and plan for the health system recognizing our unique and diverse communities.

LHIN 4 has wide variations in population density, given it includes both urban and rural land areas. While Haldimand and Norfolk have the greatest percentage of rural settlement, it is important to note that all communities in LHIN 4 include rural areas. Approximately 70 percent of the LHIN 4 population reside in Hamilton or Niagara.

Both Hamilton and Niagara are designated areas for French language services, as more than 5,000 people in each area identify their mother tongue as French. Hamilton is one of the top ports of entry for new immigrants into Canada and as a result, approximately one-quarter of the city's population are immigrants. LHIN 4 has a significant concentration of Aboriginal peoples. Two of the largest First Nations territories reside in the area extending through Brant, Haldimand and Norfolk, with about half living on Reserves. Niagara, with its close proximity to the United States border, is a major receiver of refugees, which are not likely to be captured through Census enumeration. There are also seasonal migrant workers who locate in the Niagara, Haldimand and Norfolk for temporary agricultural and tourism employment, who are not included in our official population statistics.

In general, the population is aging in all LHIN 4 communities. This changing age structure is expected to produce greater demands on the health system. The median age in Haldimand, Norfolk and Niagara is greater than the Ontario average; and Niagara has the greatest percentage of seniors 75 years + in Ontario.

Lower income is associated with increased morbidity, premature deaths, as well as greater utilization of health services. The median income of residents in LHIN 4 is below the Ontario average. Burlington is more affluent than other areas in LHIN 4, and its inclusion in the statistical calculation inflates the region's median income, which would otherwise be significantly lower. In Hamilton, one in five residents are living in poverty and the community is currently discussing an anti-poverty agenda to address this problem.

Self-reported health status is a well-known indicator of the health status of a population. Poorer self-reported health is associated with greater use of health services. In the LHIN 4 area, the percentage of the population reporting fair or poor health is higher than the provincial average for Brant, Haldimand, Norfolk and Hamilton. The percentage of residents reporting activity limitations requiring assistance is also greater than the provincial average for all areas, with the exception of Burlington.

LHIN 4 has the highest number of high volume hospitals of any LHIN area. All hospitals in the Hamilton area are teaching hospitals with tertiary care responsibilities for a large regional catchment area. Approximately one-third of hospital separations in Hamilton hospitals are for non-Hamilton residents. We have identified 340 Ministry of Health and Long-Term Care transfer payment agencies located in LHIN 4. There are other private, non-for-profit services and non-MOHLTC funded programs also providing services in the health system.

The shortage of family physicians and specialists is a concern in all communities within LHIN 4. All areas are currently designated under-serviced for family physicians with the exception of Hamilton. However, the physician per population benchmark does not take into account full-time equivalents and the majority of Hamilton area family physicians are involved in teaching responsibilities or reduced work hours, which has generated significant distress in Hamilton as well, regarding availability to primary care.

Approach to the LHIN 4 Report

Approach to the LHIN 4 Report

Summary

The Project Steering Committee for Local Health Integration Network 4 met as a Committee three times. The assumptions guiding our approach and ways of work were determined at our first meeting. Draft briefs describing integration activities and related action plans were reviewed by full Committee at our second meeting. Our third meeting focused on the role of the Academic Health Science Centre in (AHSC) LHIN 4, the role of voluntary networks, and the unique features of LHIN 4 that influence health system issues and approaches. Several persons volunteered to take the lead on required discussions (e.g. AHSCs, voluntary networks etc.). The role of the Hamilton District Health Council was to coordinate the process and communications, Chair the Project Steering Committee meetings, and finalise the workbook consistent with the directions of the Project Committee.

Ways of Work

Three principle tenets guided our work. We deemed it important to keep our audience in mind, and concluded that our first audience among others was the LHIN 4 CEO and Board. We determined that our work should be clear, concise, short and standardized. Finally, we agreed that our approach to consultation/outreach should be flexible for the identified integration activities, recognizing that in many domains e.g. mental health, there has been considerable consultation among consumers and stakeholders.

The Project Committee reviewed project management challenges to be managed: time, scope & money, and determined we collectively had no additional fiscal resources, not much time and, already busy people. The implications were assessed to impact on outreach and project scope.

Approach to Integration Activity Descriptions and Action Plans

Project champions identified at the LHIN 4 consultation day were responsible for developing and advancing the project description and the action plan. A degree of consultation was required to demonstrate support for the initiative and build on readiness and ideas. Interested parties consulted included those persons who self identified at the LHIN 4 consultation, and existing and known interested parties e.g. networks, coalitions, planning tables, forums. It was agreed that project descriptions and action plans would follow the Ministry templates.

The Project Steering Committee for Local Health Integration Network 4 unanimously determined at its meeting on January 17th, 2005, that the already identified ten (10) integration initiatives would not be prioritized or ranked, as described in Section C.

Key Learnings

Generally, it was felt that the approach and processes our Project Steering Committee adopted to complete our LHIN 4 submission worked well.

Challenges included:

- Timeframe, given already full organizational commitments.

- Available resources to consult, reflect, write, present, refine and finalise activity and action plans.

- The scope of knowledge and experience that champions had themselves or could access in a timely way to develop sound, feasible and cogent descriptions and action plans.

Opportunities included

- The valuable scope of DHC planning work served to inform many of the discussions for integrated activity and subsequent action plans.

- The advance work that Central South DHCS and Halton-Peel DHC did in early November 2004, profiling both LHIN 4 characteristics and networks, were important resources to the Project Steering Committee and other stakeholders.

Finally, the Project Committee recognized that the initiative was an opportunity to declare the readiness within LHIN 4 to champion elements of the transformation agenda for integrated, responsive and effective health services.

Organizations Involved in the LHIN 4 Report

LHIN 4 Geriatric Services Integration Participants

Annis Claire	claire.annis@metcap.com
Best Stacey	sbest@jarlette.com
Blackadar Dean	dblackadarbccc@bellnet.ca
Blunt Joan	jblunt@extendicare.com
Buck Susan	sbuck@parklaneterrace.ca
Buma John	JBuma@albrightcentre.ca
Caravaggio Sandra	scardoc@hotmail.com
Carr Rena	rcarr@thomashealthcare.com
Chartier Anne	anne@conmedhealth.com
Chaytor Marjorie	mchaytor@niagaraeventide.ca
Cripps Donna	dcripps@stpetes.ca
Dempsey M	mdempsey@alzheimerniagara.ca
Eagleton Jim	eyi_stoneycreek_lc@extendicare.com
Eyimina Virginia	veyimina@cogeco.ca
Farnham George	georgef@careplus-canada.com
Freeman Jane	jfreeman@extendicare.com
Hall Brad	bhall@hamilton.ca
Haughton Dilys	dilys@shalomvillage.on.ca
Hiscott Lisa	lisahiscott@bellnet.ca
Hughes Karen	khughes@stjosham.on.ca
Janjic Mike	info@clarionnursinghome.on.ca
Jewell David	djewell@stpetes.ca
Krolouski Janet	delhinh@kwic.com
Kruszynski Susan	skruszynski@stpetes.ca
Low Robert	rob.low@cnib.ca
Lyons Lana	llyons@jbmh.com
Mahaffy Barbara	bmahaffy@sjv.on.ca
Marshall Dale	marshalld@von.ca
McPherson Wendy	wmcpherson@niagarahealth.on.ca
Millar Deborah	dmillar@haldimandcounty.on.ca
Morden Pat	pat@shalomvillage.on.ca
Mulzer Gail	gmulzer@commrehab.com
Norton Susan	s.norton@chateaugardens.com
Okimi Rosemary	rokimi_hgnh@bellnet.ca
O'Kraftka Paul	pokrafka@sjv.on.ca
Robitaille Cathie	crobitaille@jarlette.com
Royeppen Lynette	mountnemonursinghome@cogeco.net
Saville Debora	dsaville@parklaneterrace.ca
Thomas-Morgan Natalie	nthomasmorgan@thomashealthcare.com
Thomas-Weir Shirley	sthomasweir@thomashealthcare.com
Trotman Patricia	ptrotman@extendicare.com
Turcotte Lori	lturcotte@conmedhealth.com
Zomer JoAnn	jzomer@gracevilla.ca

LHIN 4 Integrating Mental Health and Addictions with Other Sectors Participants

Name

- All mental health and addiction services/agencies in LHIN 4
- Providers of other health services that impact on or are impacted upon by mental health and/or addiction issues
- Services funded by other Ministries where there are cross-sector needs and issues (criminal justice, housing, social assistance)

LHIN 4 Health Promotion and Disease Prevention Participants

Name

- All services/agencies in the LHIN 4 region that have a prevention and health promotion focus
- Services funded by other Ministries with cross-sector needs and issues (housing, social assistance, education, and training)

LHIN 4 Cross Sectoral Palliative Care/End of Life Care Participants

Name	Title	Organization
Donna Thomson	V.P. Patient Services	St. Peter's Hospital
Carol McKenna	Program Director, Palliative Care	St. Peter's Hospital
Ingrid Fell		CCAC Niagara
Sherry Hnatyshyn		Bayshore Home Health
Janet Noble	Director	Hamilton Hospice Palliative Care Network

LHIN 4 A Role for Community Services in Continuity of Care: Mapping Independent Living for Long-Term Care Populations in LHIN 4 Participants

Name	Title	Organization
Cindy Kinnon	Executive Director	Participation House – Hamilton & District
Wendy Walker	Executive Director	Community Support Services of the Niagara Region

LHIN 4 Integrated Information Technology/Information and Communications Technology Strategy for the LHIN Participants

REGIONAL E-HEALTH FORUM REGISTRANTS
MONDAY, JANUARY 10, 2005

NAME	ORGANIZATION
BRANT/HALDIMAND-NORFOLK	
Andrews, Cindy for Phillips, Jody	Saint Elizabeth
Araujo, Tony	Brant CCAC
Clarke, John	Haldimand War Hospital
Forrest, Glenn	Six Nations Council
Hadley, Rita Marie	Grand River DHC
Little, Dave*	Norfolk General
Miller, Aisdair*	Brant Community Healthcare System
Moore, Deb	Norfolk General
Purvis, Peg	CMHA Brant
Quartermain, Bill	Brant CCAC
Raymond, Dave*	West Haldimand General Hospital
Thies?, Deanna for Boughner, Karen	Public Health, Haldimand Norfolk Unit
Tober, JoAnn	Brant County Health Unit
HALTON	
Burella, Denis	Joseph Brant Hospital
Davidson, Liz	Summit House
Doerring, Janet*	Halton CCAC
Harvey, Carmen*	Halton CCAC
Lyons, Lana	Joseph Brant Hospital
McMullin, David for Nancy Cummins	Carey House/Helen Homes
Thornborrow, Brad*	Halton CCAC
HAMILTON	
Burgess, Ken	Family Physician
Cullum, David	Hamilton CCAC
Deans, Bob	Shalom Village
Elliott, Dorothy	City of Hamilton
Farrant Steve	St. Pete’s
Farrow, Mark	Hamilton Health Sciences
Flaherty, Brenda	Hamilton Health Sciences
Fletcher, Marnie*	St. Joseph’s
Glendining, Murray*	Hamilton Health Sciences
Jodoin, Ernie	Hamilton DHC
LaForet, Joe	St. Joseph’s
Levinson, Dr. Anthony	McMaster
Martin, Murray	Hamilton Health Sciences
Miles, Melody	Hamilton CCAC
Moneta, Shelley	CritiCall Hamilton Health Sciences
Redfern, Darlene	Hamilton CCAC
Valaitis, Ruta	McMaster/Public Health
Wilson, Fiona	St. Joseph’s Hospital
NIAGARA	
Bakewell, Geoff	Regional Municipality of Niagara

NAME	ORGANIZATION
Bird, David	West Lnicoln Memorial Hospital
Creighton, Pam	Niagara CCAC
Kathiresan, Bala	Niagara Health System
Novosedlik, Steve*	Contact Niagara
Sersen, Ernie	Niagara CCAC
Stewart, Shirley	Niagara DHC
Szabo, Mary	Niagara DHC
Zalot, Gary	Niagara DHC
MINISTRY	
Hay, Darren	SRS e-Health office
Jeselon, Pat	MOHLTC e-Health Office
Lawrence, Anne	MOHLTC SSHA Office
Mings, Jerry	Facilitator
Shah, Narendra	MOHLTC Regional Office
Rigo, Mike	Canada Health Infoway

* Denotes regrets
Bolding depicts presenters

LHIN 4 Tools and Approaches to Sustain Patient-Centred Community-Based Networks Participants

Bill Adair	CPA Ontario
Don Alexander	Niagara Citizens for a Smart Growth Hospital
Cindy Andrews	Saint Elizabeth Health Care
Judy Ball	West Niagara Palliative Care Service
Judith Barker	Hospice Niagara
Carole Beauvais	Northern Diabetes Health Network
Brenda Berge	Ont. Assoc. of P. Audiology Clinics
Jocelyn Blais-Breton	French Language Services Niagara Health System
Jennifer Blythe	Nursing Research Unit, McMaster
David Brunarski	Ontario Chiropractic Association
Anne Childs	Hamilton H.S
Petra Cooke	
Michelle Cooper	St. Joseph’s Villa – Dundas
A.M. Covello-Baxter	Niagara Centre for Independent Living
Lynne Edwards	Sam Program
Beth Ellis	Dr. Bob Kemp Hospice
George Farnham	Care Plus
Janie Fraser	Niagara Red Cross
Nairn Galvin	Hamilton Urban Core Community Health Centre
Jane George	Wellwood Resource Centre
Don Gibson	Heart Niagara Inc.
Eldra Gittens	Extendicare Hamilton
Michelle Gold	Hamilton DHC

Suzanne Hotte	Niagara Health Coalition
Christopher Justice	St. Joseph Health Service Research Network
Linda Kenny	CPA Ontario
Robert King	St. Peter's
Adrian Kirby	Calea Ltd.
Bill Laidlaw	CNIB
Rob Low	CNIB
Lana Lyons	Joe Brant Hospital
Richard MacPhee	Good Shephard Centres
Jackie Malda	Mount Nemo CNH
Murray Martin	Hamilton Health Sciences
John McAdam	MCSS/MCYS
Mary McGeown	The Carpenter Hospice
Scott McLeod	Halton Peel DHC
Dave McMullin	Helen Zurbrigg Non-Profit Homes
Melody Miles	Hamilton CCAC
Debbie Millar	Grandview Lodge
Ruth Morris	FMA of Hamilton
Sherry Muir	Bayshore Home Health
Irene Mulicart	SNH
Janis Norton	VON Hamilton
Carol Overmars	Brant CCAC
Evelyn Page	West Niagara Palliative Care Services
Dan Parker	Managed Clinic, Brantford
Susan Roach	Haldimand-Norfolk Resource Centre
Bruce Robinson	Ontario March of Dimes
Amy Rothwell	Ridgeview LTC
Maureen Shantz	Region of Niagara – Regional Homes
Beth Snowden	Norfolk General/Ontario Orthopedic Association
Shirley Stewart	Niagara DHC
Sandy Street	The Carpenter Hospice Burlington
Sue Szalai	Managed Clinic, Brantford
Karen Stearne	Heart Niagara Inc Karen.stearne@heartniagara.com
Lynne Tintse	Arthritis Society
Carole Ward	Halton Regional Chapter of M.S. Society
Ron Wyborn	CMHA Niagara
Connie Wightman	Deer Park Villa
Marita Zaffiro	Marchese Pharmacy

LHIN 4 Integrated Human Services Systems Planning for Population Health and Wellness in LHIN 4 Participants

Name	Title	Organization
Jan Narduzzi	Executive Director	Brain Injury Services of Hamilton
Mae Radford	Manager	VON Hamilton Volunteer Services
Susan Roach	Program Manager	Haldimand-Norfolk Resource Centre
Peggy Guiler-Delahunt	Program Assistant and Peer Specialist Coordinator	
Gail Mores	Regional Director	Ontario March of Dimes, South Central Region

LHIN 4 Development of a LHIN 4 Report Card for Performance Measurement Participants

Name

- Adult Mental Health (Haldimand-Norfolk)
- Grand River District Health Council
- Hamilton District Health Council
- Haldimand County Hospital
- McMaster University
- Niagara District Health Council
- Norfolk General Hospital
- Regional Geriatric Program central
- Therapy Healthcare
- VON (Hamilton)
- Ontario Osteoporosis Association
- Marchese Health Care (Pharmacy)
- Therapy Health Care
- Consumer Representative

LHIN 4 Continuing the LHIN 4 Dialogue: Next Steps Participants

Name	Title	Organization
Marion Emo	Executive Director	Hamilton District Health Council
Gary Zalot	Executive Director	Niagara District Health Council

Contact Information

Before March 31:

Marion Emo
Executive Director
Hamilton District Health Council
905-529-3822 x125
emomari@hdhc.ca

After March 31:

Melody Miles
Executive Director
Community Care Access Centre of Hamilton
905-526-3610
melody.miles@hamilton.ccac-ont.ca

Appendices

Appendix A

Hamilton Niagara Haldimand Brant

Local Health Integration Network

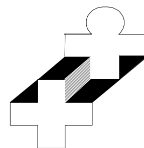
At a Glance
An Overview of LHIN 4

November 2004

Prepared by the District Health Councils
Located in the LHIN 4 Area

Grand River District Health Council

Hamilton District Health Council
Conseil régional de santé de Hamilton



Niagara District Health Council
Conseil régional de santé de Niagara

ABOUT THIS DOCUMENT….

This document, prepared by the four District Health Councils residing wholly or partially within the Hamilton Niagara Haldimand Brant Local Health Integration Network area, is intended to provide a brief overview of population, health status and health services in the LHIN 4 area.

LHIN 4 encompasses a large and diverse population with a wide range of health care institutions, programs and services. While a significant amount of population-based and health planning information already exists, data and information reports are most useful when the planning issues and questions are clearly defined. There will be the need for more reporting of data and information as the planning for LHINs and within LHINs proceeds.

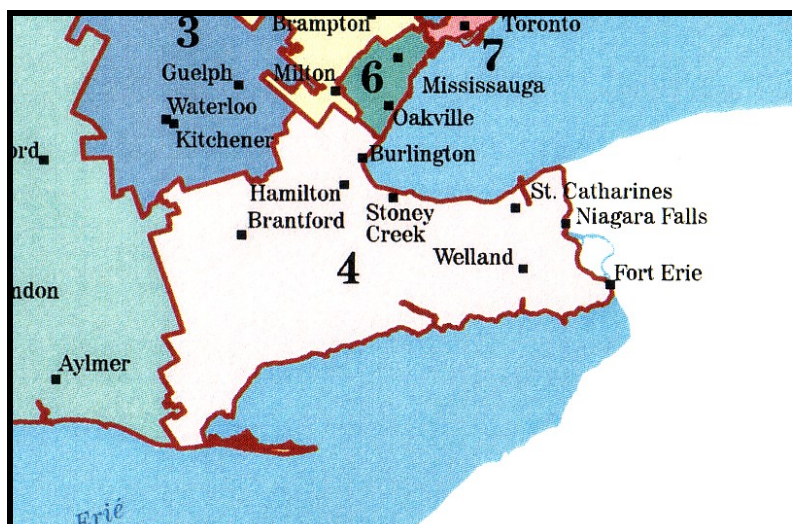
In the course of developing the LHINs, there will also be data challenges. A number of issues arise due to the creation of the new health planning boundaries for the LHIN areas. These issue are identified on page 3.

District Health Councils are planning and advisory agencies to the Minister of Health and Long-Term Care regarding local health system needs and issues. Given District Health Councils' experience with local health system planning and monitoring, we encourage the health sector to appreciate the implications of these data issues for health system planning; and that this matter be placed on the agenda for discussion with the Ministry in the early phase of the development of LHIN 4.

BOUNDARIES

LHIN 4 Area

Ministry of Health and Long-Term Care Map, October 2004



Current Planning Areas Situated within the New Hamilton Niagara Haldimand Brant Local Health Integration Network (LHIN 4) Boundary

MOHLTC Planning Regions	District Health Council Planning Areas	Corresponding Census Area	Situated Within LHINs
Central South Region	Grand River DHC	Brant Census Division	LHIN 4
		Haldimand Norfolk Census Division	LHIN 4
	Hamilton DHC	Hamilton Census Division	LHIN 4
	Niagara DHC	Niagara Census Division	LHIN 4
Central West Region[1]	Halton-Peel DHC[2]	Burlington Census Sub-Division	LHIN 4 for Burlington

[1]Central West Region also incorporates Waterloo Region- Wellington-Dufferin DHC.

[2] Halton-Peel DHC also includes Oakville, Milton, Halton Hills, Mississauga, Brampton and Caledon Census Subdivisions which have are situated in 3 other LHIN areas.

BOUNDARY ISSUES REGARDING THE DEVELOPMENT OF LHIN 4

1. Need for Boundary Clarification

Currently available maps of the new Local Health Integration Networks do not provide specific information on the geographic perimeter of the LHIN areas. The geographic boundary for LHIN 4 requires clarification and confirmation of corresponding census areas.

- There have been questions raised as to whether all of Norfolk County is included in LHIN 4 – the Grand River District Health Council has requested clarification from the Ministry of Health and Long-Term Care.
- Pending clarification, it is presumed that LHIN 4 is inclusive of Brant, Haldimand-Norfolk, Hamilton and Niagara Census Divisions and Burlington Census Subdivision.

2. Realignment of Boundaries for Receiving and Using Data

Most provincial and national agencies report population health and health system information by either health region (in Ontario this corresponds to the district health council boundary) or by public health unit boundary.

- It will be challenging to efficiently conduct population-based planning and health system monitoring within LHIN 4 until data reported by provincial and national agencies is aligned with the new LHIN boundaries.
- Local health system monitoring information is currently available from the Grand River, Hamilton and Niagara District Health Councils on their respective areas. The Halton-Peel District Health Council monitors Halton and Peel areas. While Burlington is situated within the Halton boundary – data, in some cases, is not retrievable at the Burlington level. This generates challenges in reporting population-based rates and also in aggregating data from all areas to report information at the overall LHIN 4 level.

3. Value of Sub-regions for Local Planning

LHIN 4 includes the Grand River, Hamilton and Niagara District Health Council areas. The Halton-Peel District Health Council health planning area will be apportioned and reallocated among four LHIN areas with the Burlington area being allocated to LHIN 4.

- Will there be new geographic sub-areas defined within the LHIN boundaries that will sustain 'local' health system planning?

POPULATION

Estimated 2004 Population in LHIN 4 Area

Areas in LHIN 4 by Census Division (*Census Sub-Division)	**2004 Estimate**
Brant	129,258
Burlington*	159,400
Haldimand Norfolk	115,122
Hamilton	512,663
Niagara	432,131
TOTAL LHIN 4	1,348,574

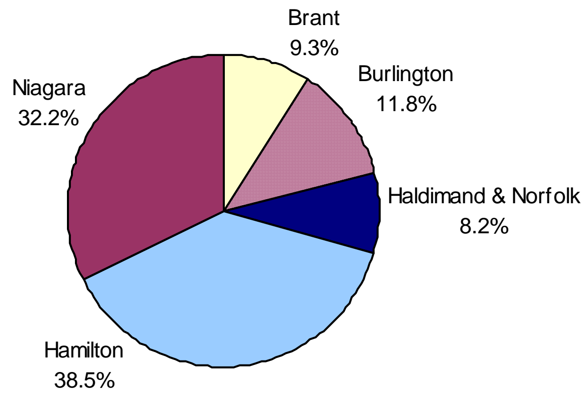
Source: MOHLTC Population Health Planning Database, 2004
* Burlington Estimate, Region of Halton, 2002.

Population and Expected Population Growth LHIN 4 Areas 2001 – 2016

Areas in LHIN 4 by Census Division (*Census Subdivision)	**Population**				**Population Growth (%)**	
	2001 (Unadjusted Count)	**2006 Projected**	**2011 Projected**	**2016 Projected**	**2006-11**	**2011-16**
Brant	118,485	131,777	136,079	140,653	3.3%	3.3%
Burlington*	150,836	163,800	172,300	178,900	5.2%	3.8%
Haldimand & Norfolk	104,670	115,610	118,672	121,780	2.6%	2.6%
Hamilton	490,270	519,180	534,550	549,290	3.0%	2.8%
Niagara	410,574	435,860	445,340	455,120	2.2%	2.2%
TOTAL LHIN 4	1,274,835	1,366,277	1,406,941	1,445,743	3.0%	2.8%

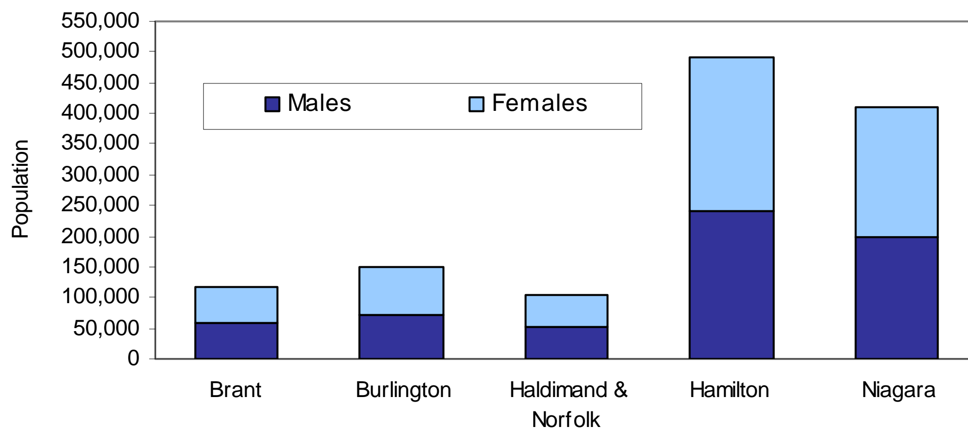
Source: Statistics Canada, 2001 Census, Community Profiles
Ontario Population Projections, Ontario Ministry of Finance date; Burlington Projections from Halton Region

Distribution of Population Among LHIN 4 Areas, 2001

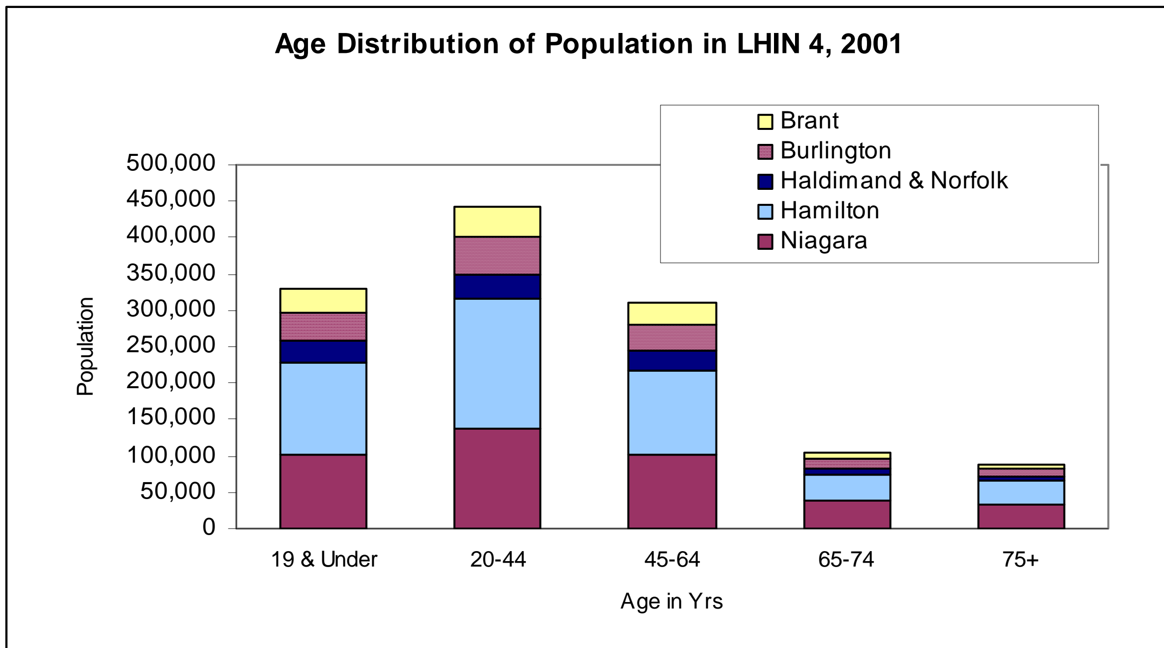


Source: Statistics Canada, 2001 Census

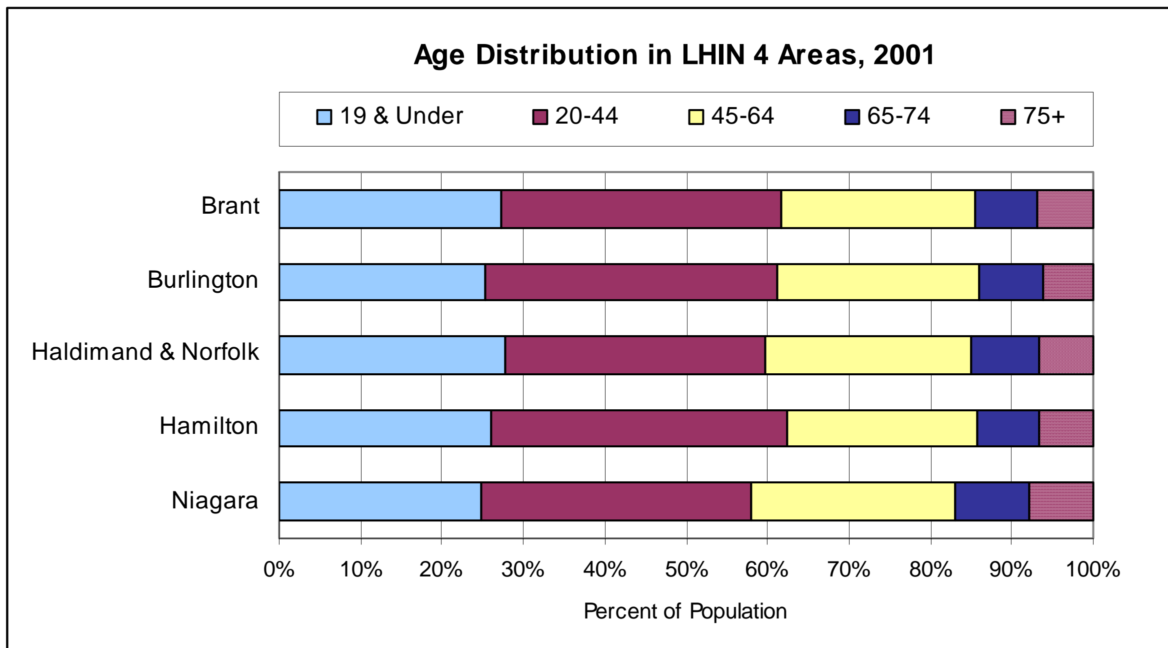
Population by Sex in LHIN 4 Areas, 2001



Source: Statistics Canada, 2001 Census



Source: Statistics Canada, 2001 Census

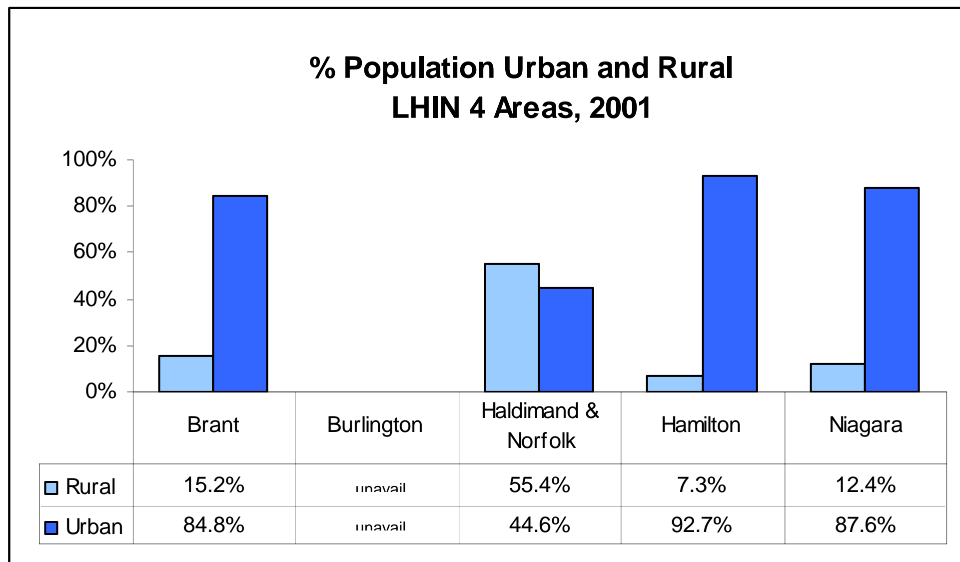


Source: Statistics Canada, 2001 Census

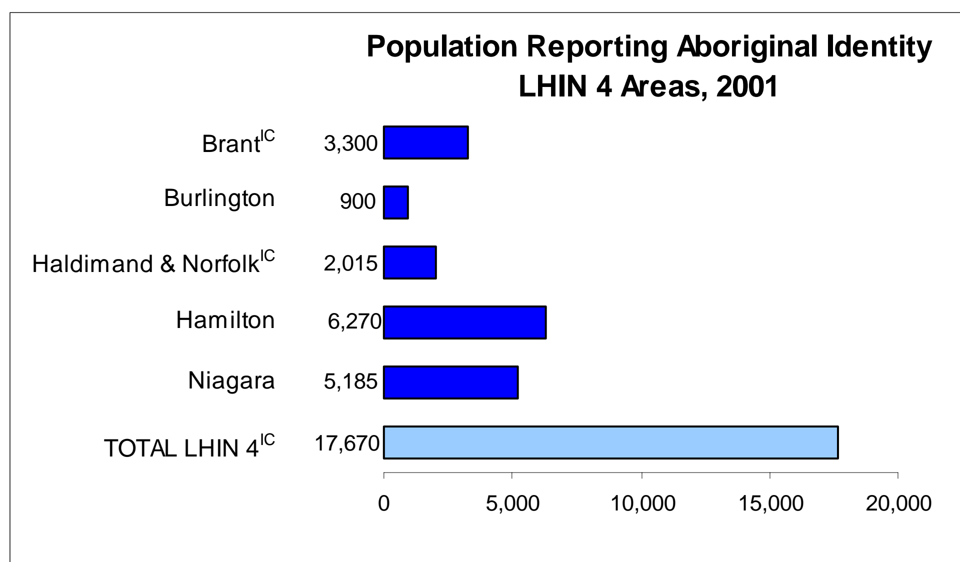
Geographic Size and Population Density of LHIN 4 Areas, 2001

Areas in LHIN 4 by Census Division (*Census Sub-Division)	2001 Population	Size of Area (sq km)	Density (Pop per sq km)
Brant	118,485	1,092.9	108.4
Burlington*	150,836	185.7	812.2
Haldimand & Norfolk	104,670	2,894.2	36.2
Hamilton	490,270	1,117.0	438.9
Niagara	410,574	1,863	220.4
TOTAL LHIN 4	1,274,835	unavailable	

Source: Statistics Canada, 2001 Census



Source: Statistics Canada, 2001 Census



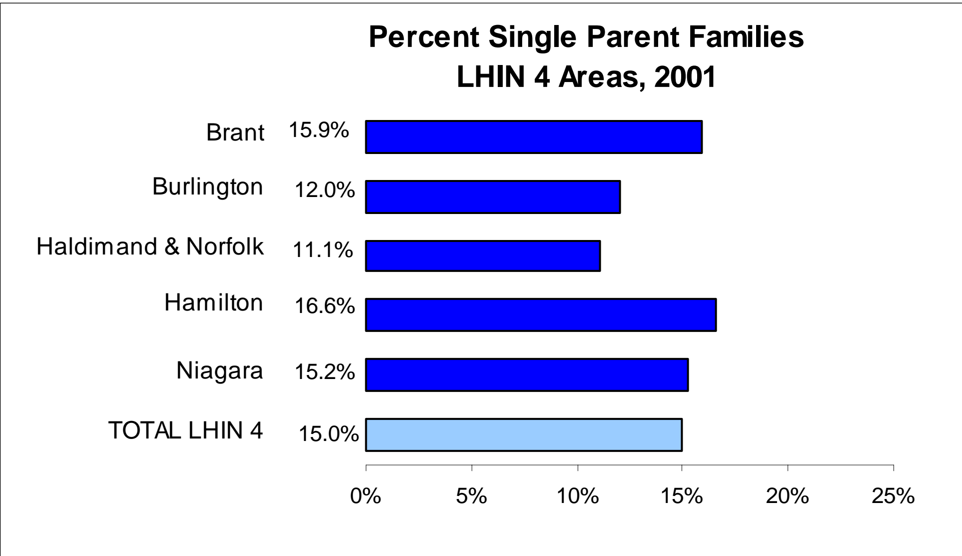
Source: 2001 Census, Statistics Canada

[IC] Incomplete Enumeration of Indian Reserves and Settlements. Two First Nations territories are located in Brant, Haldimand & Norfolk areas with a band membership of 21,103, about half of whom live on Reserve (Indian and Northern Affairs Canada, April 2001).

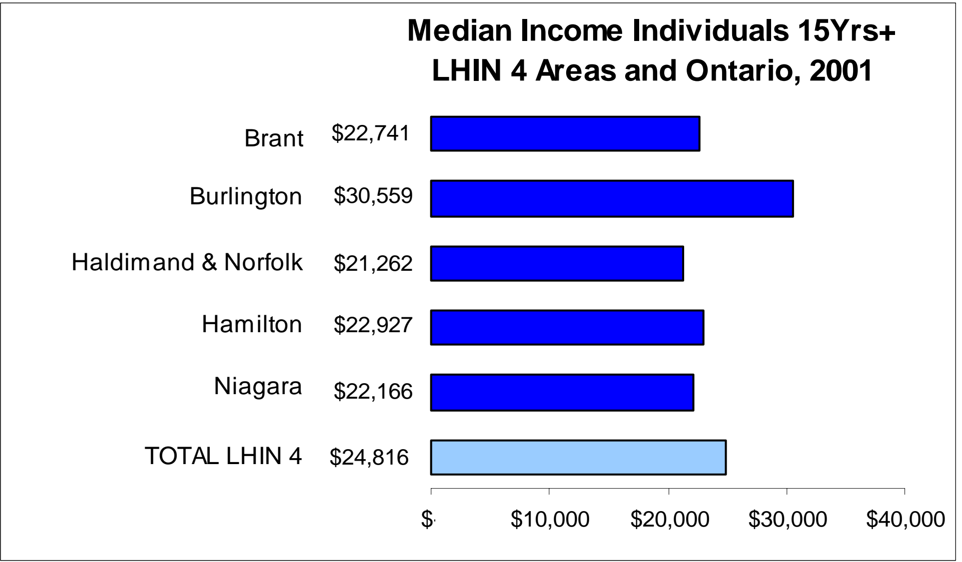
Population Reporting French as 'Mother Tongue' [1] 2001

Areas in LHIN 4 by Census Division (*Census Sub-Division)	Population	% Population Within Area in LHIN 4	Designated French Language Services Area[1]
Brant	1,585	1.4%	no
Burlington	3,270	2.2%	no
Haldimand & Norfolk	1,175	1.1%	no
Hamilton	7,595	1.5%	yes
Niagara	15,585	3.8%	yes
TOTAL LHIN 4	29,210	2.3%	

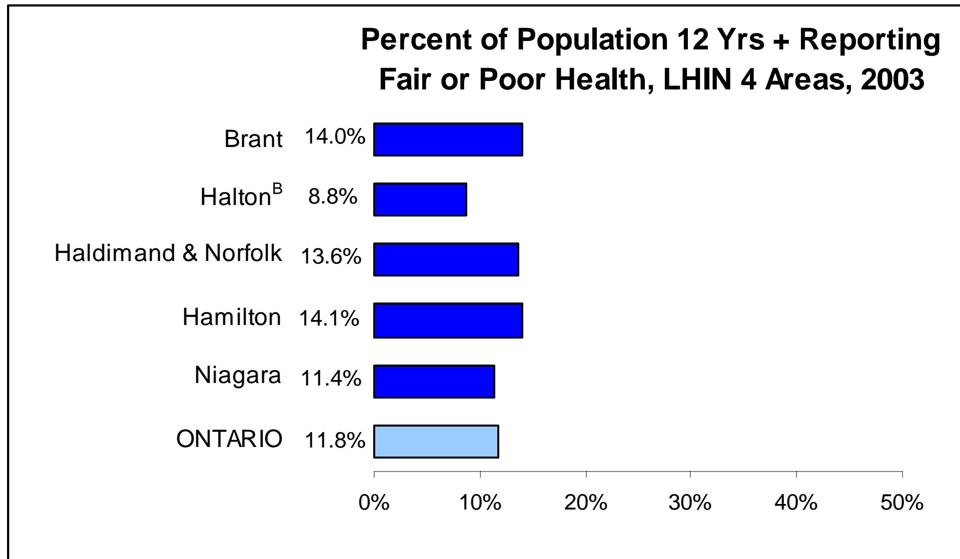
Source: Statistics Canada, 2001 Census
[1] Under the terms of the Ontario French Language Services Act.



Source: Statistics Canada, 2001 Census

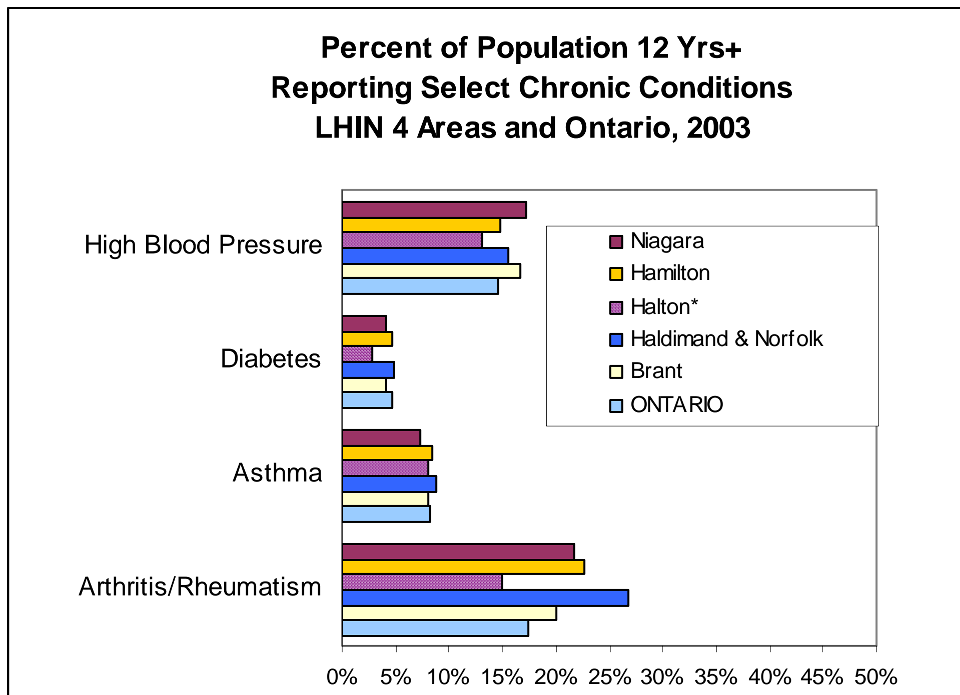


Source: Statistics Canada, 2001 Census



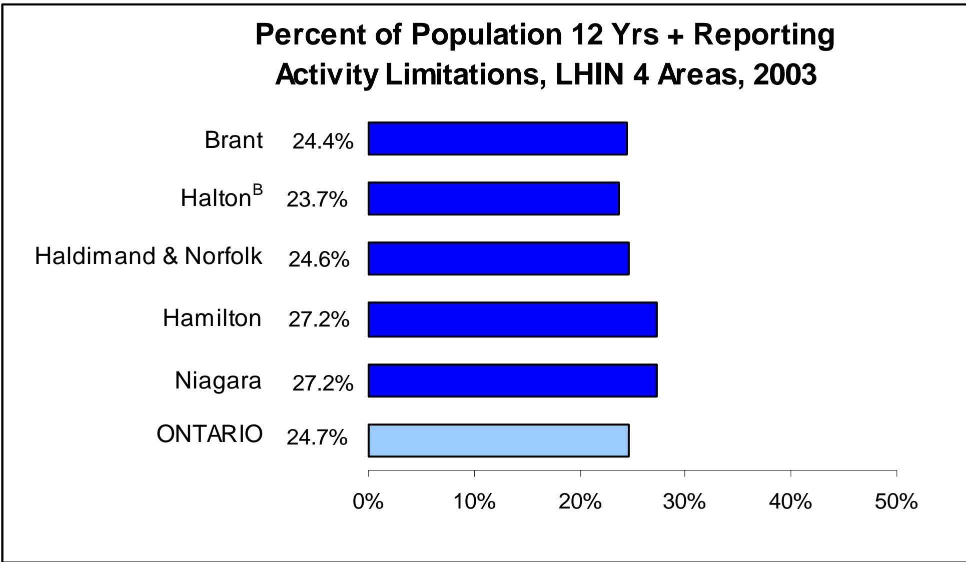
Source: Statistics Canada, Canadian Community Health Survey, 2003

[B] Burlington data unavailable. Halton Public Health Unit area includes Burlington as well as other communities allocated within three other LHINs.



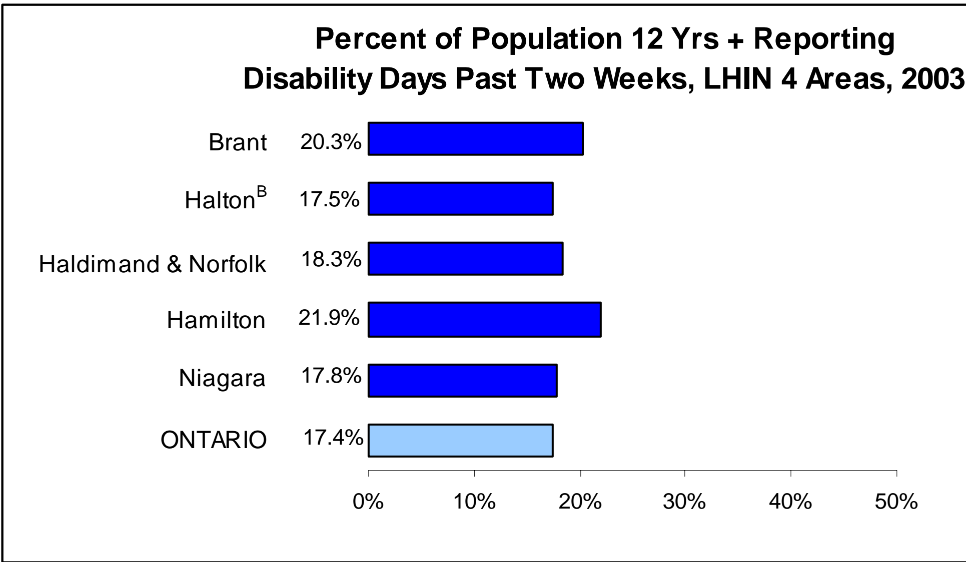
Source: Statistics Canada, Canadian Community Health Survey, 2003

[B] Burlington data unavailable. Halton Public Health Unit area includes Burlington as well as other communities allocated to three other LHINs.



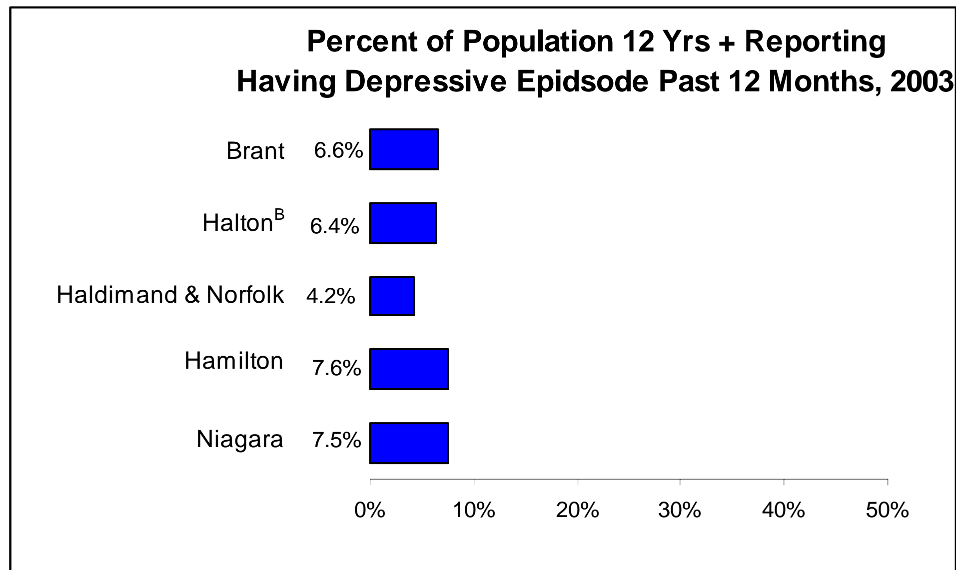
Source: Statistics Canada, Canadian Community Health Survey, 2003

[B] Burlington data unavailable. Halton Public Health Unit area includes Burlington as well as other communities allocated to three other LHINs.



Source: Statistics Canada, Canadian Community Health Survey, 2003

[B] Burlington data unavailable. Halton Public Health Unit area includes Burlington as well as other communities allocated to three other LHINs.



Source: Statistics Canada, Canadian Community Health Survey, 2003

[B] Burlington only data unavailable. Halton Public Health Unit area includes Burlington as well as other communities located within three other LHINs.

Leading Causes of Hospitalization in LHIN 4 Area Populations, 2003/04

Leading Cause	ICD-10 Chapter Categories Percent of All Acute Care Hospitalizations[1]					
	Brant	**Burlington**	**Haldimand**	**Hamilton**	**Niagara**	**Norfolk**
1st	Circulatory 13.3%	Circulatory 14.0%	Circulatory 14.2%	Circulatory 14.8%	Circulatory 14.8%	Circulatory 15.4%
2nd	Respiratory 9.9%	Digestive 9.0%	Digestive 8.9%	Digestive 9.0%	Digestive 9.4%	Digestive 10.8%
3rd	Digestive 9.2%	Abnormal Clinical Findings 8.5%	Injuries & Poisoning 8.2%	Injuries & Poisoning 7.4%	Respiratory 7.9%	Respiratory 9.1%
4th	Abnormal Clinical Findings 8.1%	Cancer 6.3%	Respiratory 8.2%	Respiratory 6.8%	Injuries & Poisonings 7.6%	Injuries & Poisonings 8.7%
5th	Injuries & Poisoning 7.5%	Injuries & Poisoning 6.3%	Genitourinary 6.2%	Cancer 6.5%	Abnormal Clinical Findings 6.3%	Cancer 7.2%

Source: Ministry of Health and Long-Term Care, Provincial Health Planning Database, 2004.
[1] Hospitalizations for Pregnancy and Childbirth included in determination of 'total hospitalizations' but not reported herein.

HEALTH SERVICES

Health Services Located in LHIN 4 Area
Receiving Ministry of Health and Long-Term Care Funding via
Transfer Payments or Fee-for-Service Billing*, 2004

LHIN 4 Areas	Type of Service [2]											
	Addiction Treatment Services	Ambulance Services	Community Care Access Centres	Community Health Centres	Community Mental Health Services	Hospital Sites	Indepen-dent Health Facilities*	LTC Community Support Services	Long-Term Care Facilities	Public Health Units	Support-ive Housing Services	**TOTAL**
Brant	2	2	1	0	2	2	4	9	8	1	0	**31**
Burlington	1	1	1	0	2	1	9	4	9	1	3	**32**
Haldimand & Norfolk	2	2	1	1	5	3	7	4	8	1	0	**34**
Hamilton	6	1	1	3	9	7	32	29	28	1	9	**126**
Niagara	6	1	1	1	7	10	22	26	31	1	11	**117**
TOTAL	**17**	**7**	**5**	**5**	**25**	**23**	**74**	**72**	**84**	**5**	**23**	**340**

Source: Grand River, Halton-Peel, Hamilton and Niagara District Health Councils.

[1] Services located in LHIN 4 area provide services to persons residing in other areas. Services located outside LHIN 4 area provide services to LHIN 4 residents.
[2] Excludes physicians, nurse practitioners, midwives and optometrists.

Hospital Beds Staffed and in Operation in LHIN 4 Areas, July 2004

Type of Hospital Care	# of Beds	# of Hospital Sites Offering This Type of Care
Acute Care – TOTAL	2,468	19
Medical	801	13
Surgical	636	10
Combined Medical - Surgical	193	8
Intensive Care	217	13
Obstetrics	157	10
Paediatrics	114	8
Psychiatric	350	8
Complex Continuing Care - TOTAL	813	14
Rehabilitation – TOTAL	232	7
General Rehab	172	6
Special Rehab	60	1
TOTAL BEDS	**3,513**	

Source: Ministry of Health and Long-Term Care, Finance and Information Management Branch, Accessed November 2004.

Number of Long-Term Care Beds in LHIN 4 Areas November 2004

Area in LHIN 4	# of Beds
Brant	890
Burlington	1,079
Haldimand & Norfolk	727+ 122 pending
Hamilton	3,964
Niagara	3,282
TOTAL LHIN 4	10,064

Source: CCAC's in Brant, Haldimand Norfolk, Halton, Hamilton and Niagara

Supply of 'Active' Family Physicians in LHIN 4 Areas as of December 31, 2003

Areas in LHIN 4	# of Family Physicians [1]	Population per Family Physician [2]	'Under-Serviced' Designation[3]
Brant	85	1,515	yes
Burlington	114	1,439	yes
Haldimand	25	1,901	yes
Hamilton	441	1,206	no
Niagara	239	1,867	yes
Norfolk	34	1,936	yes
LHIN 4	938	1,437	

[1] Ontario Physician Human Resources Data Centre, Active Physician Registry, 2004. Includes FP/GPs; excludes FP/Emergency Medicine and FP/Anesthesia

[2] Ministry of Health and Long-Term Care family physician supply benchmark is one physician for every 1,380 residents.

[3] Ministry of Health and Long-Term Care. LADAU Oct/Nov/Dec, 2004.

Appendix B

Selected Integration Activities
In LHIN 4 Areas

Prepared by the
Hamilton District Health Council
On Behalf of LHIN 4 District Health Councils

November 23, 2004

Background

Local Health Integration Networks (LHINs) will integrate healthcare at the local level by incorporating the following functions: planning, system integration, service coordination, funding allocation and evaluation of performance through accountability agreements. The first task for LHINs will be integrated health system planning.

There are many integration initiatives already occurring LHIN 4, which includes the communities of Burlington, Brant, Hamilton, Haldimand, Niagara, and Norfolk. It is anticipated that the LHIN will work with existing initiatives, demonstrated successes, and local intelligence to guide a sustainable health system.

This preliminary summary of integration activity in LHIN 4 identifies a sampling of existing networks and other sector initiatives for health system improvement. It is not an exhaustive list, and currently does not include initiatives discreet to Burlington. It does represent the breadth of activities, and identifies the enablers and barriers for change.

Some identified key enablers for successful integration initiative outcomes:

- Stakeholder readiness
- Identified champions
- Shared commitment
- Dedicated resources to support planning and implementation
- Action work plan
- Available, accessible and relevant data and information for decision support
- Flexible policy and funding for improvement solutions
- Enabling legislation
- MOHLTC support/sponsorship

The preparation of this document was coordinated by the Hamilton District Health Council (HDHC) and would not have been possible without the contributions of the Grand River and Niagara District Health Councils and local networks in Hamilton. Jackie Davy at the Hamilton District Health Council provided production and dissemination support.

The document is available on the HDHC web site at www.hdhc.ca

Marion Emo
Executive Director
Hamilton District Health Council

LHIN 4 Selected Integration Activities

Initiative	Intended Outcomes	Results to Date	Enablers	Barriers
Grand River				
1. Grand River Health Human Resource Network	1. Networking 2. Local projects x 4 3. Evaluation of ongoing value	1. Networking and sharing of knowledge 2. Local projects x 4 3. Evaluation process in progress	1. Executive support 2. Origins from the local community and building on a previous success 3. Common issue for participating agencies	1. Lack of dedicated staff to coordinate activities (competing priorities using in-kind resources) 2. Lack of provincial strategy/initiative to assist in targeting efforts and identifying priorities (i.e. only certain HHR issues can be dealt with at a local level) 3. Only certain issues can be shared within this structure locally.
2. Grand River Health Promotion Community Advisory Group	Short-term 1. Networking 2. Forum for Grand River health promotion focus – evaluation and outcome measurement 3. Research alliances	1. Increased knowledge of resources and roles – information sharing. 2. Research connection established 3. Graduate student practicum to support a partners project 4. CURA application (not successful)	1. Common goals and shared interests 2. Common pressure point and recognition of need to share resources 3. Innovativeness of the approach	1. Competing priorities for time and resources limit 2. Not a true barrier but this group is in the early stages of development -more outcomes to be realized.
3. Grand River Emergency Services Network	Emergency healthcare system [EHS] coordination via: 1. Improved utilization 2. Coordinated admission avoidance strategies & communication plan	1. Implemented system to evaluate EHS access, input, throughput process and outcomes 2. Communications system with EHS	1. Member organizations' commitment in supporting participation	1. Limited funds for coordination staff & interventions. 2. Still in relatively early stage of producing outcomes.

LHIN 4 Selected Integration Activities

Initiative	Intended Outcomes	Results to Date	Enablers	Barriers
	3. Seasonal pressure solutions	stakeholders.		
4. Rural & Northern Healthcare Networks #4 & 17	5. Coordinated and collaborative strategies for delivery of integrated hospital and related services for the broad community of Brant, Haldimand, and Norfolk.	1. Shared Care model developed for piloting 2. Schedule 1 Mental Health Needs Assessment 3. Awarded grant for Information & Communications Technology needs assessment 4. Funded to develop coordinated regional assessment process	1. One-time Rural and Northern Funding Initiative [2003/2004 – 2004/2005]] 2. DHC facilitation	1. Broad geography challenges some solutions 2. Traditional service patterns beyond network 3. Limited funds 4. Personnel availability to undertake projects in addition to service mandate
5. Rural Health Initiative (community based priority)	Others are more internally focused but externally these include: 1. Cross-sectoral networking/ knowledge transfer. 2. Collaboration to share resources and complement efforts	1. Two rural forums – 2003 & 2004 2. Networking 3. Sharing of resources and data 4. Possible collaboration in rural research project (2005)	1. Executive and staff support and interest 2. Relevant issues and common interest across sectors 3. Identification of key individuals 4. Expert consultations as required	1. No significant barriers at this time aside from being a community initiated priority that needs to be balanced against MOHLTC provincial priorities.
6. Haldimand Norfolk Mental Health Providers	1. Coordinate mental health services	1. Common intake process and communications tool	1. Member organizations' commitment in supporting participation	1. Funding, partner buy-in
7. Brant Mental Health Providers	1. Coordinate mental health services	1. Amalgamation of 3 mental health agencies	1. Member organizations' commitment in supporting participation	1. Funding, partner buy-in

LHIN 4 Selected Integration Activities

Initiative	Intended Outcomes	Results to Date	Enablers	Barriers
8. Grand River Addiction Service Planning	1. Coordinate addiction services	1. Aboriginal education day, common system planning	1. Member organizations' commitment in supporting participation	1. Funding
9. Brant Dementia Network	1. Coordinate dementia/ Alzheimer services	1. First Link services	1. Member organizations' commitment in supporting participation	1. Competing priorities for time and resources
a. Haldimand Norfolk Dementia Network	1. Coordinate dementia/ Alzheimer services		1. Member organizations' commitment in supporting participation	1. Competing priorities for time and resources
b. Brant End of Life Network	1. Coordinate palliative care services	1. New	1. Member organizations' commitment in supporting participation 2. MOHLTC policy direction	1. Short time frame for process
c. Haldimand Norfolk End of Life Network	1. Coordinate palliative care services	1. New	1. Member organizations' comittment in supporting participation 2. MOHLTC policy direction	1. Short time frame for process

LHIN 4 Selected Integration Activities

Initiative	Intended Outcomes	Results to Date	Enablers	Barriers
Hamilton				
1. Hamilton Emergency Services Network	1. A responsive hospital emergency services system	1. Eliminated CCB/Redirect ED status 2. Improved patient in/outflow: ALC swat team to reduce ALC patients; improved transfers to LTCFs; IV therapy in LTC 3. NP program for LTC 4. Public education campaign on use of ED	1. Dedicated annual resources & coordinator 2. Annual work plan 3. Provincial Network of Coordinators	1. Resources for sustainability of nurse practitioners 2. ED data systems not standardized
2. Hamilton Hospice Palliative Care Network	1. Plan, coordinate and evaluate comprehensive palliative care services for residents of Hamilton	1. Work plan 2. Chart in the Home 3. Targeted Education Events for RN & RPNs 4. Interdisciplinary Education Events 5. Partnership projects e.g.: a) CCAC Enhanced Palliative Care Program; b) Unattached clients protocol with family physicians @ Academy of Medicine, Cancer Centre, and CCAC	1. DHC system report for network foundation 2. Dedicated resources and coordinator 3. Senior leader/Decision maker membership on Steering Committee 4. Shared vision, clear accountability 5. Partner commitment to work plan/deliverables 6. MOHLTC participation 7. Stakeholder & public readiness	1. Early confusion on member role and network role

LHIN 4 Selected Integration Activities

Initiative	Intended Outcomes	Results to Date	Enablers	Barriers
3. Hamilton Addictions Mental Health Network Network Working Grps: Network Interface Ctte Concurrent Disorders	1. Facilitate planning, integration, coordination, and evaluation of a recovery-based continuum of child and adult mental health and addiction services.	1. MH System design 2. Regional database 3. Assessment of data and information capacity 4. Guidelines & protocols for collaboration & service 5. Design/creation of COAST 6. Negotiated annualized sessional fees 7. Collaborative funding proposals and research projects 8. System brokering for difficult to serve clients 9. Cross sector training and education 10. A framework and priorities for recovery-oriented services 11. Advocacy	1. Inclusive participation 2. Dedicated leadership 3. Collective vision/purpose 4. Stipend for Chair 5. Planning partnership with DHC 6. Recognized community voice 7. Non-aligned: neutral broker, system perspective and vision	1. Collaboration is resource intensive
4. Health Services Network for Older Adults	1. Information exchange, issue resolution and advocacy for older adult service providers	1. Information exchange		1. Competing priorities on member time commitment
5. Hamilton Addictions Services Coalition	1. Comprehensive and accountable system of addictions services	1. Implementation plan for system design 2. Monthly staff training and networking	1. Inclusive 2. System Design	1. Response lag from MOHLTC re information needs and initiative support

LHIN 4 Selected Integration Activities

Initiative	Intended Outcomes	Results to Date	Enablers	Barriers
		3. Expanded Men's Withdrawal Management services 4. Best practice day-evening treatment 5. Comprehensive residential addiction service for women 6. Needs assessment for collaborative mobile addiction services team 7. Collaboration with Hamilton Police 8. Public awareness and education around methadone treatment		
6. Hamilton Dementia Network	1. Continuum of care to improve well-being of persons with dementia and their families			
7. Supported Housing Coordination Network	1. Enhanced local housing options for people with severe and persistent mental illness in Hamilton	1. Increased numbers of housing units available 2. Supported/supportive housing inventory 3. Improved conditions in Residential Care Facilities Participation with local planning initiatives, e.g. DHC Housing Study '01	1. Clear mission, mandate 2. Annual work plan Sources: Housing Development Group report (99); DHC report *Housing and Support Requirements for Persons with Serious Mental Illness* (01)	1. Burnout among active members 2. Some sector rep gaps (e.g. property management, advocacy groups) missing 3. National/provincial Housing policy void

LHIN 4 Selected Integration Activities

Initiative	Intended Outcomes	Results to Date	Enablers	Barriers
8. Coalition of Community Health and Support Services (CSS)	1. Strengthen member capacity to provide quality service to vulnerable people and seniors in Hamilton	1. Shared environmental scanning and information sharing 2. Client problem solving	1. Recognized forum for consultation 2. Links with mentor, research, planning activity 3. Admin support 4. Shared commitment t CSS	1. Competing priorities for member time and resources 2. Diverse skill base 3. No consensus on advocacy role
9. Joint Task Force on Physician Recruitment and Retention		1. Shared understanding of physician supply issues in Hamilton District Health Council 2. Physician recruiter hired (announcement pending)	1. Strong leadership – Mayor convened ctte. 2. City and Chanber working with health acre partners	1. Physician supply issues complex in Hamilton 2. Hamilton surrounded by designated underserved areas 3. Absolute shortage of physicians
10. Diabetes Hamilton	1. A diabetes-friendly environment in Hamilton to provide patients and providers with tools they need to better manage diabetes	1. Voluntary registry of diabetics (1800 persons) 2. Quarterly newsletter (consumer and provider versions) Knowing Diabetes to promote evidence based diabetes related health care 3. Inventory of diabtes related community resources 4. Public forums, media & educational events	1. Multi stakeholder support 2. Initial funding from Health Canada Transition Fund 3. Diabetes "expert community" advice	1. Short term unpredictable funding

LHIN 4 Selected Integration Activities

Initiative	Intended Outcomes	Results to Date	Enablers	Barriers
11. Hamilton Diabetes Network	1. Improved diabetes management and prevention in Hamilton	1. Public Awareness Campaign 2. Health service provider needs assessment 3. Community Nurses Diabetes Teaching Guide 4. Workshop – Demystifying health promotion policy workshop	1. No charge access to facilitator expertise (community consultation program, Health Communication Unit, UofT) 2. Dedicated support and in kind member contributions 3. Links to other initiatives	1. Young organization – pace reflects network capacity 2. Sustaining momentum a function of competing priorities
12. Community Care Research Collaborative	1. Develop a research agenda relevant to organizations supporting community care and increase capacity of organizations to engage in research	1. Annual partner forum to generate local research agenda 2. A mentor/mentee program to enhance research and evaluation skills among front line Staff 3. Selected reports: 3 reports on impact of CCAC managed competition; a report on effectiveness of preventative primary care outreach for older persons	1. Grant funding 2. Multi stakeholder participation	

LHIN 4 Selected Integration Activities

Initiative	Intended Outcomes	Results to Date	Enablers	Barriers
Selected community partner activities for health promotion and health maintenance, Hamilton				
1. Healthy Living Hamilton Coalition	1. Chronic disease prevention	1. Health promotion strategies and policies introduced in work places and community at large	1. Multi partner approach	1. Lack of policy to integrate goals
2. Woman Alive	1. Enable sole support women on low income to access recreation and physical activity	1. 4 sessions/80 women. App 25% continue with YWCA membership assistance	1. Multi partner sponsorship: YWCA, Public Health, Community Services	1. Fiscal barriers limit program support and expansion
3. GROW Program	1. Provide low income children and families $$ support to access recreation programs	1. 3,000 + children served	1. Multi partner sponsorship: YW/YMCA, Kiwanis, City of Hamilton	1. Fiscal barriers limit program support and expansion
4. CASS Program/Y'Art	1. Therapeutic recreation program for special needs persons and seniors	1. 50+ adults	1. 2 partner sponsorship: YWCA and MCSS	1. Limited fiscal resources and space
5. Seniors Active Living Centres	1. Physical and recreational activities for seniors for health gain/maintenance	1. 2000+ members enrolled	1. 2 partner sponsorship: YWCA, City of Hamilton	1. Outreach 2. Limited fiscal resources

LHIN 4 Selected Integration Activities

Initiative	Intended Outcomes	Results to Date	Enablers	Barriers
Selected Hamilton Clinical Program Integration Activity				
1. Complex continuing care	1. Coordinated CCC management	1. Tri hospital Management agreement sustains an integrated program	1. Threat of hospital closure	
2. Mental Health integration Steering Committee		1. Management contract between St. Joseph's Healthcare and Hamilton Health Sciences for St. JHC management of mental health	1. Mutual and clear agreement on management leadership	1. Not all stakeholders committed, hence slow progress
3. Regional Laboratory Services	1. One program reporting to two hospital organizations	1. Coordinated activities and consolidated services to avoid duplications and maximize HR	1. Clear agreed upon long term strategic plan	1. Common list to proceed with integration
4. PMAC HOAP pilot	1. Common intake		1. Resources are in place	1. Unable to make a decision on lead

LHIN 4 Selected Integration Activities

Initiative	Intended Outcomes	Results to Date	Enablers	Barriers
Selected Hamilton Hospital Shared Services				
Current HHS shared services where HHS has participated regionally and jointly 1. Hospital laundry 2. Printing, audio visual media 3. Medical laboratory 4. Contract management and purchasing 5. National group purchasing organization 6. Warehouse and just in time replenishing services 7. Consultation services and carrier relationships 8. Employee assistance program				

LHIN 4 Selected Integration Activities

Initiative	Intended Outcomes	Results to Date	Enablers	Barriers
Niagara				
1. Niagara hospital restructuring	1. Cost-savings 2. Development of more specialized medical services locally	1. Single governance and administrative structure 2. Integration and regionalization of administrative, support and platform services 3. Consolidation of 32 bargaining units to 4 4. Standardized/integrated IS 5. Integration of clinical programs	1. Common goals and processes 2. Information sharing 3. Regionalization	
2. Integrated Planning Network	1. Evidence-based, collaborative, inter-sectoral planning for shared goals in the Niagara health system	1. Information sharing 2. Identified planning priorities for improved service coordination and integration	1. Multi-sectoral and cross stakeholder commitment 2. Common planning assumptions 3. DHC Planning support	
3. Niagara Emergency Services Network, Operating Group and ALC Working Group	1. Improved patient flow through hospital system	1. Development of local agreement for Patient Priority System 2. Common plan & community education for flu season 3. Local strategies to < inappropriate use of hospital and facilitate transition to home or community care	1. Stakeholder commitment 2. Information sharing 3. Education/support for LTC providers	

LHIN 4 Selected Integration Activities

Initiative	Intended Outcomes	Results to Date	Enablers	Barriers
4. Transitional Care Program, Rapid Response Program	1. Reduce ALC patients	1. Strategies to facilitate patient discharge 2. Reduced social admissions 3. Proactive, system approach to ALC management	1. Information sharing 2. Multi stakeholder commitment 3. Resources 4. Education/support for LTC providers	
5. Local Stroke Networking initiatives	1. Facilitate the transition and re-engagement of stroke survivors in the community	1. Six working groups in the process of developing strategies	1. Local planning support	
6. Integrated Referral System for Cardiac Rehabilitation	1. Automatic referral of acute inpatients to local cardiac rehabilitation program	1. Referral plan implemented system wide 2. Process underway to standardize AMI clinical pathway across hospital sites	1. Integrated information systems 2. Joint initiative of Heart Niagara and Niagara Health System	1. Program funding for cardiac rehabilitation
7. French Language Services Committee	1. Enhancing French language services in Niagara	1. Two designated agencies. 2. FLS implementation planning in many agencies	1. French Language Services Coordinator. 2. Strong Francophone community support	1. MOHLTC FLS templates difficult to understand 2. Competing priorities for time and resources.
8. Niagara Mental Health Directors Working Group	1. Enhanced MH system capacity & coordination.	1. System approach to service planning 2. Early intervention program. 3. Cross sector (addictions, MH, LTC) development/training	1. Member trust and commitment 2. Niagara Mental Health System Design, 2002	1. Resource pressures.

LHIN 4 Selected Integration Activities

Initiative	Intended Outcomes	Results to Date	Enablers	Barriers
9. Niagara Suicide Prevention Coalition	1. Reduce incidence and impact of suicide and suicidal behaviours.	1. Analysis of suicide rates 2. Education events. 3. Information handouts. 4. Media plan.	1. Broad stakeholder commitment. 2. DHC planning support.	1. Stigma. 2. Lack resources for dedicated coordinator.
10. Niagara Children's Mental Health Network	1. Enhanced children's mental health services.	1. Collaborative approach to funding proposals for children's mental health 2. Community networking & education forum.	1. Niagara community service plan, 2004.	1. Resource pressures.
11. Niagara Addictions Group	1. Enhanced addictions services in Niagara.	1. System approach to service planning.	1. Member trust and commitment	1. Resource pressures.
12. Niagara Mental Health Housing Coalition	1. Improved access to safe affordable housing for Niagara consumers	1. Integrated mental health housing data base	1. One time MOHLTC funding to develop housing data	1. Resource pressures.
13. Elder Abuse Network	1. Improve safety and wellbeing of Niagara's elders.			
14. Specialized Health Care for the Elderly Network	1. Improved specialized health services for Niagara's elders.	1. Networking	1. Common goals and shared interest.	
15. Niagara Dementia Care Network	1. Coordinate dementia/Alzheimer services	1. Networking	1. Common goals.	
16. Niagara Supportive Housing Network	1. Increased availability of low income housing for Niagara residents	1. Networking 2. Information sharing 3. Cross-sector planning.	1. Member trust and commitment 2. Regional resources.	

LHIN 4 Selected Integration Activities

Initiative	Intended Outcomes	Results to Date	Enablers	Barriers
Selected Regional Integration Activity				
1. Central South Networking Conference	1. Annual educational/ networking event for MH and addiction services in Central South	1. Annual Conferences x2 wo annual conferences hosted to date	1. Shared Sponsorship: MOHLTC and community partners	1. Uncertainty of funding from year to year 2. Finding a balance between learning and information needs and preferences of consumer and provider audiences
2. Regional Geriatric Program Central	1. Improved coordination, service and evaluation, best practice and knowledge development	1. Single access point for specialized geriatric services (common referral and intake, one number) 2. Centralized data base for CQI activities 3. Early response to funding opportunities 4. Office of Applied Research 5. Clearinghouse for request, issues identification 6. Web site 7. Handbook on organizing geriatric services – in progress	1. Multi program support – family medicine, emergency services, specialized services, MOHLTC 2. Inclusive participation across 7 communities 3. Awarded 7$FPs ($400K) to promote service enhancement activities 4. Leadership recognition by McMaster University and Geriatricians 5. Affiliation among 5 ON programs for best practice info exchange	1. Privacy legislation inhibits client data access across multiple sites

LHIN 4 Selected Integration Activities

Initiative	Intended Outcomes	Results to Date	Enablers	Barriers
3. Regional Stroke Steering Committee	1. Equitable access to best practice stroke care	1. Stroke rehabilitaion pilot project 2. Implementation of ON stroke strategy best practice 3. Destination and repatriation protocol 4. Prevention strategy and clinics 5. Regional stroke education plan 6. LTC/CCAC initiative for ongoing community care and LTC	1. Provincial Funding 2. Motivated stakeholders	1. Uniformity of data 2. Cross-boundary issues e.g. appropriate referral population, ambulance transportation for stroke transfers
4. Central South Rehabilitation Network	1. Enhanced care and support for rehabilitation patients and their families	1. Member participation in the Network agreement 2. Inventory of rehabilitation services in the network geography		1. No funding support 2. Cross boundary issues 3. Not all stakeholders have signed the network participation agreement

An overview of the networks and initiatives in Niagara that support collaborative planning and service coordination/integration across the broader health system

Network	Goals	Results to Date	Enablers	Barriers
POPULATION-WIDE, HEALTH SYSTEM/SECTOR-SPANNING, PLANNING/SERVICE COORDINATION NETWORKS				
Niagara Integrated Planning Network, Niagara DHC	• Evidence-based, collaborative, inter-sectoral planning • Common goals • Consistent strategic directions • Reduced duplication and improved coordination/ integration of services.	• Information sharing • Common planning assumptions • Identified planning priorities	• Stakeholder commitment • Information sharing • Dedicated planning support from DHC	
Community Advisory Committee to CCAC Niagara	Improve delivery and coordination of services for people moving through the health care system	Production/distribution of a brochure at pre-op clinics which describes services available in community to support post-surgical recovery.		
French Language Services Committee	Enhancing French language services in Niagara	Two designated agencies. Most agencies submit implementation plans outlining the steps to be taken to enhance services.	French Language Services Coordinator. Strong support for activities from Francophone community.	Mandated template difficult to understand. Competing priorities for time and resources.
POPULATION, SECTOR OR PROGRAM-SPECIFIC, PLANNING/SERVICE COORDINATION NETWORKS				
Niagara Cardiac Care Planning Network, Niagara DHC	• Update assessment of local needs for continuum of cardiac care • Address other planning issues, as needed.	• Newly established in fall 2004.	• Dedicated planning support from DHC • Local needs • Stakeholder commitment	
Niagara Emergency Services Network, Operating Group and ALC Working Group	• Monitor and reduce ALCs • Reduce inappropriate use of and overcrowding in EDs • Facilitate patient transfers to HIU • Improved patient flow through system	• Development of local agreement for Patient Priority System • Common plan & community education for flu season • Local strategies to minimize inappropriate use of hospital and facilitate transition to home or community care	• Stakeholder commitment • Information sharing • Education/support for LTC providers	
Niagara Base Hospital Advisory Council	Advise on delivery of pre-hospital EHS in Niagara, including CME, CQI, future directions; region-wide arrangements for transport; participation in research.			

An overview of the networks and initiatives in Niagara that support collaborative planning and service coordination/integration across the broader health system

Network	Goals	Results to Date	Enablers	Barriers
Niagara DHC Long Term Care Advisory Committee	To provide strategic direction and advice to the Niagara District Health Council on the continued development of the local long term care community services system, including its service access and delivery structure, service coordination and funding levels, and number and location of long term care beds.	Develop MYP or ADSP and/or Special Projects as per MOHLTC requirements Monitor, on an ongoing basis, the status of recommendations in the previous Plans Address/review ad hoc items/ issues related to, or which have an impact on, the long term care sector. Maintain close linkages with the Ministry of Health and Long-Term Care and community service agencies regarding continuing and emerging gaps, trends, and challenges in the delivery of community long term care services. Participate in the development of a seamless and integrated health service delivery system. Monitor the status of quality measurement and evaluation at the agency level and the development of indicators to measure the impact/outcome of long term care services at the system level. Evaluate the Committees performance	Broad LTC stakeholder involvement Local planning data and support Community engagement and coordinated planning efforts.	MOHLTC resource pressures to follow-up with report recommendations
Niagara End-of-Life Network	Broad system design for end-of-life care Coordination and integration of end-of life services at a system level Monitoring and assessment of community needs Promotion of service innovations	Currently under development	One-time MOHLTC funding to develop the Network Local planning data and support Community engagement and coordinated planning efforts. Broad stakeholder involvement	Limited timeframe Previous Niagara EOL Network not sustainable for lack of ongoing coordination resources

An overview of the networks and initiatives in Niagara that support collaborative planning and service coordination/integration across the broader health system

Network	Goals	Results to Date	Enablers	Barriers
Niagara Specialized Health Care for the Elderly Network	Enhanced capacity to serve Niagara's elders, improved coordination of services/system of care (including service delivery, education and research), improved access to services	1999 Action Plan Some increase in resources in some programs, but decreases in others Enhanced awareness/advocating/educating related to service and resource gaps Networking	Collaboration and support of members Common goals	Lack of dedicated resources Low profile of services for the elderly Ministry funding policy (silos)
Niagara Dementia Network	Improve and develop a continuum of care (including service delivery, education and research) for individuals with dementia, their families and caregivers	Networking Acute Decompensation Protocol	Collaboration and support of members Common Goals	Competing priorities for time and resources
Niagara Health Training Network (under discussion)	Web-based resource to pool training resources/reduce training costs, coordinate scheduling of training courses/ trainees and link health care agencies to identify shared training opportunities Clearinghouse and data base of training needs and solutions Increased access to training	Opportunity identified at Niagara Health Human Resource Forum, February 2003 Niagara Training and Adjustment Board conducted feasibility study, 2004, demonstrating support for the initiative Steering Committee formed to discuss options to operationalize the network – preliminary meeting November to be followed up with a presentation by a similar network established in Hamilton for the manufacturing sector.	Identification of sustainable funding model Commitment of Steering Committee members, health care agencies and training providers	
Niagara Gatekeepers Program	Early Identification of at-risk seniors Referrals to Niagara Gatekeepers information/referral line (at CCAC Niagara) to link individuals with required services	Partners include Community Services Department of the Regional Municipality of Niagara, CCAC Niagara, Alzheimer Society of Niagara Region and Community Mental Health Program, Public Health Department of Regional Municipality of Niagara. Community Support Services Niagara also	Commitment by partners to share responsibility for the program. Dedicated volunteer coordinator (unpaid)	Program does not receive dedicated funding, but is absorbed by community partners. Funding LTC funding policy for Client Intervention and Assistance does not incorporate the case-finding function of the Gatekeeper Program.

An overview of the networks and initiatives in Niagara that support collaborative planning and service coordination/integration across the broader health system

Network	Goals	Results to Date	Enablers	Barriers
		provides administrative support. Steering Committee in place. Expansion proposal for an integrated service model to include Outreach/Case Finding, Information/Referral and Client Intervention and Assistance submitted to MOHLTC by partners July 2000 – endorsed by NDHC Program established in Port Colborne, St. Catharines, Welland, and under development in Niagara Falls and Fort Erie - volunteers are trained to watch out for signs of a need for intervention (e.g., changes in behaviour, condition of the home)		
LTC Supportive Housing Network	Identify opportunities for improving the quality of service and access to services for clients and their families. Monitor and evaluate the broader community health services and how the services interact with Supportive Housing Programs	Optimizing PSW training funds and planning collaboratively around staff training needs on an annual basis Joint policy development Enhancing awareness of supportive housing services with referral sources inclusive of discharge planners from hospitals.	Broad LTC stakeholder involvement – with demonstrated consistency, enthusiasm and willingness to share ideas and resources among all Supportive Housing Programs in Niagara	Increased demand for service within the same level of funding; The level of acuity - care requirements for clients has increased dramatically for supportive housing providers;
Niagara Regional Housing Initiatives Reference Group	To provide a plan which addresses the provision of affordable, accessible and quality accommodation that meets the full range of shelter and support needs of all current and future residents.	Region of Niagara- People Needing Housing: A Strategy for the Niagara Community Report. Regional system coordination	Encouraging integrated community partnerships to achieve this goal. A committed local champion with a progressive vision and dedicated resources.	Fragmentation of Housing mandates

An overview of the networks and initiatives in Niagara that support collaborative planning and service coordination/integration across the broader health system

Network	Goals	Results to Date	Enablers	Barriers
Community Advisory Committee for the Adams Regional Centre for Dementia Network	To promote a client-centered continuum of dementia care and integrated service delivery among caregivers in Niagara.	A regional specialized respite care centre and complex care centre for dementia	A committed local champion with a progressive vision and dedicated resources. The cooperation and flexibility of multi-levels of government involvement Involvement of community partners and stakeholders in the planning process.	Resource pressures
Local Stroke Networking initiatives	Facilitate the transition and re-engagement of stroke survivors in the community	Development of strategies to: • engage/support stroke survivors; • identify needs/services across the district; • develop clinical pathways; • improve information/education; • improve training and the establishment of a stroke registry	• Multi-stakeholder involvement • Local leadership • H&S foundation & MoH sponsorship	
Niagara Elder Abuse Network	Co-ordination of community services Training for front-line staff Education to raise public awareness	The development of a local decision tree for service providers to use to assist in recognizing, assessing and accessing services for abused older persons. Inventory of local resources	A Provincial Strategy with dedicated resources including regional Elder Abuse Consultants	Lack of local capacity/resources to deal with elder abuse
Addictions and Mental Health Committee, NDHC	dvice and guidance to Council on issues related to addictions and mental health planning in Niagara.	Niagara Mental Health System Design 2002. Recommendations implemented to date: • Niagara Mental Health Directors Working Group. • Safe Bed Program expansion to 24/7. • Additional supportive housing resourcees. • Additional case management resources. • Assertive Community Treatment Team established. • Court Diversion Program implemented. • System approach to	Dedicated DHC planning support and resources. Committed volunteers	Time pressures on volunteer members. Lack of national mental health strategy.

An overview of the networks and initiatives in Niagara that support collaborative planning and service coordination/integration across the broader health system

Network	Goals	Results to Date	Enablers	Barriers
		staff training. Host an annual agency forum in preparation for program operating plan submissions to MOHLTC. Annual review of community based mental health and addictions operating plans. Adult Addictions and Mental Health Treatment Programs and Services Directory, 2004		
Niagara Mental Health Directors Working Group	Enhance mental health program and system capacity and coordination.	Quarterly network and planning meetings. Systems approach to planning and developing new and enhanced program submissions for MOHLTC funding, including: • Case management; • Housing supports; • Early intervention treatment program; and • Coordinated cross sector training for front line staff.	Dedicated DHC planning support and resources. Member trust and commitment. Niagara Mental Health System Design 2002, NDHC. MOHLTC funding support for staff training events.	Resource pressures. Time restrictions to plan and develop new funding proposals.
Niagara Mental Health Housing Consortium and Coalition	Improve access to safe affordable housing for consumers in Niagara	Integrated mental health housing registry/data base with Niagara Regional Housing Information System Integrated/coordinated regional mental health housing plan Consolidated Regional Homelessness Phase II Housing Program	One-time MOHLTC funding to develop the database Local planning data and support Community engagement and coordinated planning efforts. Broad stakeholder involvement	Resource pressures Time restrictions to commit/dedicate to proposal development. Resource restrictions.
Niagara Suicide Prevention Coalition	Reduce incidence and impact of suicide and suicidal behaviours in Niagara	Monthly network and planning meetings. Analysis of suicide rates in Niagara – NDHC 2003. Community education events.	Dedicated DHC planning support and resources. Member commitment and trust; shared concern.	Stigma Lack of national suicide prevention strategy. Limited planning and financial resources.

An overview of the networks and initiatives in Niagara that support collaborative planning and service coordination/integration across the broader health system

Network	Goals	Results to Date	Enablers	Barriers
		Information handouts. Media plan. Implemented process to identify a Niagara Lead agency.		
Working Group on Mental Health Services for Diverse Ethno-Racial and Cultural Communities in Niagara	Enhance mental health services for diverse communities in Niagara.	Community workshop. Cultural sensitivity survey of mental health agencies. Funding support from Heritage Canada and Trillium.	Member commitment. Funding support.	Limited resources.
Niagara Francophone Mental Health Group	Enhance mental health services for francophone population in Niagara.	Monthly networking and planning meetings.	Member commitment.	Limited resources.
Niagara Children's Mental Health Network	Enhance mental health services for children and adolescents in Niagara.	Quarterly networking and planning meetings. Agency networking forum, 2004. Directory of Niagara Child and Adolescent Mental Health and Addictions Treatment Services, 2004. District planning for Central South child and adolescent specialized mental health beds to be located at McMaster Children's Hospital, Hamilton Health Sciences.	Member commitment. Funding support from MCSS. Dedicated planning support and resources from DHC and Contact Niagara.	Cross ministry policies and funding structures.
Niagara Human Service and Justice Coordinating Committee	Enhance mental health services for individuals with mental health and/or developmental disabilities who come in conflict with the law.	Quarterly networking and planning meetings.	Broad based community support. Member commitment.	
Niagara Addictions Group	Enhance addictions treatment services in Niagara	Quarterly networking and planning meetings. Integrated Addiction Treatment Service Plan for Niagara, 2000 Implementation of Rationalization recommendations - OSAB funding.	Member commitment.	Lack of resources.
PROGRAM INTEGRATION, SHARED SERVICES, FORMAL PARTNERSHIP AGREEMENTS, ETC.				

An overview of the networks and initiatives in Niagara that support collaborative planning and service coordination/integration across the broader health system

Network	Goals	Results to Date	Enablers	Barriers
Niagara Health System – horizontal integration - 8 site hospital system	• Cost-savings • Development of more specialized medical services locally	• Single governance and administrative structure • Integration and regionalization of administrative, support and platform services has enabled standardization and cost-savings • Consolidation of 32 bargaining units into 4 • Standardized and integrated IS • Integration of clinical programs	• Common goals and processes • Information sharing • Regionalization	
Transitional Care Program, Rapid Response Program, etc.	Reduce ALC patients	• Strategies to facilitate patient discharge • Reduced social admissions • Proactive, system approach to ALC management	• Information sharing • Multi-stakeholder commitment • Resources • Education/support for LTC providers	
Integrated Referral System for Cardiac Rehabilitation – a joint initiative of Heart Niagara Inc. and Niagara Health System	Automatic referral of acute inpatients to local cardiac rehabilitation program	• Referral planimplemented system-wide • Process underway to standardize AMI clinical pathway across hospital sites	• Integrated information systems	Lack of program funding for cardiac rehabilitation
BROADER COMMUNITY PLANNING/SERVICE COORDINATION AND INTEGRATION INITIATIVES				
Niagara Physician Recruitment and Retention Program	Coordinated approach to physician recruitment and retention in the region – single point of access.	Recruitment teams in all communities 42 physicians recruited in 3 1/2 years	Dedicated funding through the Region of Niagara and in-kind support from NDHC Cooperation of all communities (regional recruitment team established) Supports for physicians, e.g., spousal employment, housing, schools, moving expenses Municipal/local support for turn-key operations	Competition – 142 communities designated as underserviced in the province; recruiters hired in neighbouring and other communities Competitive incentives Niagara lowest complement of FP/100,000 in the country Retirement rate escalating More office space required/turnkey operations

An overview of the networks and initiatives in Niagara that support collaborative planning and service coordination/integration across the broader health system

Network	Goals	Results to Date	Enablers	Barriers
Disaster (CBRN & pandemic) contingency planning	Local contingency plans in event of disaster or pandemic	CBRN – planning, proposals and funding for training/education and equipment/supplies Pandemic – awaiting provinicial plan/resources to support local planning	• Sponsorship and dedicated resources • Multi-stakeholder involvement	
Healthy Living Niagara	Chronic disease prevention	Health promotion strategies aimed at schools, the workplace and the community at large.	Multi-partner approach: a 24-member community coalition	
Niagara Schools Healthy Heart Program	Reduce the risk of cardiovascular disease	CVD risk factor measurement and information on risk factor modification for all grade 9 students in Niagara.	• Sponsorship/resource s • partnership approach	
CENTRAL SOUTH REGIONAL NETWORKS AND INTEGRATION INITIATIVES				
Regional Geriatric Program	Improved coordination, service and evaluation, best practice and knowledge development	Single point of access for specialized geriatric services; central database for CQI; applied research; website; information, etc.	• MoH support/funding • Multi-community participation • Province-wide affiliations/linkages	• Sharing of client information
Regional Cancer Program	• By 2008, RCPs to be in place across Ontario • Address needs across the continuum, from prevention to palliative care • Involve consumers & volunteers • Organizational collaboration in planning and delivery of services • Performance-based funding agreements • Accountability reporting	Work in progress, the Ontario Cancer Plan released November 2004		
Regional Stroke Steering Committee	Equitable access to best practice stroke care	• Stroke rehab pilot project • Implementation of provincial stroke strategy best practice • Destination and repatriation protocol • Regional stroke education plan • LTC/CCAC initiative for transition to community	• MOH funding • Multi-stakeholder participation	• Lack of standardized data sets • Cross-boundary issues – transportation, access, etc.

An overview of the networks and initiatives in Niagara that support collaborative planning and service coordination/integration across the broader health system

Network	Goals	Results to Date	Enablers	Barriers
Central South Rehabilitation Network	Enhanced care and support for rehabilitation patients and family	• Membership agreement • Inventory of services		• Lack of funding support • Cross boundary issues • Lack of unanimous support for membership agreement