

Integration Report North Simcoe - Muskoka (and East Parry Sound)

Local Health Integrated Network LHIN #12



February 14, 2005

LHIN Implementation Team
Local Health Integration Networks
Ministry of Health and Long-Term Care
415 Yonge Street – 10th Floor
Toronto ON M5B 2E7

Re: Integration Priority Report from North Simcoe Muskoka – LHIN #12

Please find attached the completed resource guide report prepared by the planning team for the North Simcoe Muskoka – LHIN #12. This report incorporates descriptions and action plans for the top ranked local integration opportunities identified by the local community at the LHIN community workshop.

It became increasingly clear that the move to improved integration logically follows from addressing the needs of the whole individual in an interdependent system of health and health care. The integration opportunities cited in this work are interconnected and supportive of one another. Moving forward on each initiative in isolation runs the risk of not realizing as positive an impact as possible.

Health care providers will need to be held accountable for coordinated planning and implementation of the changes necessary to move toward better balanced, more integrated, client centred health services. LHINs will need to be accountable to the local community, will need to engage the local community to give meaning to its work, and will need to report to the community on the progress of improvements.

This report is viewed as a starting position for the work that needs to be undertaken in the new network's area. Future efforts must incorporate the perspectives of all the area's communities, particularly the perspectives of the francophone and aboriginal populations.

The planning contacts appreciated the opportunity to play such an interesting role in the development of the province's new health "system". This report needs to be made available to the new LHIN's Board members and CEO. This group is prepared to meet with them as soon as they are in place to clarify any issues raised by this work.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'David Colgan', with a long horizontal flourish extending to the right.

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Facilitator - On behalf of the North Simcoe Muskoka - LHIN #12 Planning Contacts

North Simcoe Muskoka - LHIN #12 Planning Contacts

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LHIN #12 – North Simcoe Muskoka – Integration Report

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Top Integration Priorities from the North Simcoe Muskoka LHIN workshop

November 29, 2004, Orillia

1. Development of a health information management network.
2. Universal / common client record and health management system.
3. Efficient & sensitive transition between service sectors and the opportunity to move between care systems as needed by the client.
4. Establishing a Service Navigator for the Health and Social Services Systems.
5. Human Resources, recruitment/retention/utilization of staff.
6. Improvement of access to primary health care by those without family physicians.
7. Optimize the Role of Community Support Service in the Provision of the Continuum of Care.
8. Improve patient/client access to Rehabilitation Professionals and services by utilizing the LHIN resources in the most efficient and effective ways.
9. Supportive Palliative Care Team of North Simcoe Muskoka.

1) B. Description of **Administrative / Support Services** Integration Initiative

<p>Title of initiative:</p> <p>DEVELOPMENT OF A HEALTH INFORMATION MANAGEMENT NETWORK.</p>	<p>Type of integration:</p> <p>X Horizontal X Vertical X Other: Will develop to extend beyond "Health" to encompass associated "systems" e.g. Children and Youth Services, Justice, COMSOC</p>
<p>Existing or new initiative?</p> <p>X Initiated/existing Integration activity X New integration opportunity</p>	<p>List of partners involved:</p> <p>A number of individuals participated in discussion on IT and e-health technologies during the LHIN planning workshop in Orillia on December November 29, 2004 and two e-health forums were held in Barrie, on September 23, 2004 and on December 7, 2004. More than 100 people were involved in these discussions.</p>
<p>Description of the initiative:</p> <p>Use e-Health technologies to:</p> <ul style="list-style-type: none"> ❖ Develop a LHIN based health information management network. ❖ Provide a fundamental building block for an integrated, client focused and accountable information management system across the continuum. ❖ Improve clinical decision-making whenever and wherever it is provided. ❖ Improve the integration of care, services and education. <p>The opportunity exists to create a health information management strategy that seeks to integrate services across the continuum through the use of e-Health technologies. It includes an integrated common health record incorporating information such as laboratory, diagnostic, medication, treatment, care plans, service goals and other chronic disease management information needed to support sound clinical decision-making and enhance patient safety. It also encompasses integrated care pathways, teleconferencing, video conferencing and telemetry for the uses of client care, staff education and administrative efficiencies. Care standards and reliability tools will be developed. The network should enhance existing services and provide for services in locations of choice, potentially decreasing hospital ER visits and admissions wait times and provide more timely access to specialist services.</p> <p>The development of the network would support seamless accessible services and help client navigation through the services they require, by engineering one point central assessment of client needs, "triage" and intake; and the communication of a common health record of vital client information to providers. It would promote improved communication and all it could entail - real time data, transfer of knowledge, continuity of care, more timely access, common data base, common standardized information, building on existing care pathways and identification of best practices.</p> <p>The initiative to use e-Health technologies to create an integrated health information management system would have the value of potentially decreasing administrative overhead costs and supporting the development of increased network cohesion.</p> <p>Closely associated with this initiative is the development of associated "backroom" functions that can be brought together across organizations in one information management network to encompass, but not be limited to, financial, activity, utilization, material management, risk management, quality management, personnel, payroll, scheduling and planning functions. The network could also benefit from a HR database to improve planning for HR needs in the network.</p>	

Current status:

- ❖ Health care organizations have invested in IT and are looking at need for greater integration.
- ❖ 4 hospitals using Meditech systems hosted at RVH in Barrie.
- ❖ Other hospitals developing IT strategic plans. Hospitals using PACS diagnostic systems.
- ❖ Hospitals are members of North Network.
- ❖ 13 LTC facilities using single data base system. (PointClick Care/Westcom)
- ❖ CCAC - CHIN system connecting CCACs, hospitals, LTC facilities and home care providers.
- ❖ In Muskoka, connectivity between physician offices and hospital and CCAC.
- ❖ SCAN system connecting municipalities, public health and school boards in Simcoe.
- ❖ eLearning partnerships between hospitals, CCAC and Georgian College.
- ❖ eCHN being utilized by Barrie and Orillia hospitals.
- ❖ Community Health Centres have IT system.
- ❖ IT leaders in Simcoe and Muskoka have been involved in recent e-Health forums.
- ❖ Although the development of IT systems has a good start, it is still in its early stages and there are great opportunities for future integration.

Outcomes/lessons learned:

- ❖ Strong support for opportunity for integrated health information management network, if client-centred across the continuum to support improvements in client care and system efficiencies.
- ❖ This should transform the disparate components currently in place into one that will deliver more seamless care across the continuum.
- ❖ Potential for improved client flow across continuum through "navigation" tools and "client-based" communication system.
- ❖ Supports single access and single health record, improvements in data consistency and quality management systems and risk management.
- ❖ Has potential to expand use of IT technologies across network providers, particularly smaller organizations currently unable to make significant IT investment.
- ❖ Critical mass has potential for leverage with vendors.
- ❖ Has potential for "business process" improvements through effort, size and focus.
- ❖ Has potential to threaten existing systems, autonomy and control, with organizations developing barriers to integration.
- ❖ There is a real concern about organizations ability to invest in IT systems to move opportunity forward. Privacy issues need to be overcome.
- ❖ Concern about direction and support from government, which does not have a strong record of support.
- ❖ Need for vision and leadership vital. Need to develop a plan.

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2) B. Description of **Administrative / Support Services** Integration Initiative

Title of initiative:		Type of integration	
UNIVERSAL / COMMON CLIENT RECORD AND HEALTH MANAGEMENT SYSTEM.		X Horizontal X Vertical	
Existing or new initiative?	List of partners involved:		
X New integration Opportunity	<ul style="list-style-type: none"> ? Caregivers Support Network Muskoka/Parry Sound ? Simcoe Muskoka Hospital Network #1 ? Bayshore Home Health ? CCAC Simcoe County ? CNIB ? Saint Elizabeth Health Care 		
Description of the initiative:			
<p>The health care industry must become more client and consumer-centered and information rich, where information that is required for good decision-making is available whenever and wherever care is provided. Health information needs to follow the client. The LHIN requires a regional health information management strategy that includes a universal/common client record and health management system. This will transform the disparate components of the health system currently in place into one which will deliver more seamless client care across the continuum.</p> <p>Regional integration of health care requires that information such as laboratory, diagnostic, medication history, diagnosis, treatment, care plans, service goals and other chronic disease management information should be available whenever and wherever care and support are provided. Sophisticated decision-support tools that help identify treatment and care management approaches that are best suited to a given person should be available. This will help to reduce unnecessary treatments, service duplication, and ensure prevention and promotion activities are in place, all of which result in better outcomes and client satisfaction.</p> <p>In order to ensure success with this initiative, three key focus areas need to be addressed. They include:</p> <ul style="list-style-type: none"> ❖ A common integrated client care record (e-Health record) ❖ Use of technology for client focused care activities (e-Health care) ❖ Use of technology for sharing and managing limited resources across the continuum. <p>As progress is made towards an e-Health record there will be better utilization of the limited available resources and expertise within the LHIN. Clinicians and clients will have more time together freed of distractions such as searching for traditional paper records. Documentation will be more accurate and timely, but also simple and automated. Making information available to clients would facilitate their involvement in health care treatment and enable them to take more control over their health status.</p> <p>Use of e-Health care will enable health providers to take advantage of information and support whenever and wherever it is needed. Telehomecare, telemedicine and other technology enabled applications will enhance client and clinician access to best-practice knowledge and support and make optimal use of the more limited and highly specialized health providers within and outside the LHIN.</p> <p>The use of technology for secure sharing of health information across a local continuum requires strong local leadership, oversight, financial resourcing, and governance. Health information performance requirements and standards should be set and monitored at this regional level. These must be dovetailed with provincial and national standards to ensure local regional approach is consistent, affordable and in keeping with broader goals.</p>			

<p>Current Status:</p> <p>This is not a current initiative however a number of activities are underway that should be critically analyzed to determine how they could support this initiative.</p> <p>For example the SSH, e-Health Ontario, CHIN, North Network, care pathways, and other local e-Health initiatives, Development of a health information management network, etc.</p> <p>Looking to these projects presents opportunities for collaboration and building on current successes.</p>	<p>Outcomes/lessons learned:</p> <p>Key outcomes include: Focused leadership responsible for the development and execution of the Information Management Strategy.</p> <p>A defined set of information standards both locally and provincially that enable all health care organizations to meet minimal expectations for communication and information exchange.</p> <p>Streamlined and standardized business processes across the care continuum.</p> <p>Efficient and effective utilization of all health care resources.</p> <p>Improved client health outcomes and satisfaction with the health care experience.</p>															
<p>Lead contact person:</p> <table border="0"> <tr> <td data-bbox="107 831 194 861">Name:</td> <td data-bbox="318 831 513 861">Jeff Doleweerd</td> <td data-bbox="911 831 1170 861">Mary Lou Ackerman</td> </tr> <tr> <td data-bbox="107 863 175 892">Title:</td> <td data-bbox="318 863 813 892">Director of Partnerships and Planning</td> <td data-bbox="911 863 1317 892">Clinical Informatics Consultant</td> </tr> <tr> <td data-bbox="107 894 285 924">Organization:</td> <td data-bbox="318 894 597 924">CCAC Simcoe County</td> <td data-bbox="911 894 1268 924">Saint Elizabeth Health care</td> </tr> <tr> <td data-bbox="107 926 253 955">Telephone:</td> <td data-bbox="318 926 651 955">(705) 726-0039 ext 2301</td> <td data-bbox="911 926 1252 955">(905) 940-9655 ext 2219</td> </tr> <tr> <td data-bbox="107 957 201 987">e-mail:</td> <td data-bbox="318 957 792 987">jeff.doleweerd@simcoe.ccac-ont.ca</td> <td data-bbox="911 957 1344 987">mackerman@saintelizabeth.com</td> </tr> </table>		Name:	Jeff Doleweerd	Mary Lou Ackerman	Title:	Director of Partnerships and Planning	Clinical Informatics Consultant	Organization:	CCAC Simcoe County	Saint Elizabeth Health care	Telephone:	(705) 726-0039 ext 2301	(905) 940-9655 ext 2219	e-mail:	jeff.doleweerd@simcoe.ccac-ont.ca	mackerman@saintelizabeth.com
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3) A. Description of **Patient Care/Services** Integration Initiative

Title of initiative: EFFICIENT & SENSITIVE TRANSITION BETWEEN SERVICE SECTORS AND THE OPPORTUNITY TO MOVE BETWEEN CARE SYSTEMS AS NEEDED BY THE CLIENT.		Type of integration X Horizontal X Vertical X Intersectoral X Other: Inter LHIN																																
Existing or new initiative? X New integration opportunity	List of partners involved: <table border="0"> <tr> <td>? Canadian Paraplegic Association</td> <td>? Long Term Care Management</td> </tr> <tr> <td>? Alzheimer Society of Greater Simcoe</td> <td>? Royal Bank</td> </tr> <tr> <td>? Alzheimer Society of Orillia and Area</td> <td>? Barrie Public Library</td> </tr> <tr> <td>? Orillia Soldiers Memorial Hospital</td> <td>? We Care</td> </tr> <tr> <td>? Simcoe County Dementia Network</td> <td>? Vital Aire</td> </tr> <tr> <td>? Community Home Health Services</td> <td>? Mary Magill Centre</td> </tr> <tr> <td>? Brain Injury Services of Simcoe</td> <td>? CCAC Simcoe County</td> </tr> <tr> <td>? Centre for Addiction and Mental Health</td> <td>? MPP's office</td> </tr> <tr> <td>? Canadian Mental Health Association</td> <td>? Huronia Regional Centre-MCSS</td> </tr> <tr> <td>? Barrie Association of Volunteer Administrators</td> <td>? Canadian Red Cross</td> </tr> <tr> <td>? Psychogeriatric Resource Program</td> <td>? Canadian Hearing Society</td> </tr> <tr> <td>? Emergency Administrators Group</td> <td>? District Health Council</td> </tr> <tr> <td>? City of Barrie Seniors Centres</td> <td>? Barrington Retirement Home</td> </tr> <tr> <td>? CMHA York - Bradford Support Services</td> <td>? Mental Health Centres</td> </tr> <tr> <td>? Royal Victoria Hospital Healthy Aging Program</td> <td></td> </tr> <tr> <td>? Simcoe Outreach Services, Consumer Survivor Program Collingwood</td> <td></td> </tr> </table>		? Canadian Paraplegic Association	? Long Term Care Management	? Alzheimer Society of Greater Simcoe	? Royal Bank	? Alzheimer Society of Orillia and Area	? Barrie Public Library	? Orillia Soldiers Memorial Hospital	? We Care	? Simcoe County Dementia Network	? Vital Aire	? Community Home Health Services	? Mary Magill Centre	? Brain Injury Services of Simcoe	? CCAC Simcoe County	? Centre for Addiction and Mental Health	? MPP's office	? Canadian Mental Health Association	? Huronia Regional Centre-MCSS	? Barrie Association of Volunteer Administrators	? Canadian Red Cross	? Psychogeriatric Resource Program	? Canadian Hearing Society	? Emergency Administrators Group	? District Health Council	? City of Barrie Seniors Centres	? Barrington Retirement Home	? CMHA York - Bradford Support Services	? Mental Health Centres	? Royal Victoria Hospital Healthy Aging Program		? Simcoe Outreach Services, Consumer Survivor Program Collingwood	
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Description of the initiative: <p>In this client-centred initiative, clients/patients will move seamlessly between sectors to access timely, appropriate care/support as needed. Necessary health records and care plans will move with the client to avoid duplication of assessments and to ensure that there are no barriers to a smooth transition between service sectors, including different ministries, governments and transportation services, reducing wait times and enhancing care through this integrated client focus.</p> <p>This initiative will aim to:</p> <ul style="list-style-type: none"> ❖ Link Simcoe and Muskoka/East Parry Sound resources and provide opportunities for partnerships. ❖ Look at what is working well and build on it. ❖ Better manage knowledge, information and education. ❖ Ensure services are provided in the least intrusive manner and that the client/patient is at the Centre of our services. ❖ Increase the resources where gaps have been identified. <p>This initiative will offer more efficient, sensitive and effective use of resources, where clients/patients move through the system quickly and seamlessly. Where gaps have been identified resources will be developed and restructured to ensure greater consumer and service provider satisfaction.</p>																																		

Current status:

- ❖ Currently in this LHIN, Simcoe County and Muskoka/East Parry Sound are not closely/formally linked.
- ❖ There is a lack of resources such as Physicians, specialists, community care and community and hospital placement beds.
- ❖ Current lack of knowledge of each other's sectors,
 - by mental and physical health professionals, acute and community care, and transportation and emergency services,
 - contributes to stigma, (e.g. towards clients with mental health or addictions and psychogeriatric issues), barriers to service, long wait times, inappropriate care and premature institutionalization.
- ❖ Some networks are being developed to address care and system issues. e.g., networks for seniors, palliative care, dementia care, developmental disability, etc.. Muskoka-Parry Sound Community Mental Health Services are fully integrated and provide a "one-stop shopping" opportunity for clients/patients.
- ❖ Duplication or lack of coordinated services locally and through government and funding sources. These services may come from different Ministries or funding baskets, different municipalities or regions and private and non-profit agencies or facilities.
- ❖ Transportation services are challenging to access or non-existent, particularly in the rural communities.
- ❖ There are serious gaps in services and lack of resources - e.g., according to published statistics, mental health services in Simcoe County receive the lowest per capita funding in the province of Ontario.
- ❖ System is disease, not client, focused and lacks consistent sharing of accurate, relevant information to follow the clients as they transition through the system and lacks coordinated education.
- ❖ Central access through CCAC is limited by shortage of family physicians and knowledge of system. CCAC case managers have limited authority for referral, reducing central access to service.
- ❖ Lack of money is a barrier to seniors accessing LTC and retirement homes. Comprehensive, integrated, in-home care could maintain their ability to age-in-place.

Outcomes/lessons learned:

- ❖ Service providers need to have an increased awareness and understanding of each other's sectors.
- ❖ Clients/patients are the centre of the system and receive integrated support/service.
- ❖ There needs to be an improved use of existing resources:
 - sharing specialists
 - video/e-Health
 - common data collection
 - tools such as assessments and cross sector care plans.
- ❖ Sharing of non-urgent funded patient transportation services.
- ❖ There should be increased awareness and education for clients, service providers and the general public to:
 - help decrease the stigma and discrimination faced in some sectors such as mental health, addictions and
 - improve access to services and care practices
- ❖ There are some success stories – build on these i.e. Muskoka and Parry Sound fully integrated mental health services.
- ❖ There will need to be a sharing of knowledge and information between Ministries, other LHINS

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4) B. Description of **Administrative / Support Services** Integration Initiative

Title of initiative: ESTABLISHING A SERVICE NAVIGATOR FOR THE HEALTH AND SOCIAL SERVICES SYSTEMS.	Type of integration X Horizontal X Vertical X Intersectoral
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Existing or new initiative? X Initiated/existing Integration activity X New integration opportunity	List of partners involved: ? Hospice Simcoe ? Barrie Community Health Centre ? ProResp. ? Helping Hands ? Beausoleil First Nation-CSS ? Parkinson Society Canada ? Extendicare ? ALS Society of Ontario ? Arthritis Society ? Simcoe County Alliance to End Homelessness ? Caregivers Support Network Muskoka/Parry Sound ? Simcoe County Association for the Physically Disabled ? Simcoe County Coalition for Adults with Physical Disabilities and Other Sensory Challenges ? Canadian Red Cross ? City of Barrie ? Northern Diabetes Health Network ? Hospice Orillia ? Canadian Paraplegic Association ? Breaking Down Barriers ? MPP's office North Simcoe ? The Friends ? VON
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Description of the initiative:

- The health and social services sector is a very complex system of programs, individuals and services provided through a variety of funding sources. The average citizen is not aware of the range of programs and resources available to assist them or their family member in maximizing their health status in the community. The Service Navigator function will provide a single access point to identify and access a wide range of services, which support the broad determinants of health, in a defined geographic area.
- An individual is eligible for, and may receive, a range of services from different programs and groups, which support their healthy functioning in the community. One of the unique features of this function is that a trained Service Navigator will greet a consumer contacting the resource telephone number for the first time. The Service Navigator will assess the presenting needs, provide information on services and connect the person to the most appropriate staff. The Navigator function will assist the individuals in learning about and accessing these programs and supports without facing duplicate registration procedures or unnecessary waiting periods.
- From a citizen perspective, assistance with navigating the system is a prerequisite to maximizing their health and well being while using the least intrusive supports and services. The Service Navigator function can be a staff or volunteer position that is designed to assist individuals to get into and through the health and social services system. If this is a volunteer role, they will require specialized training and ongoing support. Generally the role of the navigator is described to be a consistent contact, or personal guide, someone who has, or can learn and assemble, the information needed and someone to identify possible routes and criteria for service and support. This role is not clinical in nature, and is generally short-term. This function should prevent individuals from getting lost in the system, by focusing on prevention and educational resources and supports, and minimize their use of the more costly health interventions during crisis periods.

Current status:

- ❖ The role of the Service Navigator is currently not a funded role in community health and support agencies/ programs/ organizations in Ontario. Presently, this function occurs informally in most community programs, support groups and through family caregivers and peer networks. However, it is poorly coordinated and not recognized as a valued service and important source of information regarding the functioning of the health care system. The Simcoe York District Health Council identified the need for a formalized Service Navigator function in the system as the primary recommendation in the Long Term Care Multi-Year Plan 2004-2009 produced in January 2004.
- ❖ There is information available on similar programs operating in the Winnipeg Integrated Services Initiative, the Fraser Health Authority in British Columbia (CareLinks), Saskatoon and Nova Scotia (Cancer Care). Some of these programs have been evaluated to date, and the results have been very positive, as illustrated below:
 - An evaluation of the CareLinks program of the Fraser Health Authority found:
 - The program was cost-effective, as there was a cost saving from the closure of 30 acute care beds less the costs of implementing the program.
 - Clients in the program were more likely to receive services in the community than were non-CareLink clients.
 - A survey of physicians indicated that they were generally satisfied with the discharge process and level of home support.
 - The CareLinks clients reported significantly improved health status compared to patients that did not participate in the program.
 - The Winnipeg Integrated Services Initiative found that the key benefits of the model included:
 - Enhanced access to information about a full range of health and social services available.
 - More convenient and timely access to services at locations closer to home.
 - Simplified information collection and referral processes.
 - More continuous service provision.
 - Coordinated service provision for citizens and families requiring a number of health and social services.
 - Protocols have been established to guide the case coordination and service planning process depending on whether one or more than one service is delivered.

Outcomes/lessons learned:

- ❖ The goal of the Service Navigator is to enable the consumer and caregiver to make informed decisions about maintaining and improving their own health. The Service Navigator will provide access to information about their disease or disability. This will facilitate timely access to health, long term care, community support and social services. The expected Outcomes are:
 - Individuals are aware of and can access relevant services to support their optimal functioning in the community.
 - Individuals are integrated and supported as much as possible in the community.
 - These navigators better understand the system. They can identify bottlenecks, lack of service options and duplication of service while assisting with system planning.
- ❖ This initiative complements and supports these three other priorities identified at the North Simcoe Muskoka workshop:
 - Role of community support services in the provision of the continuum of care.
 - Improving patient/client access to healthcare professionals/services.
 - Efficient and sensitive transition between care systems and the opportunity to move between care systems as needed by client.

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5) B. Description of **Administrative / Support Services** Integration Initiative

Title of initiative: HUMAN RESOURCES, RECRUITMENT/RETENTION/UTILIZATION OF STAFF.	Type of integration X Horizontal X Vertical X Intersectoral
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Existing or new initiative? X New integration opportunity	List of partners involved: ? Carolyn Shoreman, Simcoe County District Health Unit ? Lynn Livingston, Simcoe Muskoka Parry Sound Half-Way House ? Monica Murphy, OPSEUP at Malone Saint Elizabeth Health Care ? Phyllis Gordon, Simcoe Muskoka Parry Sound Half-Way House ? Michelle Hunter, Rural Ontario Medical Program ? Pat Malone Saint Elizabeth Health Care ? Doris Middleton, OPSEU/MCSS ? Elizabeth Woodward, Royal Victoria Hospital ? Wendy Martin, MDS ? Erin Evans, County of Simcoe Sunset Manor ? Donna Nairn, Muskoka Seniors ? Harold Featherston, Algonquin Health Services ? Helen Beckowski, MOHLTC ? Jack Greenlaw, Alzheimer Society Simcoe NE ? Laurene Hicks, Muskoka Seniors ? Sharon Atkinson, Helping Hands ? Brenda Spadafore, Red Cross ? Brenda MacMillan, ParaMed Home Health Care ? Ulla Rose, VON ? Barbara Barry, OPSEU Region 3
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Description of the initiative:

The ability to retain and recruit staff to run the health care system in an efficient, equitable and cost effective manner will ensure the success of health care services within the LHIN. Developing a comprehensive Human Resources Plan is needed to continue health professional development. Included in the comprehensive plan would be a LHIN IT network solution for ongoing HR management. As a leader and educator for human resource management in the local network, the LHIN would assist organizations with individual plans as well as initiate comprehensive plans for the region.

Retention being the focus of the plans addressing some of the following issues:

- ❖ Support for HR transition, i.e.: mentoring programs, support groups, local educational opportunities, paid volunteer education.
- ❖ Stability for staff in agencies affected by the LHIN:
 - communication needs to be ongoing, interprofessional and consistent
 - recognition and acknowledgement of current employment contracts.
- ❖ Full time staff, created by sharing human resources between agencies, would better utilize staff and would be more cost effective. Identify opportunities for wage parity across the LHIN would mean that smaller agencies would be able to retain staff rather than losing them.
- ❖ Ensure that employee skill sets are utilized with equity across agencies, which would increase professional job satisfaction.
- ❖ Support families as an overall HR strategy; patient is central to model with the family
- ❖ All care providers access same HR management IT resources which reduces silos; equal distribution of money for programs within LHINs
- ❖ Recruitment – professional associations should be encouraged to attract young people into their professions through mentoring, education opportunities and recruitment fairs
- ❖ Regional incentives to draw staff into the field, and into more rural areas.
- ❖ Negotiate benefit packages, especially relevant to smaller agencies that would not be able to afford this.
- ❖ Create affiliations with academic health sciences centres to attract professionals who would like to combine their work with research opportunities.

- ❖ Establish formal linkages to educational facilities (colleges, universities, high schools etc.)
- ❖ Volunteerism - recruit, train, support and recognize volunteers
- ❖ Integrate international healthcare workers more easily into the system so they can work
- ❖ An effective regional HR plan will offer better care, less errors and increase delivery

Current status:

- Part-time employees; lack of full-time.
- ❖ Employee retirement.
 - ❖ Current workers are aging/injured/stressed/burned out.
 - ❖ Workers aren't choosing to work or stay in rural communities.
 - ❖ Dissatisfied staff.
 - ❖ Shortage of health care professionals.
 - ❖ Lack of efficient marketing of health care professions to encourage people to enter into healthcare fields.
 - ❖ Lack of funding for education i.e. scholarships, paid internships travel/accommodation reimbursements, recruitment and retention incentives.
 - ❖ Employees don't feel their jobs are protected and valued by employers or communities.
 - ❖ International health care workers aren't integrated well into the system.

Outcomes/lessons learned:

- ❖ Retirements will outstrip new graduate resources.
- ❖ Staff productivity declines with higher stress and workloads.
- ❖ Part-time employees are not retained for future full-time positions.
- ❖ Departures of new graduates to USA.
- ❖ Retiring staff are completely departing from health care.
- ❖ Different skills sets of retiring professionals vs. replacement (new grads).
- ❖ Budget constraints and deficits of institutions/ organizations and effects on salaries, staff training, integration, recruitment and retention.
- ❖ Lack of a central HR inventory prevents collaboration and cross utilization of staff between organizations

Lead contact person:

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6) A. Description of **Patient Care/Services** Integration Initiative

Title of initiative:		Type of integration
IMPROVEMENT OF ACCESS TO PRIMARY HEALTH CARE BY THOSE WITHOUT FAMILY PHYSICIANS.		X Horizontal X Vertical
Existing or new initiative?	List of partners involved:	
X Initiated/existing Integration activity X New integration opportunity	? Anne Bell, Community Care Access Centre ? Cherylyn Cameron, Georgian College ? Michelle Clifford-Middel, Nurse Practitioner ? Anna Moller, Nurse Practitioner ? Sara Stainton, Reg.M., Barrie Midwives ? Kirsten Krull-Naraj, Royal Victoria Hospital ? Carla Palmer, Barrie Community Health Centre ? Dr. Anne DuVall, MD, President Barrie Medical Clinics ? Dr. Laura Crook, MD, Clinical Director Womens Health Program ? Dr. Brent Elsey, MD, Hospitalist and Family Practitioner ? Nancy Roxborough, Canadian Mental Health Association ? Dr. Sue Surry, Paediatrician, Associate Medical Officer of Health, Health Unit ? Eric Sutton, York-Simcoe District Health Council	
Description of the initiative:		
The Primary Care Forum provides a platform for the networking of existing primary care providers, to co-ordinate existing activities, to launch new ones, and to plan for access to primary care of people who do not have a family doctor. This is an existing and developing initiative focused on Central Simcoe, which we hope in turn may be improved or replicated by what is happening in other parts of the LHIN region, of which we know little at this time.		
Current Status:	Outcomes/lessons learned:	
<ul style="list-style-type: none"> ❖ The partners listed above meet monthly to identify access issues, improve the coordination of service, support the start of new clinics to provide service for priority populations that do not have access to primary care (newborns, prenatal, medically vulnerable in terms of chronic disease). The group is also looking longer- term to develop models of primary care service delivery: family health teams, access by those with significant mental illness, an 'incubator' clinic that would provide support to recruiting and retaining new medical graduates. ❖ Existing activities that focus service on those without family doctors include the involvement of varied primary care providers (solo NP practices, midwives, the After Hours Clinic, the Barrie Community Health Centre Teen Parent pre and post natal clinic). ❖ The development of a proposal for a family health team that would serve many purposes including an 'incubator' clinic supporting the recruitment and retention of family physicians working within interdisciplinary teams. ❖ The development of integrated prevention and care pathways focused on the prevention and management of chronic diseases, supported by e-Health technology. 	<ul style="list-style-type: none"> ❖ There are systemic blocks to working in interdisciplinary teams, e.g. legislation that doesn't enable the referral to specialists from the full range of primary care providers. ❖ There are underdeveloped areas of practice, and practice coordinating opportunities over which we have local control: e.g. the development of care pathways and the development of a case management role for the R.N. ❖ We are just starting to learn how we can harness existing resources to work in complementary and coordinated ways. ❖ Change of this magnitude requires an ongoing and concerted effort to educate the public and market 'new' approaches to health care. 	

- ❖ The development of initiatives to engage the community in taking responsibility for their health. This would include setting up public forums and systems to connect those who do not have a family doctor.
- ❖ The evolution of the Primary Care Forum into an integrated primary health care community governance structure, eventually to fall within the LHIN's purview.

Lead contact person:

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7) B. Description of **Administrative / Support Services** Integration Initiative

Title of initiative: OPTIMIZE THE ROLE OF COMMUNITY SUPPORT SERVICE IN THE PROVISION OF THE CONTINUUM OF CARE.	Type of integration X Horizontal X Vertical X Intersectoral
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Existing or new initiative? X Initiated/existing Integration Activity X New integration Opportunity	List of partners involved: ? Hospice Orillia ? Canadian Paraplegic Association ? Brain Injury Services of Simcoe County ? Parkinson Society Canada Barrie Chapter ? The Friends-Muskoka/Parry Sound ? Beausoliel First Nation-CSS ? Alzheimer Society North East Simcoe ? Alzheimer Society of Greater Simcoe County ? Barrie Community Health Centre ? Canadian Hearing Society ? Caregiver's Support Network Muskoka/Parry Sound ? Breaking Down Barriers - Independent Living Centre ? Simcoe County Alliance to End Homelessness ? Simcoe County Association for the Physically Disabled ? Senior Interagency Network and Simcoe Coalition for Adults with Physical Disabilities and Other Sensory Challenges ? Muskoka Seniors ? Canadian Red Cross ? Helping Hands, Orillia ? VON ? Huronia Hearing Impaired ? Algonquin Health ? ALS Society of Ontario ? CNIB ? Arthritis Society
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Description of the initiative:

Recognize and Support the Role of Community Support Service in the Provision of the Continuum of Care.

Community Support Service (CSS):

- Promotes choice by helping individuals live at home in their own community, by providing assistance through caring, friendly, professional staff and well-trained volunteers.
- Provides preventative and proactive services through approaches similar to "Population Health Promotion" and sees the people they serve as client/consumers, not patients.
- Encourages and enables people to take responsibility for their own health, promoting independence, optimal function, quality of life and community integration.
- Recognizes and supports the essential role of caregivers and the client's informal support system.
- Has a grassroots approach which is flexible and can adapt to local and diverse populations; geographical, urban/rural, ethnic, language, etc... The CSS organizations range in size from small volunteer agencies to large multi-service providers.
- Are often the first point of contact, creating the opportunity for referrals and links to the broader community. Has the flexibility to deliver a broader range of services to bridge barriers to equity including deafness, mental health issues, learning challenges, homeless, etc...
- Delivers cost effective services that augment and support primary and acute health care services. Investing in the community and developing closer partnerships between these service sectors would allow greater access for the client/consumers and reduce the pressures in all sectors.
- Are well positioned to identify changing needs, gaps and duplications in community services. They are the organizations that are actively involved in ground level problem solving within our communities and could play a larger role when it comes time to aggregate information.
- Operates in rural and aboriginal communities.
- Supports increased access to professional services.
- Positively impacts their community economically, an effect which is more pronounced in small

communities.

- Can take a leadership role in community development by creating programs that increase awareness and support for identified gaps. CSS often fills the void for services not offered in mainstream health care.
- Creates support for transportation, whether locally or to major centres to increase access to other services.
- Engages and works with volunteers, municipalities, other agencies, different ministries and still remain grassroots.

Resource References

Population Health Promotion An Integrated Model of Population Health and Health Promotion, Public Health Agency of Canada. Population Health (<http://www.phac-aspc.gc.ca/ph-sp/phdd/php/php2.htm>)

Lives in the Balance, Dennis Raphael

WHO's Ottawa Charter for Health Promotion

The Expanded Chronic Care Model: An Integration of Concepts and Strategies from Population Health Promotion and Chronic Care Model Hospital Quarterly VOL. 7 No. 1 - 2003

Achieving Health for All: A Framework for Health Promotion - A document released by First International Conference on Health Promotion hosted in Canada in 1986

Current Status:

- "211 Information Services" are being created. Needs to be promoted to all individuals as their access point to community supports and information.
- Shared education and partnerships with existing CSS are happening on an informal basis.
- Several "self-management programs", focused on a chronic disease, (such as The Arthritis Society's Arthritis Self-Management Program) are being led by trained volunteers.
- Local initiatives to collaborate for service delivery and program development including sharing office space, information systems, data management, transportation and education opportunities.
- Important partners in DHC planning processes.

Outcomes/lessons learned:

- Greater access is available because of CSS
- Increased awareness of supports/services
- Adaptability is available to meet the changing needs of the clients
- CSS are effective and responsive to the community's needs
- More resources are required to meet the mandate
- Increased demand in the area of basic needs in the general population base is impacting the capacity of non-profit organizations to meet increased demands.

Lead contact person:

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Current Status:

- ❖ Rehabilitation services are provided by a multitude of organizations and agencies.
- ❖ Hospitals, long-term care facilities, CCACs, Community Health Centres, other public and private agencies provide rehabilitation services.
- ❖ Due to inadequacies in the system, patients return to physicians or hospitals unnecessarily.
- ❖ Wait time reduction is necessary for patient and professional satisfaction.
- ❖ Funding is inadequate for necessary treatments.
- ❖ Patient records are not universally shared between organizations and agencies (as the patient navigates the system, additional wait times, multiple information collection points and processes, and several different service providers can be experienced for a single health or illness episode) -- Assessments and administrative necessities are duplicated because of current system demands -- Each organization administers care by using non-integrated and organizationally-specific admission criteria and processes, waiting list systems, data collection, record keeping systems, and clinical resources.
- ❖ Professional isolation is experienced, limiting access to common patient information, joint education and opportunities for sharing skills and knowledge.
- ❖ Innovations (such as technological advances in speech-language pathology and e-Health) are not being embraced.

Outcomes/lessons learned:

- ❖ Recruitment and retention of skilled health care professionals is challenged due to isolation, sporadic workloads, administrative burdens.
- ❖ Duplication of clinical admission processes, assessments, and treatments are occurring.
- ❖ Direct patient care is adversely affected by current "need" for expenditures on administrative functions and duplication of processes.
- ❖ Skills, knowledge, and innovations of Health Care Professionals in the rehabilitation sector are often overlooked or under-appreciated.
- ❖ Scarce physician and hospital/emergency room resources could be better used if system allowed more direct and immediate access to rehabilitation professionals.
- ❖ Benefits of better use of rehabilitation professionals in health promotion and disease prevention is only beginning to be recognized and would benefit the entire health care system.

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9) B. Description of **Administrative / Support Services** Integration Initiative

Title of initiative: SUPPORTIVE PALLIATIVE CARE TEAM OF NORTH SIMCOE MUSKOKA.	Type of integration X Horizontal X Vertical X Intersectoral
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Existing or new initiative? X New integration opportunity	List of partners involved: ? Bayshore Home Health ? Hospice Orillia ? Hospice Huronia ? Extendicare (ParaMed Home Health Care) ? Canadian Red Cross ? Bracebridge Hospice ? Hospice Muskoka ? Hospice Huntsville ? Georgian Triangle Hospice ? Hospice Simcoe ? County of Simcoe ? Royal Victoria Hospital Cancer Care Program ? CCAC Muskoka East Parry Sound ? Hearing Impaired ? Victorian Order of Nurses (Pain & Symptom Mgt. Program) ? Pain & Symptom Mgt. Program of Simcoe County ? Pain & Symptom Almaguin Palliative Care Team ? Hospice Palliative Care Committee of Simcoe County
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Description of the initiative:

People with life-threatening illnesses and their families/friends are a vulnerable population. Dr. Harvey Chochinov, in a testimony before the Senate Subcommittee in 2000, said, "Unfortunately in end-of-life care we do not have a vocal constituency. The dead are no longer here to speak, the dying often cannot speak and the bereaved are often too overcome by their loss to speak." From the time of diagnosis of a life-threatening illness, a person's normal life changes to one of uncertainty and anxiety. This population has always had to depend on others for advocacy.

The providers of palliative care in North Simcoe Muskoka are proposing a new initiative to implement a Supportive Palliative Care Team. The objectives of this initiative are as follows:

1. To provide standardization of care.
2. To ensure early access for all clients, of all ages, in all settings.
3. To establish a navigating process.
4. To provide hospice palliative care education and training to volunteers.
5. To provide psychosocial support from diagnosis throughout the illness including bereavement to affected individuals.
6. To increase public awareness of the value of early access to hospice palliative care support services.

At present, there is a provincial initiative to establish Regional End-of-Life Networks that will focus on the last months of a client's life, primarily looking at alternative settings, interdisciplinary education and pain and symptom consultation. However, this LHIN initiative creates a horizontal integration opportunity to network the many existing volunteer driven hospice palliative care programs and services from across the North Simcoe Muskoka region to enhance the continuum of care as a client makes his/her way through the life-threatening illness. There are now National Norms of Practice that are being developed into standards of practice for all settings of hospice palliative care. This provides the vertical integration opportunities for hospice palliative care organizations to work collectively and collaboratively to provide best practices, consistent programs and services. The Canadian Hospice Palliative Care Association is also developing accreditation standards through the Canadian Council of Health Services Accreditation for hospice palliative programs in all settings. The Supportive Palliative Team would be able to benchmark their practice against national standards of care providing consistency of high quality practice throughout the LHIN.

This new initiative will establish key navigators/coordinators, with the following goals for service delivery:

- ❖ Help clients identify needs, options and choices,
- ❖ Connect clients with appropriate services,
- ❖ Develop and work with overall care plans, and
- ❖ Provide system-wide case management services,

The overall philosophy would be the access and integration of client services with these navigators/coordinators working for the system on behalf of the clients. For these populations, the implementation of these key navigators/coordinators will promote and integrate the continuum of care all through the illness. They will be able to ensure barrier free services when required and hence improve the quality of care for clients and family/friends.

All hospices in Ontario currently receive very limited Ministry of Health & Long Term Care funds for volunteer training in hospice palliative care. Our opportunity here is to develop a vertical integration strategy with existing hospice palliative care training resources in North Simcoe Muskoka and propose enhanced funding to extend standardized training collaboratively across the volunteer sector. Training opportunities provided through this new initiative would allow volunteers to become certified and have transferable skills to build increased community capacity and expertise amongst our volunteer sector in all settings for this client population.

This initiative would also include establishing an accredited psychosocial supportive counseling and bereavement service to meet the needs of clients and families/friends accessing care. Many communities offer this type of service presently without standardization or dedicated funding. Evidence indicates that ongoing support through illness and appropriate bereavement support will reduce the need for further health services intervention.

Historically clients have hesitated to access hospice palliative care resources due to the connotation or stigma of the word "hospice". The Supportive Palliative Care Team will work towards breaking down this barrier by focusing on increasing public awareness of the value of earlier access to support at the time of diagnosis, through the illness and including the bereavement period. New horizontal integration opportunities can be implemented such as establishing linkages and case referrals with the local regional oncology programs for early diagnosis support, with Long Term Care facilities and with the proposed specialized Regional End-of-Life Network and other service delivery providers.

In summary, this initiative would propose the implementation of a Supportive Palliative Care Team for the North Simcoe Muskoka LHIN made up of the following: Navigators/Coordinators, Educators, Bereavement Counselors and Public Education Coordinators to be strategically placed in existing hospice palliative care organizations in the LHIN. This team would meet on a regular basis.

This initiative will ensure that a hospice palliative care strategy can be developed that is based on the strong foundations provided by the existing stakeholders and structures. This will also include new partnerships and opportunities for additional horizontal, vertical and multi-sector integration within the planning area. This needs-based initiative would streamline the delivery of supportive palliative care services, enhancing the continuum of care for the client from the point of access at diagnosis through illness, end of life care and bereavement.

"Hospice Palliative Care is appropriate for any patient and/or family living with, or at risk of developing a life-threatening illness due to any diagnosis, with any prognosis, regardless of age and at any time they have unmet expectations and/or needs and are prepared to accept care." (from A Model to Guide Hospice Palliative Care, CHPCA, March 2002)

Current Status:

The Hospice Palliative Care system is presently very fragmented and different in every region. This new initiative would standardize a level of care across the LHIN, yet be geographically sensitive to the existing services within the LHIN. The North Simcoe Muskoka LHIN has some of the following current characteristics:

- ❖ Rural and urban population,
- ❖ High senior retirement and single population,
- ❖ Existing knowledge of community services,
- ❖ Persons with hospice palliative care knowledge base exist within the LHIN,
- ❖ Hospice Palliative Care Networks already exist in this LHIN area, but no dedicated funding is available (except palliative initiative funding).

The lessons learned with the current status include:

- ❖ Lack of recognition for hospice palliative care as a core service allows organizations to ignore the more specialized needs of this group,
- ❖ Lack of access or no access to psychosocial and bereavement support,
- ❖ Late referrals to CCAC services for end-of-life care,
- ❖ Clients are living and dying in pain, lessening their quality of life,
- ❖ Clients have difficulty navigating the system from the time of diagnosis to bereavement,
- ❖ Lack of integration in hospice palliative care services between community, hospital and long-term care,
- ❖ Lack of appropriate alternative settings when patient unable to die at home,
- ❖ Lack of Hospice Palliative Care knowledge and information at all levels,
- ❖ No incentive for client and administrative integration opportunities for Hospice Palliative Care such as client electronic record,
- ❖ Lack of incentives for enhancing intersectoral initiatives to improve coordination and communication.

Outcomes/lessons learned:

This new initiative would provide an opportunity linking the community and facility services together within this LHIN for enhanced quality of care and also provide hospice palliative care education to all persons involved. Positive outcomes include:

- ❖ Improved quality of life for both clients and caregivers for all cancer and non-cancer life-threatening illnesses
- ❖ Early access to hospice palliative care services for vulnerable populations.
- ❖ One overall care plan for both clients and caregivers.
- ❖ Improved access to end of life services and pain and symptom management.
- ❖ Access to information, resources and support.
- ❖ Greater opportunities for administration support service integration in areas of education/training, back door supports in finance and fundraising, and information technology.
- ❖ A huge cost-effective component in integrating hospice palliative care services in the LHIN. Current evidence indicates that coordinated specialized palliative care saves health care dollars by assisting the client to move along the natural course of life's journey.
- ❖ Greater opportunities with intersectoral integration in areas such as the Ministry of Community and Social Services, Educational Facilities, etc.

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C. Priority Setting of new Integration Opportunities

I. Patient Care/Services Integration Opportunities		
	Priority Opportunity	High-Level Action Plan
1	<p>Efficient & Sensitive Transition between service sectors and the opportunity to move between care systems as needed by the client.</p>	<p>This initiative includes a broad-spectrum of providers in both horizontal and vertical integration. Time lines and a logic model will guide its implementation, which when achieved will have a high impact on patient care. Short-term action during transition to long-term outcomes include:</p> <ol style="list-style-type: none"> 1) Develop partnership strategies for the integration of all the above service sectors: <ul style="list-style-type: none"> ❖ Review existing Best Practices on integrated services and transitions to develop local best practices. ❖ Review existing local models i.e: the Muskoka Mental Health Model, Residential Assessment Inventory, Wound Care Program, CASS Clinic, Homeless Initiative, Video Case Consults as well as broader models such as CACHET and SIPA. It is recommended that LHINs work together to develop models. ❖ Include the full spectrum of providers including peer support, volunteers, primary care, long term care. ❖ Muskoka's effective lead agency model for "one-stop" shopping for mental health should be maintained, reviewed and possibly include psychogeriatrics. ❖ Evaluate existing local community support service hubs to maximize resources and where appropriate to assist in promoting the concept of "one-stop" shopping. 2) Develop strategies and provide resources necessary to ensure care/service is provided in the least intrusive manner at the right time and place. <ul style="list-style-type: none"> ❖ Use of common assessment tools. Ensure that pertinent, appropriate and accurate clinical records move with the client/patient. Integrate with the e-Health Priority. ❖ Use of compatible/transportable technical equipment and processes in each sector. ❖ Ensure that clients/patients are fully informed so they can make the right choices. ❖ Develop Care Management teams, Case Management and Service Navigators who can successfully ensure access for appropriate and timely service across sectors, including efficient and sensitive transition. 3) Develop a Health Promotion and Prevention Strategy. <ul style="list-style-type: none"> ❖ Promote the determinants of health with effective use of the media – raise issues and build on success stories. ❖ Population management of health issues –where individuals learn to be active participants in their own health and prevention of health problems. ❖ Universal screening for some conditions – early detection and diagnosis and connection to appropriate service. Could be specialized weekly clinics for children, seniors and other populations as identified. ❖ Address the stigma and discrimination related to mental health, addictions, dementia and disabilities, with education of clients/patients, service providers and professionals.

I. Patient Care/Services Integration Opportunities		
		<p>4) Develop a strategy to identify and address barriers to efficient & sensitive transitions between service sectors.</p> <p>5) Ensure evaluation practices are developed and implemented (e.g., common data collection) to reduce wait times and length of stays and improve client satisfaction.</p> <p>6) Share successful local integrations and consider from a provincial perspective.</p>
2	<p>Improvement of access to primary health care by those without family physicians.</p>	<p>1. Pilot Incubator Clinic being developed in the Barrie area to recruit and retain new medical graduates. If successful, to then facilitate the development of similar clinics in other communities throughout the LHIN – ACTION: proposal submission February 2005.</p> <p>2. Develop community health centre (CHC) presence through the LHIN. This includes satellite sites or new CHCs for population groups facing barriers to access (mental health, shut-ins, the homeless). A community-based francophone workgroup has already developed a CHC proposal – this could be supported to be submitted to the Ministry of Health for ACTION by April 2006.</p> <p>3. Develop an inventory of those people without access to primary care to evaluate the risks and needs, and then to allocate resources to those areas of highest risk. Recommended ACTION for the Primary Care Planning Forum, Completion by September 2005. The approach should engage those people in the process.</p> <ul style="list-style-type: none"> ❖ Triage and waiting list management for people without access to primary care, including rapid access systems; engaging the ‘orphan patient’ population in public forums etc. ❖ Population groups facing barriers to accessing primary care may be identified that fit with the family health team or CHC models of primary care: people with serious mental illness, people with physical disabilities and/or sensory deficits. <p>4. Integration of health care services for chronic disease management, using diabetes as an initial template, based on the North Diabetes Health Network Model (Parry Sound). We open room for people to access primary care by increasing the efficiency of existing services. Include integrated patient care information through use of e-health technology.</p> <p>5. Across LHIN provincial intervention. A) Implement telehealth capacity to support people without other access to primary health care. B) Expand the number of nurse practitioners within interdisciplinary team support</p> <p>6. Ensure Rural needs are identified and have a voice in planning and resource allocation.</p> <p>A) Ensure there is a mechanism for recognizing the rural/urban diversity of the LHIN and ensuring a rural voice in planning primary health care services, especially around the recruitment and retention of health providers ACTION Recommended for the new LHIN in first year</p> <p>B) Develop mechanisms by which those living in the rural areas can have access to the specialized care (e.g. ophthalmology) ACTION Recommended for the new LHIN in the second year</p>

I. Patient Care/Services Integration Opportunities	
	<p>7. Coordination of expanded recruitment initiatives within the LHIN. For primary care providers (physicians, nurse practitioners, midwives, dietitians, social workers) – ACTION ongoing through Recruitment Committee</p> <p>8. Continue The Primary Care Planning Forum</p>

II. Administrative / Support Services Integration Opportunities	
Priority Opportunity	High-Level Action Plan
1 Development of a health information management network.	<ul style="list-style-type: none"> ❖ Year 1 - Referencing provincial e-Health strategy and in the 2005-2006 fiscal year, LHIN moves to undertake local SWOT analysis to determine strengths and opportunities to build the health information management network and document challenges and potential barriers to initiative. <ul style="list-style-type: none"> ➤ In 2005-2006, establish "network" steering group under direction of LHIN to develop regional strategy and plan for development of North Simcoe Muskoka health information management network. ➤ The "Network" steering committee and the development of the e-Health strategy will be inclusive as to incorporate institutional and community health care providers across the continuum. This should include Family Health Teams and be extended to primary care providers and to the Public Health system. ➤ In 2005-2006, LHIN declares focus of health information management network to be "client-centred", based on "best-practice" and to develop / utilize region-wide standards, including consideration of technical hardware and software architecture aligned with federal, provincial and regional initiatives. ➤ In 2005-2006, LHIN establishes accountability for leadership and participation in establishing health information management system. ➤ In 2005-2006, through the steering committee and contracted external expertise, LHIN undertakes inventory of existing "systems" of provider organizations. They also determine the utility of existing e-Health and IT systems as foundation for health information management system considering potentials, advantages and disadvantages. ➤ By end of 2005-2006, LHIN develops the health information management network strategy and plan to share with the community for feedback, including options to action and potential cost impact and relationship to Ministry's provincial e-Health strategies and other LHINs' plans. ➤ Employ like process to address information management network to encompass "backroom" functions. ➤ Evaluate course of action through Year 1 and report to the Ministry, the provider stakeholders and the community. ❖ Year 2 - Referencing provincial e-Health initiatives, begin implementation to establish North Simcoe Muskoka health information management network. <ul style="list-style-type: none"> ➤ Regularly report on progress to the Ministry, provider stakeholders and the community.

II. Administrative / Support Services Integration Opportunities

<p>2</p>	<p>Universal/ Common client record and health management system.</p>	<ol style="list-style-type: none"> 1. Establish a Chief Information Officer position to guide the development and deployment of the information strategy for the LHIN: National and provincial health information strategies must be considered to ensure future growth and flexibility. 2. Reduce the risk and/or avoidance of electronic health record investment by establishing incentives for the adoption of the electronic health record. A priority focus should be supporting electronic health records supporting the primary care sector. 3. Enable sharing of information across all sectors within the LHIN, interconnecting clinicians, fostering client care collaboration and knowledge transfer. 4. Ensure that health information is available to the consumer, encouraging autonomy, improved knowledge, and personalized care. 5. Build towards a common database of health information reflective of the population needs within the region, thereby streamlining quality and health status monitoring. 6. Ongoing communication to all stakeholders. Goal includes building confidence in privacy and security of information within populations subject to stigma. (e.g., mental health)
<p>3</p>	<p>Establish a Service Navigator for the Health and Social Services Systems.</p>	<ol style="list-style-type: none"> 1. The Service Navigator needs to be supported as a funded function within the health care system, and identified as an important integration opportunity during this transition period. This role is not clinical in nature, and is generally short term. This may be effective as a provincial program, or a local initiative. 2. Job descriptions need to be developed with expectations to include service coordination across the broad health care sectors and provide client linkage to other sectors. Training and support for the individuals who supply this service need to be supported to maintain optimal functioning for individuals with significant and ongoing care needs. Service Navigators need to be empowered to assist individuals with self-advocacy regarding accessing required services and supports. 3. This function needs to be available for specific populations regarding their disability and medical needs, and could be incorporated formally as part of the funded service for specific populations by community agencies/groups and the CCAC when they are involved. 4. A shared database with the 211 initiative needs to be developed to ensure current and relevant information throughout the system. A standardized reporting system could be used to supply information to the health system regarding pressure points and under-serviced areas. 5. Protocols need to be established to guide the case coordination and service planning process depending on whether one or more than one service is delivered. These should be focused on local networks wherever possible.

II. Administrative / Support Services Integration Opportunities	
	<p>6. A standardized reporting mechanism to capture the function and outcome of this service navigation needs to be developed and shared throughout the system. This will support specific program feedback and broader planning function of the health care system.</p>
<p>4 Human Resources, recruitment/ retention/ utilization of staff</p>	<p>Current human resource planning done by individual organizations and agencies is to promote themselves as the 'employers of choice'. This often makes the problem of scarce resources even worse in such a competitive environment. Individual organizations need to continue to improve working environments and recognize the needs of employees but collaborative approaches are more likely to provide long-term, system wide solutions. The LHINs should provide a management of the tension of collaboration and the competition between and within organizations for integration of health human resources.</p> <p>Intra LHIN</p> <ul style="list-style-type: none"> ❖ The LHIN needs to begin by understanding the current situation – consultations with the various communities and agencies/organizations in each community and determine the critical shortages (any surpluses), status of current levels and any known future changes, this data needs to be collected and retained for future analysis. The LHIN would work to provide a comprehensive HR strategy by developing a needs analysis for the region with detailed inventories for each professional group and each community agency and organization. ❖ Within the region, LHIN collaboration would be a competitive strategy. LHINs should develop an HR inventory as a platform for networking and building relationships starting sector by sector and then moving to a system wide collaboration (identify trends, current and needed relationships) ❖ LHIN would develop an IT solution for regional candidate management: HR availability, opportunity and effective utilization. ❖ Encourage a community approach to recruitment, retention and deployment of resources. ❖ Develop and promote health careers within the region and develop plans to attract youth to training for health careers. ❖ Develop mentorship programs across professions and across the region to encourage retention, career development, and job satisfaction. ❖ LHIN needs to encourage providers to think collectively, and they can also suggest possible collaborations based on the information they may have collected from various organizations and communities as well as interprofessional collaboration ❖ Ensure that funding continues for recruitment and retention efforts (ie UAP incentive grants) and perhaps fund new incentives to be developed that are unique to region of LHIN and across various professions. Education subsidies for retraining or for retaining the youth of the region. ❖ The LHIN needs to empower people/workers and establish a healthcare culture that values people at the local "primary" level <p>Inter LHIN</p> <ul style="list-style-type: none"> ❖ LHINs must work with the MOHLTC to develop policies, legislation and regulations that support innovative practices and remove barriers to health human resource deployment. ❖ Research and identify existing integrated Human Resource strategies locally, provincially and nationally. LHINs should be responsible for doing more system wide analysis, in order to anticipate and deal with the effect of

II. Administrative / Support Services Integration Opportunities

		<p>different policies at the provincial level.</p> <ul style="list-style-type: none"> ❖ LHINs provincially need to ensure that any incentives etc are designed to reward innovation and collaboration and apply consistency. LHINs need to encourage succession planning to address the aging of the workforce and the technological changes; especially specialized skills (tech, xray) that have great impact on system. LHINs will need to collaborate with the province on international recruitment programs and planning. ❖ LHINs will need to facilitate collaboration among regulatory bodies and across sectors to explore scope of practice issues, and should work with unions, employers, professional associations and the provincial government to develop less rigid approaches to employment. ❖ LHINs will also need to work with various labour organizations, professional associations and employers to develop better wage equity across professions. Currently different organizations have very different wages for the same profession. ❖ Advocate regional LHINs with tertiary centres LHINs. ❖ The LHIN needs to coordinate the human resource needs with the education and training being provided within the region and within the province. ❖ LHINs should provide the Ministry of Education, Ministry of Training, Colleges and Universities with information regarding needs for local training courses and for appropriate numbers of spots for training courses offered. (Regional seat guarantees in education programs). ❖ LHINs will need to send feedback from the MOE and MTCU to the stakeholders in the region. ❖ Academic health science centres/education centres should have priorities in developing community practitioners for sustainable Ontario healthcare. ❖ LHINs need to promote through IT and communication technology, professionals are now provided with the opportunity for research, education and diversity of practice in any Ontario community. <p>Minimize competition between LHIN by sharing resources and maintain equalization of services and pay.</p>
5	<p>Optimize the Role of Community Support Services in the Provision of the Continuum of Care.</p>	<p>1. Improve Client and public awareness of service and issues:</p> <ul style="list-style-type: none"> ❖ Promote Community Support Services (CSS) by increasing awareness of the services, how to access them and to encourage volunteerism. Provide support for public education, training and facilitated collaboration between Community Support Services. ❖ Implement and expand “211 Information Service”. To ensure a virtual point of access for the client/consumer. Opportunities for single access/referral hub to CSS for client/consumers and caregivers. Ensure promotion of the “211 Information Service” to the client/consumer. <p>2. Improve access to CSS:</p> <ul style="list-style-type: none"> ❖ Standardize information collection. Duplicate intake and record keeping can be an ineffective use of time and prone to errors. Support CSS to standardize and share IT services where possible and develop common intake processes when practical. It is important to link CSS with the common health record/IT initiative. ❖ Implement a Service Navigator role. To help individuals make informed choices and linkages to other services. Please note that a Service Navigator is non-clinical in focus, and generally a short term role, which differentiates it from a case manager.

3. Assure input of Community Support Serve providers, clients and caregivers:

❖ **Involve CSS stakeholders in planning and decision-making.** The people who deliver and receive the services should have some say in service delivery planning. Establish a communication and feedback mechanism for representatives of CSS organizations and their clients. A mechanism for initiating action and providing input on issues to be developed for each geographical area and service sector as appropriate. This could include area meetings, survey processes and internet communication.

❖ **Recognize and support formal and informal community supports for client/consumers.** To develop the most support possible for client/consumers the formal service providers (organizations, professionals, etc...) will:

- be aware of the resources of other organizations.
- encourage and support the client/consumer's informal supports (family, friends, community connections).

This process would include education and training, networking sessions or supporting existing networking/planning groups with information and/or administration supports. LHIN assistance would be helpful for community planning and joint efforts.

4. Address LHIN coverage area issues:

❖ **Resolve geographic and jurisdiction issues.** The area covered by this LHIN is problematic. There is a wide range of geographical areas, population concentrations, municipal, county and hospital jurisdictions. There are divisions of traditional Community Support Service (CSS) intake areas. The CSS providers will work with the LHIN, in good faith, to generate confidence that all areas will have their issues heard and addressed.

❖ **Facilitate vertical integration.** There is a great opportunity for cooperation between acute care and CSS over a specific disease focus. For, example a client requiring dialysis treatments in a hospital would benefit from personal support services, hospital and transportation services working together to coordinate their services.

5. Address sustainability of Community Support Services:

❖ **Provide funding for programs or organizations that are filling the health care gaps.** The very nature of working in the area of community support services often means agencies run full-tilt, reacting to emergencies and client needs and creating a high burn-out rate among service providers. Not-for-profit organizations striving to help the most disadvantaged and vulnerable of our society often piece meal funding together from various sources and make do with little or no core funding. Non-funded CSS will continue to collaborate with other non-funded or funded CSS for possible resource sharing. This includes integration opportunities for shared resources, administration, office space (hotel/motel office system), support by volunteers and co-education of staff.

II. Administrative / Support Services Integration Opportunities

6 **Improve patient access to Rehabilitation Professionals and services by utilizing LHIN resources in the most efficient and effective ways.**

Plan for Rehabilitation Services that allow patients to experience "seamless care with dignity", by enabling an individual rehabilitation professional to follow the patient/client through the series of service locations that can occur from "hospital to home and long term care facility."

1. Consider planning and funding improvements to provide for intersectoral permeability of clinical services in the best interest of the patient, enabling the rehabilitation health care professional to receive referrals directly and follow the patient through the system and in various treatment locations.
2. Implement a common patient record to allow direct access to information by the professionals who require that information to best treat the patient.
3. Maximize the experience, skills, and full scopes of practice of health care professionals in the following ways:
 - ❖ Implement health promotion and disease prevention strategies, developed and/or led by rehabilitation professionals
 - ❖ Embrace innovations in the rehabilitation sector, such as e-Health
 - ❖ Offer joint education and mentoring
 - ❖ Allow preceptor opportunities in the region
 - ❖ Recognizing when group treatment is a potential option
4. Work with the Rehabilitation Committee and consider recommendations developed by the District Health Council.
5. Develop a common "wait list strategy" in the LHIN, focusing on recommendations made by health care professionals in the best interests of the patients instead of funding issues.
6. Investigate methods of permitting physician recommendations to lead to immediate treatment by rehabilitation professionals in the same manner as "specialists" by relying on physician referrals to direct, necessary treatments instead of the current additional layers of bureaucracy, assessments, and wait times at each funded site.
7. Consider options for direct access to rehabilitation professionals to decrease the burden on physicians and hospitals for those patients who recognize their specific needs due to patient history or other factors (see example of audiology model with direct access to audiologists for patients suffering from noise-induced hearing loss).
8. Plan for evaluation and measurement of patient satisfaction as well as for Ministry of Health and Long Term Care and inter-Ministerial cost-savings to the system.
9. Advocate for and provide for incentives, based on successful outcomes like the satisfaction and cost savings incurred within the system.

II. Administrative / Support Services Integration Opportunities

7 **Supportive Palliative Care Team of North Simcoe Muskoka.**

This initiative would propose the implementation of a Support Palliative Care Team for North Simcoe Muskoka LHIN. The Team would include:

- ❖ Navigators/Coordinators: would identify needs, appropriately refer, develop and work with overall care plans and provide system-wide navigation services, ensuring barrier-free services that would improve the quality of care.
- ❖ Educators: would extend standardized collaborative, certifiable volunteer training.
- ❖ Bereavement Counsellors: would be accredited and funded providing psychosocial supportive counselling and bereavement services, reducing the need for further health service interventions.
- ❖ Public Education Coordinator: would increase awareness of the value of early access to supportive palliative care services.

These team members would be strategically placed across the LHIN in existing Hospice Palliative Care organizations who would meet regularly. The Team would develop a Hospice Palliative Care strategy built from existing stakeholders and structures and encourage new partnerships within the planning area. This needs-based initiative would streamline the delivery of supportive palliative care services enhancing the continuum of care for the client from the point of access at diagnosis through illness, end-of-life care and bereavement.

The planning and collaborative partnerships would use standards for both service delivery and organizational structure as developed and published by the Canadian Hospice Palliative Care Association, March 2002. This model is also currently being used in several planning workshops to complete the "End-Of-Life Care" Strategy for Ontario.

Planning for integration, coordination and funding accountability will focus on these core areas:

1. What services are required at diagnosis and/or at an acute phase of an illness?
2. Assessment and navigation of client services from within the hospice palliative care support sector and primary care sector to various other health sectors such as hospital, specialized services such as cancer care, community care access centres, and disease prevention and treatment educational associations.
3. Design and implementation of outcome measurement evaluation tools through coordinated academic research institutes within community-based settings.
4. Implementation priorities with Provincial e-Health initiatives for client integration health management systems.

Community engagement strategies have begun with key stakeholders in North Simcoe Muskoka and continue to flourish, as outlined in the integration initiative description. This model of a team to navigate and support the client facing a life-threatening illness could easily be adapted throughout the province of Ontario providing high impact outcomes for not only the client and family, but the health care system.

D. Unique Characteristics of LHIN #12

The role of Academic Health Sciences Centre and voluntary Networks in LHIN #12.

There is no academic health science centre in the area. The health care service organizations have developed existing relations with facilities in through out the province with academic health sciences centres.

Unique Characteristics/features of LHIN #12 that impacted this process.

Demographics & Growth: Simcoe County is one of the fastest growing areas in the province with a growth rate more than double that of Ontario, and four times that of Canada. According to the 2001 Census, over the last 5 years Ontario grew by 7.3%, and Simcoe County grew by 14.3%, ranking third provincially and seventh nationally in percentage growth. Over the past ten years, a 26% increase has translated to almost 80,000 new residents in Simcoe County. Almost all areas in Simcoe have seen growth since 1991, with Central Simcoe experiencing the largest population growth over the past 10 years.

Such growth in Simcoe has resulted in, and will continue to require, increased demand for all types of health care and social services, as well as affordable housing and other social and community resources.

Simcoe is anticipating continued growth, which will affect every service sector over the next few decades. From 2001-2016, Simcoe's population is projected to experience a growth rate of almost 40%, compared to a provincial growth rate of 17%. The age sex structure of the population is also expected to change considerably, where there will be a significant increase in the older cohorts. Over the next 15 years the fastest growing cohort will be the 85+ age group, which is projected to double between 2001 and 2016.

The 2001 population for the District of Muskoka was just over 53,000 residents, with the majority residing in the Towns of Huntsville, Gravenhurst and Bracebridge. The District experienced a 5.2% change in population between 1996 – 2001. The District of Parry Sound on the other hand experienced a population decline of –0.6% during those years. In East Parry Sound, the population is concentrated in villages along the Highway 11 corridor.

It is projected that Muskoka's growth rate will increase slightly to 1.8 % per annum from 2001-2016. The age sex structure of the population is also expected to change, where there will be a significant increase in the 65+ age group and resulting demand for health services. The Lakelands District School Board is projecting a significant decline in school enrolment of 14.5 % over the next 3 years affecting almost every elementary school. The region is losing people in the 25 – 34 age group due to lack of employment opportunities.

Both Simcoe and Muskoka regions, and to some extent East Parry Sound, are highly regarded seasonal playgrounds for much of South and Central parts of Ontario and therefore population surges are typical in the months of July and August with smaller but still significant population increases throughout the winter months. Anecdotal information suggests that many of the current vacationers/cottagers will choose to retire in these regions.

Rurality: Simcoe is a mixture of urban and rural areas that is densely populated when compared to the province overall. Barrie has a population density of almost 1,350 people per square kilometre, amongst the highest in the province after such municipalities as Toronto, Mississauga, Newmarket and Orangeville. The area has a number of dispersed population centres instead of one major urban centre.

Muskoka and East Parry Sound are predominantly rural areas, dotted with small towns, villages and hamlets. Overall the population density is 13.7 persons per square km for Muskoka and 4.3

for Parry Sound. There is a strong sense of community within the settlement areas, with neighbours and volunteers providing important services necessary for health and well-being.

Access issues result from the limited amount of transportation options available in Simcoe County and the Districts of Muskoka and Parry Sound. There are no transit systems that connect the regions and very few towns have transit available. For a person without a car or not able to drive, which includes a large portion of the elderly population, many health services located throughout the County and Districts as well as specialty and/or tertiary services outside the region are inaccessible. Transportation issues further impact the delivery of community support services throughout the rural areas.

As a result of the low population density and the rural character of Simcoe's northern region and the Districts of Muskoka and Parry Sound, problems with access to health and social services can occur.

Income: Simcoe County has a lower average income than the rest of the province. The average individual income of the population aged 15 years and older is \$30,350 in Simcoe compared with \$38,150 in York and \$32,900 in Ontario. The average family income in Simcoe is approximately \$7,000 less than the provincial average. Muskoka residents have an average household income more than \$14,000 lower than the provincial average. Residents of Parry Sound are further disadvantaged, earning \$20,000 less than the provincial average.

Aboriginal: Simcoe has a sizable Aboriginal population, above the proportion of the population of Aboriginal people in Ontario. The majority of residents in Mnjikaning First Nation and Christian Island identify themselves as North American Indian as their ethnicity. While the absolute number of people living in these two areas is small, the total number of residents identifying as Aboriginal is highest in Barrie (1,520), Penetanguishene (1,110) and Midland (1,155).

Muskoka District is home to over 1,000 Aboriginal people, mainly residing at Wahta First Nation.

Francophone: Knowledge of official languages is an important factor in accessing resources within the district. The percentage of people who can speak neither English or French in Simcoe, is quite a bit lower than the province. While most municipalities have primarily English speaking populations, Tiny (21%) and Penetanguishene (27%) have a substantial proportion of the population that speak both official languages.

Of the population in Muskoka and Parry Sound, over 99% speak English as their home language compared with 89% in Ontario, including a very low percentage of visible minority populations.

Primary Care: Within the borders of the North Simcoe Muskoka LHIN #12 there are seven communities and/or areas designated as under serviced for general/family practitioners (GP/FP) with a total of 45 vacant positions (December 2004). In addition there are 59 vacancies for specialty positions as of June 2004 (ROMP) Estimates as high as 30% of the population in the Barrie area are without a family physician.

Resource Allocation: The increasing demands of a growing population without any systemic investment of base funding in many community based programs for the past 10 years have crippled the entire continuum of health services. For example, the Ministry of Health and Long-Term Care have documented the community mental health system as the lowest per capita funded region in the province. In a current review of long-term care beds in the County, the Ministry long-term care redevelopment team has documented that the County has the highest LTC bed utilization rate in the province. In a recent study (March 2004), the Simcoe York DHC found that the County had a bed supply ratio lower than the provincial benchmark accounting for a waitlist of over 1,000 people. A similar situation exists in Muskoka and Parry Sound.

Current Planning Networks: There are a number of examples of improving healthcare integration that already exist in the areas covered by the new **North Simcoe Muskoka LHIN**. Examples include:

- The work of the Simcoe Muskoka Health Network include:
 - Regional Laboratory Program
 - Simcoe Muskoka End Stage Renal Dialysis Network
 - Network 1 Acute Mental Health Coordinating Committee
 - Development of a shared ALC policy
 - Central Ontario Healthcare Purchasing Alliance

- Other examples include the work of various structures that have been formed in Simcoe County, the District of Muskoka and East Parry Sound that may provide a foundation on which LHIN planning work can develop.
 - Simcoe County Mental Health System Management Group
 - Coalition for Child, Youth and Family Service in Simcoe County
 - Simcoe York Addiction Services (and Problem Gambling) Management Committee
 - Simcoe Seniors Health Planning Committee
 - Simcoe York Muskoka Cardiac System Planning Committee
 - Simcoe Dual Diagnosis Committee
 - Simcoe Human Services Justice Coordination Committee
 - Simcoe Muskoka Rehabilitation Task Force
 - French Language Service Advisory Committee
 - Hospice Palliative Care Committee of Simcoe County
 - Simcoe County Dementia Network
 - Simcoe York Dual Diagnosis Education Committee
 - Simcoe County Geriatric Grand Video Rounds
 - Adult Educators of Simcoe County
 - P.I.E.C.E.S Initiative Network
 - Homeless Initiative
 - Muskoka-Parry Sound Community Mental Health Service
 - Crisis Management Centre
 - Divestment of RVH Crisis Line to Community
 - Central Simcoe Primary Care Planning Forum

E. Description of the Transformational Thinking and the process that guided our approach to the task.

The North Simcoe Muskoka – LHIN #12 Planning Team was formed at the November 29, 2004 LHIN community workshop held in Orillia.

The first meeting was held on December 8, 2004 in Barrie, at which overarching principles about how to conduct the team's work were agreed upon, as well as an action plan to complete the work by the February 14, 2005 submission date. Team members felt the advance planning, the leadership and facilitation, and the input, provided by the Simcoe York District Health Council was invaluable in starting-off the project and for its ultimate successful completion. At this meeting it was decided to re-frame a number of the integration opportunities as "patient care" integration priorities, rather than "administrative/support", based on the original intent of those who put forward these topics.

The team had reservations about the tight timeline, in light of the upcoming holiday season and members' very busy schedules.

The team was concerned whether the group created at the November 29th LHIN community workshop was truly representative of the leadership of the health care "system" of north Simcoe, Muskoka and East Parry Sound. There was concern about representation from Muskoka and East Parry Sound areas. And additionally, although representatives from the francophone and aboriginal communities were represented at the LHIN community workshop in Orillia, team members felt that the issues and concerns of the francophone and aboriginal populations of the district are not adequately addressed in this document and much work will need to be done to add the perspectives of these populations to future work of the North Simcoe Muskoka – LHIN #12.

Nonetheless the team moved forward, with the expectation that this process was only the beginning and that the community input process would be an on-going function of the North Simcoe Muskoka – LHIN #12.

Because of the concern about adequate representation, the need for strong communications was identified early as a critical component and team members took leadership positions. The extensive area covered by North Simcoe Muskoka – LHIN #12 made regular meetings of all contacts impossible. A listserv was set up and used as the primary communication tool throughout the process. (The government eRooms would have been valuable if created earlier.)

The planning group met four times providing excellent opportunities for developing thinking and the project's overall direction as well as commenting on individual initiatives. The creation of the report was a very collaborative experience among team members. Meetings were held on December 8, 2004, January 19, 2005, January 28, 2005 and February 9, 2005.

The team made the best use of existing processes and existing groups to undertake its consultation. Planning team members responsible for specific integration opportunities approached existing Simcoe York District Health Council planning groups and other local and regional support groups for input. Team members responsible for e-Health, IT and a common client record were active participants at e-Health Forums put on by the Ministry of Health and Long-Term Care and the Simcoe York District Health Council and took information back to integrate into their reports. Numerous community contacts and small group consultations were held. PowerPoint presentations were developed and shared. Again, keeping remote members informed was challenging and ultimately e-mails were necessary to connect some individuals. Efforts were made to ensure the inclusion of representatives from Muskoka and East Parry Sound. It was noted that the area this LHIN covers would be better identified as North Simcoe, Muskoka, and East Parry Sound.

The job of assessing local concerns, issues and initiatives is not finished. One of the first tasks of the new North Simcoe Muskoka – LHIN #12 will be to undertake a series of public consultations to engage the community and to educate both consumers and providers about the role of the LHINs and what expectations the public and stakeholders should have to measure the performance of the LHIN.

No extraordinary costs were expended by this LHIN to write this report. However, very busy people gave of their time and talents throughout this process and expect their input to be taken seriously and have an impact on the future of the health care “system” in north Simcoe, Muskoka and East Parry Sound. Throughout the process team members expressed their hope that the work undertaken is seriously considered to guide the new LHIN/or by the new LHIN board as the North Simcoe Muskoka – LHIN #12 becomes a reality and that they offer their continued support and consultation as the LHIN moves ahead, in spite of comments that their work will be over on February 14th.

Team members also expressed their appreciation to have been given the opportunity to play such an interesting role in the development of the province’s new health “system” and felt that they had been involved in an incredible learning experience.

Top 10 Integration Priorities
from the North Simcoe
Muskoka LHIN workshop
November 29, 2004, Orillia

Patient Care / Service Priorities			
Number	Report #		Votes
1	18	Efficient and Sensitive Transition between acute Care, Long Term Care, Mental Health, Community, Developmental Disabilities etc and the opportunity to move between care systems as needed by client	55
2	21	The opportunity exists to improve access by people without a family physician to appropriate and cost effective Primary Health Care.	49

Administrative / Support Priorities			
Number	Report #		Votes
1	8	Using e-Health Technologies for Integrated Care, Services and Education across the Continuum	60
2	24	Universal/common patient record and health management System	58
3	1	Integrated IT systems	49
4	6	Optimize the Role of Community Support Services in the Provision of the Continuum of Care.	45
5	13	Improving patient/client access to health care professionals/services by utilizing the LHIN resources in the most efficient and effective way (including speech-language pathology, audiology, occupational therapy, dietetics, social work, physiotherapy, etc.)	37
6	19	Human Resources, recruitment / retention utilization of staff. When, where, how?	53
7	20	Establish a Navigator System for Health and Social Systems	54
8	4	Hospice Palliative Care in North Simcoe/Muskoka	28

All Priority Integration Opportunities

November 29, 2004, Orillia

#	Opportunity	Initiator	Total Votes
8	Using e-Health Technologies for Integrated Care, Services and Education across the Continuum <i>(Priority # 1 and #8 were later combined.)</i>	Helen Russell	97
24	Universal/common patient record and health management system	Jeff Doleweerd	95
1	Integrated IT systems <i>(Priority # 1 and #8 were later combined.)</i>	David Colgan	94
6	Optimize the Role of Community Support Services in the Provision of the Continuum of Care.	Patricia Mueller	86
13	Improving patient/client access to health care professionals/services by utilizing the LHIN resources in the most efficient and effective way (including speech-language pathology, audiology, occupational therapy, dietetics, social work, physiotherapy, etc.)	Beth Ann Kenny	69
18	Efficient and Sensitive Transition between acute opportunity to move between care systems as needed by client	Val Powell	65
19	Human Resources, recruitment / retention utilization of staff. When, where, how?	Doris Middleton	61
20	Establish a Navigator System for Health and Social Systems	Dan McGale	61
4	Hospice Palliative Care in North Simcoe/Muskoka	Brenda Smith	53
21	The opportunity exists to improve access by people without a family physician to appropriate and cost effective Primary Health Care.	Carla Palmer	52
17	Building Intellectual Capacity To Facilitate Transformational Change That is Evidence / Research-Based.	Kirsten Krull-Naraj	48
12	Volunteerism in Health Care	Tammy Stadt	47
2	Single point of access to community services 24/7	Monique Lafleur	46
22	Emergency Care	Gord Key	46
26	Administration efficiencies	Margie Draper	45
11	To ensure a local continuum of mental health and addiction services	Lorna Tomlinson	41
10	Mental Health and Addiction integrating into primary care	Greg Howse, Nancy Roxborough	38
14	Multisector integrated planning for children	Varouj Eskedjian	36
29	Long Term Care Placement : Permanent and Temporary	Deborah Wall-Armstrong	36

3	Aboriginal Health	Yvon Lamarche	27
7	Advocacy / Education for Chronic Disease Prevention	Christine McIntosh	26
9	Diabetic Care Continuum	Anne Bell	26
25	There is an opportunity for long term care facilities to integrate with the CCAC, specialized mental health/geriatric services and other educational or clinical resources to optimize the function of residents in facilities. This has great potential for citizens as well as for other sectors in health care.	Maureen O'Connell	24
28	Diagnostic Services	Rose Mary Squires	23
16	What opportunities exist for the coordination of emergency surgical services whilst maintaining a critical mass of surgical specialists within each community?	Gabrielle Coe	19
30	Integration of Psychogeriatric and Adult Psychiatry at Community Mental Health Clinics	Dale Graham	19
27	Services en français/french language services	Nicky Rauzon-Wright	16
23	Access for People with Disabilities	Louise Gagne	15
5	Patient Advocacy	Julian Kusek	12
15	Integration of Chiropractic Management for Neuromusculoskeletal problems within hospitals and community networks.	William Charlton	4

Organizations participating in this process...

- Algonquin Health Services
- Alliance of Professional Associations for Community-Based Therapy Services (APACTS)
- ALS Society of Ontario
- Alzheimer Society North East Simcoe
- Alzheimer Society of Greater Simcoe
- Alzheimer Society of Orillia and Area
- Alzheimer Society Simcoe NE
- Anna Moller, Nurse Practitioner
- Arthritis Society
- Barrie Association of Volunteer Administrators
- Barrie Community Health Centre
- Barrie Medical Clinics
- Barrie Midwives
- Barrie Public Library
- Barrington Retirement Home
- Bayshore Home Health
- Beausoliel First Nation-CSS
- Brain Injury Services of Simcoe County
- Breaking Down Barriers - Independent Living Centre
- Canadian Hearing Society
- Canadian Mental Health Association York - Bradford Support Services
- Canadian Paraplegic Association
- Canadian Red Cross
- Caregivers Support Network Muskoka/Parry Sound
- Centre for Addiction and Mental Health
- City of Barrie
- City of Barrie Seniors Centres
- CNIB
- Collingwood General and Marine Hospital
- Community Care Access Centre Simcoe County
- Community Care Access Centre York Region
- Community Care Access Centre Muskoka – East Parry Sound
- Community Care Access Centre Simcoe County
- Community Home Health Services
- Consumer Survivor Program Collingwood
- County of Simcoe
- County of Simcoe Sunset Manor
- District Health Council York – Simcoe
- Dr. Brent Eley, MD,
- Emergency Administrators Group
- Extencicare
- Georgian College
- Hearing Impaired
- Helping Hands, Orillia
- Hillcrest Village
- Hospice Bracebridge
- Hospice Georgian Triangle
- Hospice Huntsville
- Hospice Huronia
- Hospice Muskoka
- Hospice Orillia
- Hospice Palliative Care Committee of Simcoe County
- Hospice Simcoe
- Huronia Hearing Impaired
- Huronia Regional Centre -MCSS
- Jarlette Health Services
- Long Term Care Management
- Mary Magill Centre
- MDS
- Mental Health Centres
- Michelle Clifford -Middel, Nurse Practitioner
- MOHLTC
- MPP's office North Simcoe
- Muskoka Seniors
- Northern Diabetes Health Network
- Ontario Association for Families of Children with Communication Disorders
- Ontario Association of Speech -Language Pathologists and Audiologists (OSLA)
- OPSEU Region 3
- OPSEU/MCSS
- OPSEUP at Malone Saint Elizabeth
- Orillia Soldiers Memorial Hospital
- Pain & Symptom Almaguin Palliative Care Team
- Pain & Symptom Mgt. Program of Simcoe County
- ParaMed Home Health Care
- Parkinson Society Canada
- Professional Rehabilitation Outreach
- ProResp.
- Psychogeriatric Resource Program
- Public Health Unit
- Roberta Place
- Royal Bank
- Royal Victoria Hospital Cancer Care Program
- Royal Victoria Hospital Healthy Aging Program
- Rural Ontario Medical Program
- Saint Elizabeth Healthcare
- Senior Interagency Network and Simcoe Coalition for Adults with Physical Disabilities and Other Sensory Challenges
- Simcoe County Alliance to End Homelessness
- Simcoe County Association for the Physically Disabled
- Simcoe County Coalition for Adults with Physical Disabilities and Other Sensory Challenges
- Simcoe County Dementia Network
- Simcoe County District Health Unit
- Simcoe Muskoka Hospital Network #1
- Simcoe Muskoka Parry Sound Half-Way House
- Simcoe Outreach Services
- The Friends-Muskoka/Parry Sound
- Victorian Order of Nurses (Pain & Symptom Mgt. Program)
- Vital Aire
- VON
- We Care
- Womens Health Program