

Waterloo – Wellington Local Health Integration Network (LHIN #3)



**Final Report to the LHIN #3 Board
February 2, 2005**

LETTER OF TRANSMITTAL

February 2, 2005

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

Dear Ms. Paech:

On behalf of the Waterloo Wellington LHIN #3 Steering Committee, I am conveying our completed resource guide to you within the specified time frame. Our report prioritizes the LHIN #3 top ranked integration initiatives identified by our community. It also proposes some high-level action plans that will enable the LHIN CEO to implement them with the support and involvement of local stakeholders.

It is the desire of the Steering Committee to remain in tact. Members will want to reconvene immediately following the appointment of the LHIN #3 CEO and Board Chair. A designate from the Steering Committee will arrange a meeting with the CEO and the Steering Committee to discuss this report, its priorities, and acquaint the LHIN CEO with the unique features of our geography. The health care agencies comprising the Steering Committee are prepared to work in partnership with the LHIN Board to address the priorities summarized in our report.

Thank you for the opportunity to lay the groundwork for identifying and implementing the community's integration initiatives. Our community looks forward to the establishment of a mutually supportive relationships with our LHIN #3 CEO and Board.

Yours truly,

A handwritten signature in cursive script that reads "Susan Burns".

Susan Burns, Facilitator
LHIN #3 Steering Committee

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Table of Contents

1.	Introduction and Background	1
1.1	Waterloo-Wellington Area	1
1.2	System Integration Opportunities Identified at November 19, 2004 Community Workshop	2
1.3	Top Ten System Integration Opportunities Identified	3
2.	System Integration Opportunities	4
2.1	Templates A and B	4
3.	Priority Setting of Integration Opportunities	25
3.1	Overview	25
3.2	Template C – High Level Action Plans	26
4.	Capturing Unique Characteristics of LHIN #3	33
4.1	Template D	33
5.	Transformational Thinking and Process (Template E)	35
5.1	Approach and Process	35
5.2	Key Learnings	36
5.3	List of Organizations Involved in Process	38
6.	Concluding Comments	39
	Appendices	40
A	Templates A/B for System Integration Opportunities (other than the top ten) as identified at November 19, 2004 Community Workshop	
B	LHIN #3 Steering Committee: Planning Lead Contact Information	
C	Distribution List for Final Report to LHIN#3 Board	

Waterloo – Wellington Local Health Integration Network (LHIN #3)

1. Introduction and Background

1.1 Waterloo-Wellington Area

Waterloo Region and Wellington County comprise a mix of small-medium urban centres, small villages and hamlets, and rural-dispersed farm-based communities. The population density for Waterloo Region is 344.7 persons/square kilometer, and for Wellington County it is 76.4 persons/square kilometer. Waterloo and Wellington have reached a population threshold (~700,000) that is now conducive to the development of specialty regional programs and services.

Stakeholders in Waterloo and Wellington have a long history of using voluntary-based networks as mechanisms for service coordination, planning, and the ongoing development of services and service relationships.

The Waterloo-Wellington LHIN (LHIN #3) does not have any Academic Health Science Centres within its boundaries.

The table below provides an overview of the health services available in Waterloo-Wellington.

	<u>Waterloo Region</u>	<u>Wellington County</u>	<u>Total</u>
Acute Care	3	3	6
Complex Continuing Care	2	3	5
Hospitals with Schedule 1 Mental Health Beds	1	1	2
Long-Term Care Facilities	23	11	34
Home Care (CCAC)	1	1 *	2
LTC Community Support Services	19	7 *	26
Mental Health & Addiction Services	11	8	19
Community HealthCentres	3	1	4
Public Health Units/Departments	1	1	2
Supportive Housing Services	3	2	5

Source: WRWDDHC, December 2004

*these organizations serve both Wellington and Dufferin Counties

Additional information on the unique characteristics of LHIN #3 can be found in Section 4.

1.2 System Integration Opportunities Identified at November 19, 2004 Community Workshop

The following topics were presented as potential Priority Integration Opportunities. They are not listed in any particular order or prioritization.

1. LHIN-side Health Human Resources Plan
2. Communicable Disease/Infection Control
3. Accessible Integrated Electronic Health Records
4. Community Care Services Remodeling
5. Accessing Services
6. Integration of Access, Assessment, Case Management, Case Service Management & Discharge Planning
7. Developing Models of Service that Empower Individuals to take responsibility for their health and related services
8. Seniors Health – Education of Services
9. Patient Care/Service – incorrect terminology
10. Shift thinking fro Continuum of Care to System
11. Hard to Serve Clients – Complex Care Needs
12. Public Reporting and Scorecard Measurement
13. Integration of Rehabilitation for People with Disabilities
14. Admin and Support Opportunities (other than IT)
15. Mental Health Services / System
16. Integration of Community Health with Mental Health
17. Health and Addiction Programs
18. Utilizing of the Provincial Bed and Resource Registry
19. Integration of Health Care Providers in the Treatment of Musculoskeletal Problems
20. Integration of Hard to Serve Younger Adults into LTC
21. Role of Community Support Agencies in Health Services
22. Recruitment and Retention of Health Human Resources
23. Conversion of Existing Networking Groups into Action Groups
24. Funding for Long Term Care Services
25. Role of Volunteers in the Health Care System
26. Patient Populations: Service Delivery in LHINs: Better/Worse?
27. Cross-Sector Training
28. Fair Funding for Waterloo/Wellington
29. Regional Care Maps
30. Rural Intersectoral Integration and Planning for Intersectoral Collaboration for Health Promotion, Disease Prevention, Service Delivery
31. Multidisciplinary Primary Care
32. Networks
33. Ensuring Care in the Community for People with ongoing Chronic Needs/Conditions

1.3 Top Ten System Integration Opportunities Identified

From the list of 33 identified integration priorities the following eleven (11) were identified. Based on the scoring / voting, there was a tie for the tenth priority. In addition, it was noted that several of the 33 priorities were actually duplicated, and as such, adjustments were made to better reflect the community's choices. The Integration Opportunities are listed here in order of the scoring exercise completed at the LHIN #3 Community Workshop on November 19th.

Integration Opportunities Identified at November 19th Community Workshop <i>(Not in Priority Ranking – See Section 3.1)</i>
<ul style="list-style-type: none"> LHIN – wide Health Human Resources Plan including Recruitment & Retention (both Admin & Patient Care) <i>*LHIN-wide Health Human Resources Plan / #22 Recruitment & Retention of Health Human Resources</i>
<ul style="list-style-type: none"> Regional Care Maps (both Admin support and Patient Care) <i>Regional Care Maps</i>
<ul style="list-style-type: none"> Integrated Performance Measurement and Public Report Cards (Admin support) <i>Public Reporting and Scorecard Measurement</i>
<ul style="list-style-type: none"> Integrated Electronic Health Record (Admin support) Accessible Integrated Electronic Health Records
<ul style="list-style-type: none"> Discharge Planning and Integrated Case Management (Patient care) <i>Integration of Access, Assessment, Case Management, Case Service Management & Discharge Planning</i>
<ul style="list-style-type: none"> Admin support other than IT (Admin support) <i>Admin and Support Opportunities (Other than IT)</i>
<ul style="list-style-type: none"> Integrating Community Health with Mental Health and Addiction Programs (Patient care) <i>Integrating Community Health with Mental Health and Addiction Programs</i>
<ul style="list-style-type: none"> Role of Community Support Agencies in Health Services (Patient care) <i>Role of Community Support Agencies in Health Services</i>
<ul style="list-style-type: none"> Use of Existing Service Networks (Admin support) <i>Networks</i>
<ul style="list-style-type: none"> Developing Models of Service that Empower Individuals to take responsibility for their Health (Patient care) <i>Developing Models of Service that empower individuals to take responsibility for their health and related services</i>
<ul style="list-style-type: none"> Mental Health Service and System Integration Opportunities (Patient care) <i>Mental Health Services/System</i>

*Ministry's priority titles are in italics

2. System Integration Opportunities

2.1 Templates A and B

Templates A and B have been completed for the Integration Opportunities Identified at November 19th Community Workshop. Again, these Integration Opportunities are not in Priority Ranking – See Section 3.1.

Title of patient care/service initiative: LHIN-Wide Health Human Resources planning with an emphasis on recruitment and retention.		Type of integration (more than one box can be checked) <input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe: Engaging in HHR planning activities can include a variety of integration types, depending upon the initiative. There is opportunity for both inter-sectoral and inter-professional collaboration, focusing on job classes across the continuum of health care. Partnerships with the education sector in particular, should be developed to enhance HHR strategic planning.
Existing or new initiative? <input type="checkbox"/> Initiated/existing integration activity* <input checked="" type="checkbox"/> x New Integration Opportunity New integration opportunity The local DHC, in its report on HHR identified the need for a district-wide mechanism to coordinate planning. A LHIN #3 mechanism will achieve the same ends in HHR planning.	List of partners involved: Local involvement in HHR planning activities cross organizations and sectors, with activities that focus on issues related to physician recruitment, the availability of specialty care services, inter-agency recruitment of nurse practitioners, and strategies pertaining to the provision of shared services. Partners include the local Chambers of Commerce (which sponsors the Physician Recruitment Committees in Waterloo Region and Guelph), member organizations of the Wellington County Hospital Network (Network # 3) as well as various community-based organizations working together to provide health services to residents in Waterloo and Wellington. The Waterloo Wellington Training and Adjustment Board also partners with stakeholders in education and the health industry to determine action plans for preparing the workforce to meet the demand for service.	
Please briefly describe the initiative. Increasingly, HHR concerns dominate the agenda in health care. Issues include: meeting human resource demand, identifying and applying the appropriate skill mix within health care settings, accessing training and education opportunities, and addressing challenges related to staff retention. All of these issues are even more pressing within the community health care services sector. For example, recruitment and retention problems exist in the Personal Support Worker (PSW) sector, exacerbated by the wage disparity between community and Long-Term Care facility PSWs, and the difficulty that community colleges are experiencing in attracting students to the field. The Waterloo Wellington Training and Adjustment Board reports on trends influencing the health human resource supply, including an aging workforce, and a critical shortage of professionals and skilled technical workers. Examples of health human resource coordination/integration projects that have recently been undertaken in our district include: The Wellington County Hospitals Network (WCHN) is conducting a review of Specialists offering medical care to County residents. The review is aimed at developing strategies to increase access to a full range of physicians that provide medical specialty care services, through program development, and shared human resource strategies. Additional integrated HHR planning includes shared psychiatry recruitment initiatives within Wellington and the submission of a proposal for a primary care nurse practitioner to serve the addictions service sector in Waterloo - Wellington. Stakeholders within the Long-Term Care sector in particular note the challenges presented by competition and scarce resources, and the difficulty in partnering locally regarding recruitment strategies. Provincially, the Ministry of Health and Long-Term Care provides a website aimed at promoting the long-term care facility sector and providing a recruitment service for long-term care facilities. Health Human Resource challenges in the nursing sector are well documented, and as in long-term care, competition for scarce resources is a barrier to collaborative HR planning. Provincially, the RAO is working to promote the nursing profession and is engaged in activities to increase the supply of nurses provincially. Hospitals in Waterloo Region and Wellington-County participate in the OHA annual workforce census, and the OHA has a Provincial Health Human Resources Strategic Group.		

A network structure for planning health human resource initiatives within the LHIN is recommended as the mechanism through which continued coordination/integration can occur. Identified potential opportunities to be pursued include:

- Building on the Ontario Health Care Labour Market Survey Report 2003 (prepared by the District Health Councils across Ontario) and the OHA Annual Workforce Census, examine the local health care labour market, partnering with the Waterloo Wellington Training and Adjustment Board) identifying size and composition of existing work force, projecting gaps across disciplines, and identifying strategies to address shortages.
- Identify gaps in physician primary care and specialty services,
- Provide a clearinghouse for information related to medical manpower planning locally.
- Building on the 2003 DHC’s of Ontario Report and local DHC report on HHR Capacity and Utilization, identify “best practices” in human resources recruitment and retention, with the intent of reducing inter-LHIN competition for scarce resources and developing retention strategies to meet community need.
- Consider the merits of shared HHR recruitment and retention strategies, such as, a central bureau for recruitment, sharing scarce specialty resources in underserved disciplines, collaboration between providers in the development of retention strategies that balance the opportunity for employee growth with the protection of an organization’s human resources.
- Provide a clearinghouse for collaborative HHR planning initiatives across the district, fostering partnerships and increasing the opportunity for joint ventures.
- Based on clinical expertise and specialty standard of care, identify consistent criteria for provider qualifications across the health care continuum, thereby reducing disparities between sectors, e.g., acute vs. community care, long term care vs. acute and chronic care, and urban vs. rural health care. Consistent criteria will also help to promote the utilization of providers within their full scope of practice.
- Provide an opportunity to identify shared training and education for disciplines that cross the health care continuum.
- Encourage a shared health care culture that attracts scarce providers to Waterloo-Wellington, with such features as workplace policies that offer flexible scheduling, and opportunities to create full time positions for specialty providers who may require more than one employer to make working in Waterloo-Wellington viable.
- Consider the merits of better utilization of community care resources through integrated referral or call centres.
- Partner with local educational institutions to increase the capacity of the health education sector to meet community health human resource needs, for example, maximize community placements to complement local HHR requirements.
- Recognizing the contribution of volunteers to the long-term care sector, promote collaborative ways of recruiting and retaining the volunteer labour force.

In addition to proving local integration and coordination of HHR planning activities, a LHIN HHR Network could interface with other LHIN ‘s working on similar issues, as well as participate with the province in the development of HHR policy. Data regarding HHR supply from the professional Colleges, the Nursing Secretariat of the MOHLTC and the Ontario Hospital Association will be key to advancing LHIN HHR planning locally. Partnerships should include provincial policy development and planning bodies, such as the Ontario Hospital Association HHR Strategic Group.

<p>What is the current status? Currently a single Network for HHR Planning does not exist in the district. Current HHR activities tend to take place within organizations rather than between organizations, with some notable exceptions, such as the physician recruitment committees in Waterloo Region and Wellington County. Recent DHC HHR planning indicates strong community support for a joint HHR planning body that can address numerous system-wide coordination and integration issues and prioritize them for collaborative community action.</p>	<p>What are the outcomes/lessons learned (if any)?</p> <ul style="list-style-type: none"> • Locally, recruitment and retention efforts of individual organizations have been fraught with challenges based on competition, insufficient support for specialty disciplines, and wage disparity issues. • The efforts that have met with success include those where organizations and practitioners from across organizations and communities have come together to address their staffing concerns. • Past DHC HHR planning has identified community leaders in the HHR arena that have indicated interest in a joint HHR planning network. • The complexity of HHR strategic planning and the numerous activities occurring in the district will require dedicated planning and coordination support to realize the benefits of the network. • It will be important to focus on local opportunities while remaining involved with provincial policy development and inter-LHIIN planning initiatives.
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Lead contact person:

Name: Cheryl Batty, Senior Planner, WRWDDHC, Phone: 519-836-7440, X229 Email: cbatty@wrwddhc.on.ca
 Susan Burns, Executive Director, WRWDDHC, Phone: 519-836-7440, X224 Email: sburns@wrwddhc.on.ca
 Suzy Young, St. Mary’s General Hospital, Phone: 519-749-6578 X1953 Email: syoung@smgh.ca
 Blair Philippi, Administrator, Caressant Care Nursing Home, Arthur, Phone: 519-848-3795 Email: bphilippi@caressantcare.com

Title of patient care/service initiative: Regional Care Maps (both Administration Support and Patient Care)	Type of integration (more than one box can be checked) <input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input checked="" type="checkbox"/> Other, describe:
Existing or new initiative? <input type="checkbox"/> Initiated/existing integration activity* <input type="checkbox"/> New integration opportunity	List of partners involved: Community Support Services, Community Health organizations CCAC, DHC, Public Health Long Term Care LHIN hospitals, and Tertiary care hospitals Private health care providers MOHLTC Universities
Please briefly describe the initiative. Goal of Initiative: <ul style="list-style-type: none"> To develop and implement new innovative ways of delivering patient/client care in an effort to improve outcomes, reduce wait times, contain costs and enhance the level of satisfaction both patients and caregivers have with Ontario's health care system and services. Critical to the success of this initiative will be the development of care plans that enable patients to seamlessly move between care environments, whether it be from hospital-to-hospital, hospital-to-LTC or homecare, family practitioner-to-physician specialist or from a tertiary centre-to-local LHIN based facility. What are Care Maps? <ul style="list-style-type: none"> Care maps or clinical pathways are tools or guides that facilitate the implementation of evidenced-based best clinical practice in a seamless and integrated way. This is accomplished by designing and assembling the optimal care guidelines into a comprehensive and cohesive set of processes that are not organizationally bound. The question of who is best positioned to provide a particular element of the plan is only asked after the optimal care process has been designed. More simply put, it means re-examining what needs to be done and how best to do it before deciding who should be doing it. An excellent example of an effective Regional Care Map model is the Coordinated Stroke Strategy which has resulted in an improvement in stroke care across the continuum. . Care maps will focus on the development of new technically advance methods of delivering care fostering fuller coordination and integration of services across the spectrum of providers within the LHIN and with providers who reside outside of the LHIN. Roles and responsibilities will be delineated, recognizing the important contribution each organization has to make. However, it will be critical for each organization to be prepared to accept that its primary responsibilities may change across different care maps and that over time its role may evolve into something significantly different from the role it is playing today. Challenges needing to be address? <ul style="list-style-type: none"> There will be many challenges to overcome along the path of successfully implementing care maps. The existing funding model, the potential resistance from key stakeholders and the lack of resources available to foster the appropriate environment to stimulate innovation and appropriate risk taking were seen by the LHIN workshop team as being potentially some of the biggest issues needing to be addressed. Funding as it stands today is primarily organization dependent and based upon traditional methods of delivering care. Health care now has available to it a vast array of new enablers, many of them technology based, that have the potential to afford us the opportunity to truly transform the way care is delivered. However, like many other industries, economic and regulatory models have not kept pace with technological advances and thus, have become major impediments to change. For example, a significant number of treatment cases in both home care (greater than 50%) and health care facilities are wound related. Front-line nursing staff increasingly need additional support from Wound and Ostomy Resource Nurses (WORNs) and Enterostomal Therapists (ETs) to achieve successful outcomes. Both WORNs and ETs are very scarce resources (there is only about 200 ETs in all of Canada). To address this shortage new care paths have been trialed that enable a front-line nurse to electronically receive the advice of the specialist via the use of digital photography thus, eliminating the need for the specialist to make a physical visit. ET productivity improvements of 60% have been demonstrated in the trials. What's the barrier? Service providers currently do not get paid for virtual visits and hence there has not been wide-spread adoption of this innovative care path. Gaining key-stakeholder (including patients) 'buy-in' is often sighted as a key barrier inhibiting the development of new innovative care plans. Often seen as a 'recipe' for care and leading to a path of 'de-humanization' and 'Americanization' of our health system, past initiatives to develop comprehensive care plans have often been thwarted by key stake-holders even when the plan is only addressing care procedures within a single facility. The perception that each physician has a different way of doing things and that a particular patient's requirements are 'unique' have prevented the development of innovative 	

care plans in many areas of Ontario's health system. To overcome this challenge, the care plans developed need to be outcome focused and flexible enough to allow for some differences in their execution. For example, in the case where the hospitals within the LHIN wish to discharge a cardiac patient on post-operative day 3 instead the usual day 7 through the use of tele-health applications, they should have the flexibility to customize/individualize what equipment, education materials and daily activities are performed – what remains consistent across institutions is the fact that the patient leaves the hospital on day 3 thus, reducing wait time because throughput is improved and potentially eliminating the need for re-admittance due to post-discharge complications.

- Due to today's budget constraints and the general pressures being placed on all aspects of Ontario's health care system, there is a feeling that an environment which fosters innovation does not currently exist. Innovation typically requires 'risk taking' not in a negative sense but in the sense that out of 12 things that are tried, 4 might be 'home runs', 4 might be 'okay' and 4 might be 'duds'. To truly develop new innovative care plans, all participants must be in a position to accept and accommodate failures – otherwise breakthroughs will not occur.

How should Care maps be developed?

- To ensure buy-in and to ensure executable and practical practices/processes are implemented within the care plans developed for the Waterloo/Wellington LHIN, **front line staff**, including physicians, family practitioners, nurses, personal support workers, and other front line caregivers from local agencies must be the drivers behind the development of the plans.
- A coordinating committee or resource person is required to ensure that the agreed upon process is coordinated and followed. Clerical support will be required
- Start with high volume/cost conditions /hard to serve/ probability of success and early wins/ and leverage other transformation priorities with predictable outcomes that move patients, clients and residents through the system
- Care maps should be algorithmic in nature, such to allow individual organizations some flexibility and buy-in from clinicians.
- Interdisciplinary teams from organizations providing services and care will be involved in the development of the care map
- As care maps are developed, education regarding the capacity and abilities of each health care provider is required. On going education and training once the care map is completed should be offered to all and shared.

Critical Success Factors:

- Front line service providers, including physicians, need to be involved in the development and implementation of care maps to ensure buy-in and compliance.
- Flexibility in the care map is required to meet the specific needs of clients and different organizations.
- Adequate funding models to ensure appropriate levels of community support services.
- Access to primary care
- Reward and recognize good behaviours related to using the care maps
- Patient/client/resident outcome focus

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

What is the current status?

Currently there are several care maps that individual organizations are using. However, most do not cut across the health care system.

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

- Must have front line service providers including physician buy-in for success.
- Access to primary care is critical
- Focus needs to be on outcomes
- Require appropriate levels of community capacity
- Need to reward and recognize good transition of care.

Lead contact person:

Name: Neil Barran
 Title: Senior Vice President
 Organization: Saint Elizabeth Health Care
 Telephone: 905 940-9655 ex 2103
 Email address: nbarran@saintelizabeth.com

Name: Marianne Walker
 Title: President & CEO
 Organization: St Joseph's Health Centre, Guelph
 Telephone: 519 824-6000 ex 4403
 e-mail: mwalker@sjhh.guelph.on.ca

Name: Susanne Gillespie
 Title: Manager of General Support
 Organization: Canadian Hearing Society
 Telephone: 519 886-6298
 e-mail: sgillespie@chs.ca

Name: Kristine McGregor
 Organization: Professional Respiratory
 Telephone: 519 886-0202
 e-mail: kmcgregor@proresp.com

Title of patient care/service initiative:		Type of integration (more than one box can be checked)	
Public reporting and score card measurement		<input checked="" type="checkbox"/> Horizontal <input checked="" type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:	
Existing or new initiative? <input type="checkbox"/> Initiated/existing integration activity* <input type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>		List of partners involved: All Ministry-funded health care services; provincial and national health associations; provincial and national health research institutes (ICES, CIHI); Ontario Health Quality Council; the National Health Council; and the Ministry of Health and Long-Term Care (specifically Steinni Brown, Information Systems Lead with the Health Results Team).	
Please briefly describe the initiative: If LHINs are to be held accountable for making demonstrable improvements in the integration, coordination, and performance of their local health systems, they need to develop a sophisticated health information measurement system and a meaningful and informative public reporting mechanism. LHINs will need to develop appropriate baseline information in their first year of operation and should develop a Balanced Scorecard reporting strategy that allows for comparison of performance across LHIN areas but also allows each LHIN to describe unique features of their particular service delivery areas (especially those 'health determinants' that lie outside of the health care system, i.e. socio-economic, education and environmental indicators). The use of a Balanced Scorecard will: (i) support sharing of best practice approaches; and (ii) create a platform for inter-agency dialogue based on a 'systems' perspective. In addition to the development of robust health system performance and population health indicators, the LHIN will need to work with its funded agencies to ensure that appropriate and relevant performance indicators are captured in funding accountability agreements.			
<i>If this is an initiative/existing activity....</i> What is the current status? There are a number of provincial and national report card/measurement systems already in place such as the OHA's Report Card for hospitals and CIHI's Health Indicators Framework for all health regions in Canada. Ontario's District Health Councils have been working on a Local Health System Monitoring project which has allowed DHCs to collect and track a variety of standardized health indicators for their particular planning regions. DHCs have also recently released a report on "Measuring Access, Equity and Integration" and the Ministry through its Health Results Team has made measuring Access & Wait Times a top priority. In terms of other new developments, ICES has released a framework for balanced scorecard reporting among public health units. Canada's new National Health Council and Ontario's new Health Quality Council are both expected to begin public reporting in 2005/06.		What are the outcomes/lessons learned (if any)? Existing health information systems do a decent job of measuring and reporting on: overall health system inputs (e.g. funding, numbers of health care professionals); certain population health status measures for particular disease entities (e.g. cancer, diabetes, cardiac etc.); and on utilization of hospital services. Existing reporting systems do a poor job of measuring the capacity and utilization of community-based health services (long term care, home care, mental health & addictions); and are still in their infancy in developing indicators for health system integration. There is still much work to be done in effectively linking health system input indicators with population health outcomes.	
Lead contact person: Name: Randy Peltz Title: Director of Operations Telephone: 1-866-469-8949 X703 Name: Jim Whaley Title: Executive Director Telephone: 519-348-4498 Organization: Regency Care Corporation Email address: rpeltz@regencycare.ca Organization: Grey Bruce Huron Perth DHC Email address: jwhaley@gbhpdhc.on.ca			

Title of Admin/Support initiative: Integrated Electronic Health Record	Type of integration (more than one box can be checked) <input checked="" type="checkbox"/> Horizontal <input checked="" type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:
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Existing or new initiative? <input type="checkbox"/> Initiated/existing integration activity <input checked="" type="checkbox"/> New integration opportunity	List of partners involved: Attachment: Lists of members and member organizations Client Mental Health CCACs Private Imaging/Labs DHC FHNs & FHGs LTC Community Support Services (public & private) Physicians Community Health Organizations Public Health(s) University of Waterloo/Conestoga College Hospitals Smart Systems for Health Agency (SSHA) EMS/RSA Ministry of Health & Long Term Care
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Please briefly describe the initiative.

Background/Context:
Increasingly, technology is able to assist in health care delivery. An Integrated Electronic Health Record is one such technological solution that would contribute greatly to more effective and efficient health care services. Within LHIN #3, numerous organizations are using electronic health record processes independently. Consequently, movement of clinical information between these organizations is not always well coordinated, resulting in many challenges and inefficiencies. A LHIN-wide Integrated EHR will provide an informational foundation for the coordination of all levels of care thereby allowing for smoother transitions across the continuum of services (e.g., hospital to hospital, hospital to community services, etc.), increasing care provider capacity, and increasing patient/client satisfaction. At a systems level, an Integrated EHR will support the monitoring and evolution of standards of care and increase the efficiency of health-related services, while meeting the legal and ethical requirements for privacy and confidentiality. Specific goals are identified below.

Leverage the development of a client integrated electronic health record, serving the communities within the LHIN to achieve the following goals:

1. Through the provision of electronic health information to clinicians, improve the coordination, quality and consistency of health care delivered to clients.
2. Use the collected aggregate data to assist LHIN partners in evaluation, planning and further system development of the Waterloo-Wellington health services, designing an infrastructure which supports the development of improved disease management strategies.
3. Empower clients to become active members of the health care team in order to maximize their own health and well being. This may take the form of web-based access to their electronic health information and tools which individualize the health being sought.

Key Components:

- network connectivity infrastructure (relying on SSHA)
- leverage and consolidation of existing investments, in order to minimize disparate systems
- coordinate the acquisition of new or replacement investments
- planning for a shared repository of information related to point of care & system planning
- implementation of a robust Enterprise Master Patient Index application
- secure integrated presentation of electronic health information through a shared clinical view with future capacity to support scheduling, ordering and billing
- developing technologies and systems to support client involvement in the management of their health and well being
- leverage current and future technologies to automate patient processes across the continuum of care
- develop required legal frameworks and agreements to ensure that information sharing and confidentiality requirements are met

High Level Action Plan:

- advocate for support and implementation from the LHIN for the electronic health record project
- work with provincial and federal processes on integrating electronic health information processes (e.g., e-Health Council, SSHA, Canada Health Infoway, etc.)
- define project outcomes and scope for the short/medium and long term
- inventory of current applications and infrastructure relevant to the electronic health record
- strategic IT plan for the implementation of the electronic health record as the driver for any future technology investments/planning
- acquisition process by LHIN partners
- initiate the phased implementation plan to address the needs of patients, providers and LHIN strategic directions

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

What is the current status?

- North Waterloo Hospitals have reviewed HIS integration solutions;
- Wellington County Hospitals Network has established an IT planning process;
- Community Care Access Centre (Waterloo) CHIN initiatives and specifically the infection control project;
- CCACs and hospitals are (or soon will be) using SSHA infrastructure;
- CCACs are currently able to use secure e-mail between all CCACs.

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

- core infrastructure components such as Electronic Master Patient Index are essential
- integration with legacy systems is complex and requires the use of industry standards/protocols (HL7, IHE, CCOW)
- phased approach to implementation
- collaborative effort to include the end users
- plan, implement, evaluate “action” cycle

Lead contact person:

Name: Grant Hollett

Title: Senior Health Planner, Waterloo Region-Wellington-Dufferin District Health Council

Telephone: 519-836-7602 ext. 234

Email address: ghollett@wrwddhc.on.ca

Name: Glen Kearns

Title: Chief Information Officer, Grand River Hospital

Telephone: 519-742-3611

Email address: glen_kearns@grhosp.on.ca

Name: Maureen Carli

Title: President, Hospice Waterloo Region

Telephone: 519-743-2037

Email address: ecarli@sympatico.ca

Name: Roberta MacDonald

Title: St. Mary's General Hospital

Telephone: 519-749-6578

Email address: rmacdonald@smgh.ca

Title of patient care/service initiative: Integration of Access, Assessment, Case Management, Case Service Management and Discharge Planning		Type of integration (more than one box can be checked) <input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input checked="" type="checkbox"/> Other, describe: Inter-LHIN
Existing or new initiative? <input type="checkbox"/> Initiated/existing integration activity* <input type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	List of partners involved: Clients, Hospitals, 2 CCACs, LTC, Community Care, Service Providers, Physicians, Mental Health, Community Support, Public Health, Social Services, Alzheimers Services, Specialty Assessment and Treatment Services, Continuing Care, Legal, Community Health Centres	
Please briefly describe the initiative: It is acknowledged by several stakeholders associated with this initiative that systemic issues exist with respect to access, assessment, case management, case service and discharge planning in health care. Although there are examples of CQI initiatives that have resulted in ad hoc and incremental improvements to continuity of care for clients, there is still a need for substantial improvements. At all parts of the continuum, the group has identified duplication of functions such as assessment, lack of consistent information sharing and the need for better information on access to services for the public. As noted in Norton and Bakers study on patient safety, there is a belief and evidence that demonstrates that clients/patients are more susceptible to an adverse event every time there is a transition or hand off from one provider to another in the system. The need to improve client/patient access, management and discharge process is the motivation and justification for advancing the initiatives associated with this theme. Specifically, the goals of this set of activities are directed at: <ol style="list-style-type: none"> 1. Improving the navigation of people through the health care system from primary care, hospital, long-term care facility to community care. 2. Reducing duplication of function and ensuring that clients receive the right services, information at the right time and in the right location. There are 5 targetted initiatives associated with this theme that are viewed as key activities that will result in significant system improvements in the areas of navigation and improved access. The initiatives are listed below: <ol style="list-style-type: none"> 1. Rationalize the functions of case management and discharge planning between hospitals and CCACs in the LHIN area. This re-engineering process would result in a functional integration of care planning and management through the acute system and back to a long-term care home or to the community. The consolidation of these functions results in improved client service through redefined roles and accountabilities for the client transition/management process. 2. A forum or group needs to be established that will monitor and share information on best practices. There is significant research and pilot testing of new approaches directed at enhancing client assessment and management/transition through the system. Examples of practices that have been developed in Regional Health Authorities in other provinces are relevant and instructive. There is also the need to evaluate new practices as they are adopted and best practice/research information on evaluation needs to be monitored. This activity ensures that the right initiatives are selected in terms of best practice information that has been established. 3. The group also believes that a valid survey of consumers/clients is important in order to ensure that the right problems regarding access and client transition are being addressed. A study based on survey data defining the problems of access from the clients' perspective provides validation of the systems' issues in the LHIN boundaries. 4. Advancement of the required networks of support and teams of interdisciplinary professionals to provide Specialized Geriatric Services. LHIN 3 is not adequately serviced by a Regional Geriatric Program and there is a need to provide enhanced specialized geriatric services to improve treatment and management of clients in the system in hospitals, community and in long-term care facilities. This activity and service development is consistent with ensuring that clients receive the right service at the right time and in the right location. 5. Connectivity and the sharing of client information electronically in a secure format is required to improve consistency of treatment across the continuum of care. Advancing the Community Health Information Network, or similar connectivity solution, 		

will increase the current functionality of the system and the ability to share information. This technology initiative is consistent with reducing duplication and improving access and navigation in the system. Specific activities would involve increasing the number of connections and the applications used on a CHIN.

It is envisioned that the projects/initiatives identified represent broad system issues that are complex and composed of several sub-projects. The management of each initiative and the further scoping needs to occur by means of a multi-disciplinary steering committee that can take responsibility for establishing scope, priority and will assume accountability for deliverables and outcomes. It is suggested that the steering committee could be composed of the membership of the CCAC – Community Advisory Councils and broadened as required to ensure appropriate representation.

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

What is the current status?

There are currently initiatives underway with respect to the integration of discharge planning and case management with hospitals and CCACs in parts of the region.

Connectivity is also underway between several partners and additional applications are being developed.

Specialized Geriatric Services is being examined within LHIN 3 and the analysis of preferred options is being discussed with the MOHLTC.

There is genuine interest across the sector to break down the silos and improve client service.

Client satisfaction surveys are occurring in several health care organizations.

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

The establishment of the above-mentioned steering committee to plan, manage and monitor the progress of the defined initiatives will ensure multi-stakeholder commitment to the improved client service goals identified.

The projects themselves when completed or more fully operationalized result in more accurate assessment for service and a more client-centred approach to delivering services. Services will be more closely aligned with client-specific needs and will be provided at the right time, right location and by the right provider.

Efficiency in the system will be increased, thus enhancing capacity and allowing for shorter wait times for service.

Lead contact person:

Name: Kevin Mercer
 Title: Executive Director
 Telephone: 519-883-5576

Organization: CCAC of Waterloo Region
 Email address: kevin.mercer@waterloo.ccac-ont.ca

Name: Nancy Kaufman-Lambert
 Title: Administrator
 Telephone: 519-653-5493

Organization: Golden Years Nursing Home
 Email address: nancy@goldenyears.cambridge.com

Name: Toni Lemon
 Title: Manager, Client Services
 Telephone: 519-576-3570 ext 228

Organization: Pace Homecare
 Email address: toni@pacehomecare.com

Title of administrative support service initiative:		Type of integration (more than one box can be checked)	
Administrative and Support Services Integration Opportunities (Other than Information Technology)		<input checked="" type="checkbox"/> Horizontal <input checked="" type="checkbox"/> Vertical <input checked="" type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:	
Existing or new initiative?		List of partners involved:	
<input checked="" type="checkbox"/> Initiated/existing integration activity* <input checked="" type="checkbox"/> New integration opportunity		Acute Care Hospitals of Wellington County, Waterloo Region Long Term Care Facilities Wellington Dufferin Community Care Access Centre Waterloo Region Wellington Dufferin District Health Council Other Health Care Providers/Supporters in Wellington County, Waterloo Region	
Please briefly describe the initiative.			
<p>All health care providers and supporters in Waterloo Region and Wellington County have a limited amount of scarce resources available to provide patient care services. In order to ensure that the maximum level of resources is directed to patient care services while ensuring adequate support and infrastructure is provided to facilitate front line care, it is the responsibility of each organization to ensure that the administrative and support services are provided in the most efficient and effective manner possible. Information Technology, while a key part of administrative and support services, is deserving of a separate discussion and integration initiative.</p> <p>Numerous opportunities exist for health care organizations to replicate and expand on current integration activities. Implementation of additional integration opportunities within the confines of the clearly defined geographic boundaries of the Waterloo-Wellington LHIN will be possible given the success of previous projects within this LHIN and elsewhere and the expressed commitment of the health care organizations within the LHIN to work together.</p> <p>A number of the small non-profit or volunteer organizations expressed the challenges of dealing with administrative and support issues with limited staff or resources. Providing payroll processing, financial processing and support along with general administrative services which may currently be absent or provided by volunteers would allow these small organizations to devote more of their scarce financial and human resources to patient care activities.</p> <p>Numerous health care organizations have already been very successful at sharing and integrating administrative and support services. However, through the experience gained in past initiatives there are a number of integration initiatives that would be unreasonable to implement including:</p> <ul style="list-style-type: none"> • Financial management and reporting to governing body • Matters impacted by privacy legislation • Matters limited by bargaining group impacts (e.g. avoiding all wage rates and benefits migrating to the highest common denominator). <p>Beyond the listing above, the administrative and support initiative possibilities are extensive. Shared policies and procedures, education and training materials, and shared management are opportunities that exist within almost all administration and support functions. In addition to these, the integration opportunities include:</p> <p>Finance</p> <ul style="list-style-type: none"> • Common financial information systems • Centralized accounts payable and accounts receivable processing <p>Human Resources</p> <ul style="list-style-type: none"> • Labour negotiations expertise • Payroll processing • Centralized staff scheduling • Benefit purchasing and administration • Co-ordinated approach to physician, primary care, specialist and staff recruiting • Network Human Resources Planning <p>Communications, Public Relations and Legal Services</p> <ul style="list-style-type: none"> • Shared expertise of communications department and staffing • Shared language and translation services • Shared legal services <p>Fundraising, Development and Foundation Support</p>			

- Shared resources to support fundraising activities when appropriate

Quality Assurance Activities

- Common quality models and reporting

Health Records

- Centralized transcription services

Materials Management

- Standardized materials distribution and procurement
- Common product selection (Operating and Capital)
- Joint Request for Proposals
- Standardized pharmacy purchasing

Laundry and Linen Services

- Central laundry and linen processing and distribution system

Facilities and Maintenance

- Common suppliers and contracts for preventative maintenance and other facility services e.g. backup generators, waste disposal services or systems.
- Shared expertise. Small organizations may not have access to all trades such as electricians, plumbers, biomedical engineering etc.
- Utilization of existing facilities such as schools or university classrooms during off-season more meetings, conferences, education.
- Sharing of boilers and steam plants with nearby buildings including schools.

Food Services

- Common food services systems
- Utilization of existing food service resources to provide Meals on Wheels or Wheels to Meals

The integration of administration and support services has occurred in various forms in the past. The shared administration and support services have varied between being organized and well planned to haphazard based on the strengths and capabilities of the organizations agreeing to share services. With clearly defined geographic boundaries for the Waterloo-Wellington LHIN, a coordinated approach to integrating administration and support services can be undertaken. A number of organizations within the LHIN have a long and successful history of collaboration and integration of administration and support services. Building on successful models will improve the likelihood for success.

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

What is the current status?

There are many examples of Health Care organizations initiating successful integration opportunities such as those listed above.

Many examples are on a smaller scale than the geographic area defined by the Waterloo-Wellington LHIN. Other examples of integration initiatives by Waterloo-Wellington health care providers have been implemented with organizations outside the boundaries of the Waterloo-Wellington LHIN.

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

- The integration activity must be mutually beneficial to the parties involved.
- A strong working relationship at all levels including leadership and operational is necessary for success.
- Adequate resources at all levels of the system are required to deliver coordinated/integrated services
- Integration opportunities can be achieved without amalgamating or consolidating organizations. Once organizations are amalgamated wages and benefits, the largest single cost driver, will migrate towards the highest common denominator of the predecessor organizations. Standardized policies, procedures and operational best practices can be implemented without consolidating the governance structure of the organizations.
- Physician acceptance of the integration activity may determine the success or failure of the initiative.
- Initial investment in information systems, training and infrastructure to allow for realization of real savings and efficiencies for all partners will be necessary.
- The uniqueness of the rural, small urban and large urban communities must be recognized and respected. For example; Hospitals are the centre of health care in rural communities. The expansion of initiatives that currently exist in urban communities into rural and small urban centres may be possible by leveraging the use of existing staff and facilities of small rural Hospitals.

Lead contact person:

Name: Karl Ellis, Vice President – Corporate Services, North Wellington Health Care

Telephone: 519-323-3333, Ext. 2279

Email address: kellis@nwhealthcare.ca

Name: Stewart Boecker, VP and CFO, Grand River Hospital

Telephone: 519-

Email address: kellis@nwhealthcare.ca

Name: Karl Ellis, Vice President – Corporate Services, North Wellington Health Care

Telephone: 519-323-3333, Ext. 2279

Email address: kellis@nwhealthcare.ca

Title of patient care/service initiative: Investigate integration opportunities for integration of community health, mental health and addiction services.	Type of integration (more than one box can be checked) <input type="checkbox"/> x Horizontal <input type="checkbox"/> x Vertical <input type="checkbox"/> x Intersectoral <input type="checkbox"/> x Other, describe:
Existing or new initiative? x <input type="checkbox"/> Initiated/existing integration activity* x <input type="checkbox"/> New integration opportunity *Mental Health networks that undertake planning and system development have been active in this planning district under the auspices of the Waterloo Region - Wellington-Dufferin District Health Council (WRWDDHC). A similar function has been undertaken by the WRWDDHC district-wide Addictions Services Group. Bringing addiction, mental health and community health planning groups together with the goal of enhancing services to people with both mental health and addictions is a new initiative. With the dissolution of the DHC, networks will be without planning and coordination resources.	List of partners involved: Chair and members of Waterloo Region –Wellington-Dufferin Addiction Services Group, chair and members of the Waterloo Region Mental Health Planning and Advisory Committee, chair and members of the Wellington/Dufferin Mental Health Planning and Advisory Committee, Waterloo Region – Wellington- Dufferin District Health Council staff and Ministry of Health and Long Term staff. Attachment: Lists of members and member organizations attached.
Please briefly describe the initiative. Mental health and addiction problems affect a significant proportion of the population. Untreated, they represent a significant burden for those who are directly affected, including individuals, families, the community and the health care sector as a whole. Appropriate and adequately resource mental health and addiction services are required to serve this population, and to improve the system of services and supports available to people in need. Currently, the mental health and addictions service systems exist as largely parallel systems, and can be difficult to navigate for consumers, including those who require services for the treatment of concurrent disorders (co-existing mental health and addictions issues). Service system integration is required to develop services to address the needs of the consumer with concurrent disorders. Service integration within the mental health and addictions sectors should ensure that the service system is accessible, effective and funded across the health care spectrum, from early intervention, community treatment, specialized treatment and recovery. In addition, primary care and community health services need to be available for addictions and mental health consumers. Examine service system integration opportunities for addiction and mental health services in the LHIN area to maximize the effectiveness and quality of services individuals are receiving. In order to treat the individual more holistically, further the integration of community health, including public health, primary care and community support service, with the addiction and mental health sectors. The goals of further integration include: <ul style="list-style-type: none"> • A Concurrent Disorders planning project is underway in Central West Region that will further the development of integration between the mental health and addictions sectors. The project will include developing a service inventory, reviewing service models, recommending appropriate models for communities within the Central West region, and laying the foundation for the development of service agreements across the two sectors. • Develop a strategy to make health information about mental health, substance misuse and addiction, general health issues more readily available and have this information centralized. Focus on knowledge transfer about mental health and addiction issues to mental health agencies, and also to sectors such as police, physicians, the education system, and long term care facilities. • Further the integration of components of community mental health and addictions services with hospital and other institutional services in areas where the sharing of resources can increase our capacity/efficiency. For example, integrate with services delivered by organizations that provide care to the elderly with mental health needs. • Pursue the development of an effective public awareness, education, and advocacy strategy aimed at stigma and discrimination that builds on existing addiction treatment and mental health initiatives, but that brings together local, LHIN-wide and ideally, inter-LHIN partners (such as public health) in the development of key messages, public education materials and other educational resources. • Work toward the development of proposals for new funding that focus on addressing the needs of individuals with both addiction and mental health issues. An example is placing a mental health and addictions support person in the emergency room to assist with those who have mental health and addiction related health issues. • Enhance primary care and mental health/addictions integration with the development of nurse practitioner positions with the purpose of meeting the primary care needs of persons with mental health and/or addictions issues. • Work with public health to provide enhanced access to health promotion/prevention and diagnostic services (i.e. TB testing, sexually transmitted diseases) • Partner with the community support sector to enhance services for those with mental health and/or addictions issues • Consider meaningful ways for clients to become involved Partners in the mental health and addictions sector alike share a long history of developing innovative, client-focused	

integration strategies within their respective sectors. Some recent examples of integration include:

- Amalgamation of two residential services as well as some community –based services in addiction treatment
- Early discussion of utilization of beds for stabilization MH and addiction
- Addiction services for pregnant women; service agreements between exist between Alcontrol, GRH Withdrawal Management Service, Stonehenge Therapeutic Community and GRH Labour and Delivery
- Multi-sectoral planning and educational initiatives regarding serving people who are prescribed methadone.
- Development of primary care and psychiatric services for people who are prescribed methadone.
- Integration of some community-based mental health services
- Development of mental health crisis response systems in each of Waterloo Region and Wellington/Dufferin (including the establishment of service agreements which continue to be developed and refined);
- Development of an access/discharge protocol for children/adolescents from Wellington County seeking admission to inpatient mental health beds at Grand River Hospital;
- Development of educational opportunities for staff and physicians of Wellington County hospitals dealing with mental health emergencies that present to the county’s ERs;
- Shared psychiatry recruitment initiatives within Wellington County;
- Joint mental health case management intake processes in Wellington and in Waterloo Region (the latter nearing completion);
- The Kitchener Downtown Community Collaborative recently recruited a psychiatrist to provide outreach services to people who are homeless, many of whom have concurrent mental health and addictions disorder

Waterloo Region and Wellington/ Dufferin have a long and successful history of collaborative mental health planning and addiction services planning. Under the auspices of the WRWDDHC, the Waterloo Region Mental Health Planning and Advisory Committee and the Wellington/Dufferin Mental Health Planning and Advisory Committees have served for many years as the principal mechanisms through which system planning and service coordination/integration opportunities have been discussed, planned, developed and implemented. Membership includes community mental health agencies and organizations, hospitals, psychiatrists, consumer and family representatives. The Waterloo Region – Wellington-Dufferin Addictions Services Group has served a similar function in addictions system development, and includes representation from addictions services across the health planning district, as well as MoHLTC and CAMH representation.

In addition to increasing the coordination/integration of LHIN-wide mental health and addictions and services, mental health and addictions stakeholders within our LHIN, in conjunction with those of other LHINs, could form an alliance of experts that focuses on province-wide opportunities, such as providing advice to the MOHLTC on issues related to policy development, standards, targets and benchmarks, priority resource needs, and potential province-wide initiatives, such as the one referred to earlier with respect to stigma.

If this is an initiative/existing activity....
What is the current status?
 A Concurrent Disorders planning project is underway in Central West Region that will further the development of integration between the mental health and addictions sectors.

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

- The networks are a successful umbrella mechanism for undertaking community health, mental health and addiction treatment planning and development activities
- Continuity of process and relationships is important
- The network mechanism is a successful model for harnessing the leadership required to achieve desired results in implementing health reform activities
- Expert planning skills are required to navigate the complexities of system planning. It is important to maintain the skills resource and knowledge base
- Adequate human and financial resources at all levels of the system are required to deliver effective/accessible coordinated/integrated concurrent disorder services
- Adequate financial and support resources are required to allow agencies and individuals to participate in the planning process. If these resources are not provided patient care is directly impacted as FTE equivalents decrease. Additionally, this decrease in resources available at the agency level results in a loss of expertise, further eroding the system of services and supports available to provide appropriate care.
- Partnerships with the educational sector need to be developed to promote appropriate training of health care professionals in providing health care to people with a concurrent disorder
- Resources are essential for continual training for health care professionals, to ensure that providers are equipped to address issues related to the emergence of new substances
- Key system players need to be actively involved in the planning process for it to be successful
- The province has a role to play by developing policy around important issues, by developing province-wide standards for level and quality of service and by providing resources for services that adequately reflect the cost of operating.

Lead contact person:

Pam Gardiner, Prog. Director Addictions Services, House of Friendship, PH: 519-745-4691 Email: pamg@houseoffriendship.org
 John Jones, ED, CMHA Waterloo Region and CMHA Wellington-Dufferin 519-766-4450 X223 Email: jonesj@cmhawrb.on.ca
 Cheryl Batty, Senior Planner, WRWDDHCPH: 519-836-7440 x238 Email cbatty@wrwddhc.on.ca

ACCESSIBILITY

Hospitals and Institutional Care = + access

CCAC, Drug and Alcohol Assessment Centers, CMHA etc

Community Support Agencies = ++ access

Family, peer groups, faith groups = ++++ access



COST

Hospital and Institutional Care = \$\$\$\$

CCAC, Drug and Alcohol Assessment Centers, CMHA etc

Community Support Agencies = \$

Family, peer groups, faith groups = no \$



Title of patient care/service initiative:	Type of integration (more than one box can be checked)
Continuing the network model of health planning and development to achieve further coordination/integration of the health system across the LHIN catchment	<input checked="" type="checkbox"/> Horizontal <input checked="" type="checkbox"/> Vertical <input checked="" type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:

Existing or new initiative?	List of partners involved:
<input checked="" type="checkbox"/> Initiated/existing integration activity* <input type="checkbox"/> New integration opportunity *Many networks that undertake planning and development already exist in this Health Planning District.	See body of report.

Please briefly describe the initiative.

Waterloo Region and Wellington/ Dufferin have a long and successful history of collaborative health planning. A range of both LHIN-wide and community specific networks have served for many years as the principal mechanisms through which system planning and service coordination/integration opportunities have been discussed, planned, developed and implemented. Network membership includes community health agencies long-term care homes, hospitals, physicians and other relevant organizations.

Examples of coordination/integration projects undertaken in our district in recent years include are listed below.

Wellington(-Dufferin)	Waterloo	Waterloo Wellington-Dufferin
Wellington-Dufferin Mental Health Planning and Advisory Committee	Waterloo Region Mental Health Planning and Advisory Committee	Waterloo Wellington Emergency Services Network
	Waterloo Region Mental Health Crisis System Working Group	Grand River Cancer Centre Advisory Committee
Wellington-Dufferin Dementia Network	Waterloo Region Dementia Network	Waterloo Region-Wellington-Dufferin Dual Diagnosis Committee
Wellington-Dufferin Hospice Palliative Care Network Steering Committee	Waterloo Region Hospice Palliative Care Network Steering Committee	Waterloo-Wellington-Dufferin Child and Youth Planning and Advisory Committee
Physician Recruitment Committee – Guelph-Wellington	Physician Recruitment Committee - Waterloo Region	
Physician Recruitment Committee Centre-Wellington		Waterloo-Wellington Stroke Strategy
Physician Recruitment Committee North Wellington		
Wellington-Dufferin Specialized Geriatric Services Reference Group	Regional Geriatric Program (central) Advisory	Waterloo Region Specialized Geriatric Services Group
Wellington-Dufferin Seniors Services Network	Cambridge Seniors Network	
Wellington County Hospital Network-Rehabilitation Services Committee	Waterloo Region Suicide Education Working Group	
Wellington County Hospitals Network	Hospital/CCAC/CEO Group	
	Waterloo Region Social Services Emergency Planning Group	
Waterloo-Wellington-Dufferin Addictions Services Group	School Boards/CCAC/Provider Committee	
	Difficult to Serve Committee	
CCAC of Wellington-Dufferin Advisory Committee	Waterloo CCAC Community Advisory Committee	
	CMH/CCAC Falls Committee	
	Inter-agency Elder Abuse Case Review working group	
	CHIN – Infection Control Working Group	
	Community Palliative Rounds	
	Community Health Information Network	

	(CHIN	
Wellington-Dufferin long-term care homes group	CCAC/LTC/Discharge Planning Committee	
	Waterloo Region Committee on Elder Abuse	

Maintenance and revision of existing network structures for planning/development of health system initiatives within the LHIN is recommended as the mechanism through which continued coordination/integration occur.

- The issue of building community service delivery and system capacity is a local priority currently, in alignment with current MOHLTC funding and policy direction. The Region of Waterloo and Wellington & Dufferin Counties have previously and are currently been involved in projects to identify priorities, policies, development of standards and benchmarks.
- Planning for the continuing shift in service delivery from one focusing on hospital provision of care to one focusing on a fuller and more coordinated and integrated system of community supports/services that recognizes the unique role of both hospitals and of community support services/supports
- The integration of components of community services with institutional services in areas where the sharing of resources can increase our capacity/efficiency, such as staff education/training.
- The coordinated development of a LHIN-wide inventory of available resources, with agreements for access to service (beds, physicians, referral protocols) as exists for medical specialties (eg. Trauma, neurology, burns, etc.)

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

What is the current status?

Numerous system-wide coordination/integration initiatives have been undertaken under this structure as indicated by the above listing.

Key to the success of Networks has been dedicated staffing support. For example,

- The Wellington County Hospitals Network received provincial funding to support Network planning and development.
- The Waterloo CHIN has staff support to facilitate development and expansion to other communities.

Our recommendation is to continue network-based coordination/integration efforts within the LHIN. Leaders within existing local networks have the opportunity to review mandates and determine opportunities to leverage local successes within the LHIN.

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

- The networks have already demonstrated itself as a successful mechanism for undertaking planning and development in several fields such as:
 - emergency services – shared contract across Waterloo-Wellington for non-emergency patient transportation;
 - care for the elderly- access to expert geriatric and gero-psychiatric assessment in Waterloo and in Wellington-Dufferin;
 - children’s mental health services- Grand River Hospital selected as host for 12 bed unit for child and adolescent mental health beds for Waterloo-Wellington; to name but a few.
- Expert planning skills are required to navigate the complexities of system planning and the existing networks have already gathered together expert leadership
- Adequate resources and key players at all levels of the system are required to plan and deliver coordinated/integrated services
- Funding for Integrated networks is required for the Network as a existing entity in order to support quick and efficient planning/activities. Funding and resources should not be seen as the responsibilities of individual agencies/participants.

Lead contact person:

Name:	Ross Kirkconnell	Nancy Dunbar;
Title	Executive Director	Administrator
Organization:	CCAC of Wellington-Dufferin	Leisureworld Caregiving Centre - Elmira
Telephone:	519 823 2550	519 669 5777
Email address:	ross.kirkconnell@wd.ccac-ont.ca	ndundar@leisureworld.ca

*We gratefully acknowledge Harriet Lenard of the Waterloo Region, Wellington-Dufferin District Health Council for her support.

Title of patient care/service initiative:		Type of integration (more than one box can be checked)	
Empowering people to take responsibility for their health		YHorizontal <input type="checkbox"/> Vertical YIntersectoral	
<input type="checkbox"/> Initiated/existing integration activity YNew integration opportunity		List of partners involved: Community service agencies Attachment: Lists of groups consulted	
Please briefly describe the initiative. Conversations at the MOH Open Space reflected some common themes: a desire for the health system to be more client-focused, community focused, and to maximize peoples' ability to live healthy in the community. Participants discussed how to better serve clients by having system where providers and community worked more collaboratively, planned more broadly and shared information and resources more widely. Review of participants' suggestions led to the following proposed model: Local Health Hubs that provide health (and social service) support to people living in a defined "naturally" occurring service area. Each Hub would be required to provide an array of core supports and services to people living the area, to service providers (including voluntary groups) and to the community as a whole. How these would be organized and provided would be a function of local circumstance and preferences of the community. Additional required services would also be identified through a community process. The supports and services of each hub would be built on a determinants of health perspective that acknowledges the importance of health (including physical, emotional and mental health), social support, housing, and other services. Hubs would be community governed and ideally would be an addition to an existing agency. If no appropriate agency could be identified, the hub could be a new organization.			
Services & Support Areas	Client Supports/Service	Service System Support	Community Focus
Activities:	<u>Information and connection to other community services</u> - self-serve service inventory - system navigation support <u>Health information resources</u> <u>Transportation</u> <u>Cultural interpretation</u> <u>Access/Coordination</u> - navigation support includes organizing access and coordination for those who need it. <u>Provision of Primary Care</u> - physician, nurse, social work and other services can be provided if identified by the community	<u>Coordination and linkage of services:</u> - support for networks of health service providers - creation of co-ordination protocols - encourage and support cross-agency program collaboration and planning - assistance in tracking and evaluation of local needs <u>Space</u> The provision of: -office space for small agencies and groups -program space for small agencies and groups that have office space as well as others that may wish to provide a service - administration supports for small onsite agencies and groups as well as others -peer-based support group space <u>HR support</u> -payroll -recruitment/retention -volunteer recruitment <u>IT support</u> - interagency/service linkages, support etc <u>Cross-Agency Training</u> -sharing agency skills and expertise -student placement support/coordination -staff and client groups <u>Program effectiveness and measurement</u> -evaluation/ training support -best practice	<u>Create awareness of community investment opportunities</u> -volunteer recruitment -fundraising <u>Health Promotion</u>

Target group:	Health Service Clients	Service Provider Community	Community at Large
Short-term Outcomes	-Improved client knowledge of supports/services -Increased utilization of appropriate community services	-Increased knowledge of health services/supports and gaps in the community, leading to better planning -Increased collaboration between service agencies -Increased capacity to assess effectiveness of services -Increased ability to serve complex clients -Increased ability to serve rural areas -cost savings through sharing of resources	-Increased community participation in community health including voluntary and business sector -Increased awareness of services -Increased awareness of the importance of maximizing health and ways in which to do so
Long-term Outcomes	Improved access Improved health	Decreased duplication of services Increased capacity to serve target populations More clients requiring support being served	Improved access Increased commitment and support to maximizing health

Goal: Integrated Community Service System that Empowers People to take responsibility for their health

*If this is an **initiative/existing** activity...No.*

What is the current status? The Health Hub model that is being proposed borrows from the Ministry of Children and Youth Services' Ontario Early Years Centre program logic model and associated community planning process to identify a lead agency and plan for the delivery of core services.

Some of the elements of this model can also be found in the logic model for Community Health Centres in Ontario

At the LHIN #3 planning day the value of multiple services under one roof was identified and various examples in our area were mentioned.

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What are the outcomes/lessons learned?

An implementation review of the Ontario Early Years Centres was released in November 04. The review considered program effectiveness, efficiency, and equity. The findings were generally positive noting increased access for families in the target population and increased knowledge and improved social networks for participants. There also is increased collaboration among service providers and decreased duplication of services,

Critical Success Factors for the Health Hubs

- the provision of the system navigation and coordination function
- integration with the primary health system in the community
- the ability to provide primary health services that the community is in need of (in some areas this may include primary medical care from physicians and/or nurse practitioners)
- adequate physical space(s) and resources to support service provision in the community by groups and services that do not have (or require) permanent space and infrastructure in the community (eg diabetes support, Arthritis society, CNIB etc)

Lead contact person:

Name: Konnie Peet

Title: Executive Director Organization: Guelph Community Health Centre

Telephone: 519.821.5363 x310

Email address: kpeet@gchc.on.ca

Name: Katherine Soule Blaser, Director of Program Development, Independent Living Centre of Waterloo Region

Telephone: 519-571-6788

email address: Katherine@ilcwr.org

<p>Title of patient care/service initiative:</p> <p>Continuing the network model of mental health planning and development to achieve further coordination/integration of the mental health system across the LHIN catchment</p>	<p>Type of integration (more than one box can be checked)</p> <p><input checked="" type="checkbox"/> Horizontal <input checked="" type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral</p> <p><input type="checkbox"/> Other, describe: Maintaining a network configuration is horizontal integration; initiatives to be undertaken within this structure will achieve horizontal, vertical, intersectoral and inter-LHIN integration.</p>
<p>Existing or new initiative?</p> <p><input checked="" type="checkbox"/> Initiated/existing integration activity* <input type="checkbox"/> New integration opportunity</p> <p>*Mental Health networks that undertake planning and development already exist in this Health Planning District.</p>	<p>List of partners involved:</p> <p>Chair and members of the Waterloo Region Mental Health Planning and Advisory Committee; chair and members of the Wellington/Dufferin Mental Health Planning and Advisory Committee; Waterloo Region Wellington Dufferin District Health Council staff.</p> <p>Attachment: Lists of members and member organizations</p>
<p>Please briefly describe the initiative.</p> <p>Waterloo Region and Wellington/ Dufferin have a long and successful history of collaborative mental health planning. The Waterloo Region Mental Health Planning and Advisory Committee and the Wellington/Dufferin Mental Health Planning and Advisory Committees have served for many years as the principal mechanisms through which system planning and service coordination/integration opportunities have been discussed, planned, developed and implemented. PAC membership includes community mental health agencies and organizations, hospitals, psychiatrists, consumer and family representatives.</p> <p>Examples of coordination/integration projects undertaken in our district in recent years include: the development of mental health crisis response systems in each of Waterloo Region and Wellington/Dufferin (including the establishment of service agreements which continue to be developed and refined); the development of an access/discharge protocol for children/adolescents from Wellington seeking admission to mental health beds at Grand River Hospital; the development of educational opportunities for staff and physicians of Wellington hospitals dealing with mental health emergencies in the county's ERs; shared psychiatry recruitment initiatives within Wellington; joint case management intake processes in Wellington and in Waterloo Region (the latter nearing completion); mechanisms and protocols, including access to flexible funding to deal with children and adults with developmental handicaps in Wellington who present with very challenging circumstances; the development of community level recommendations to the Southwest Mental Health Implementation Task Force; the development of advice to the MOHLTC on the sizing and siting of children's, adult acute and adult longer term mental health beds; linkages to the children's mental health system, including participation at a joint planning table with our MCSS, MCY, and MOE partners; and development of Specialized Geriatric Service models for frail elderly people with complex needs.</p> <p>Maintenance of a network structure for planning/development of mental health system initiatives within the LHIN is recommended as the mechanism through which continued coordination/integration occur. Identified potential opportunities to simplify, streamline, and make our system more understandable, responsive and navigatable include:</p> <ul style="list-style-type: none"> • Planning for the continuing shift in service delivery from one focusing on hospital provision of care to one focusing on a fuller and more coordinated and integrated system of community supports/services that recognizes the unique role of both hospitals and of community support services/supports. Planning includes the development of protocols that define the roles and responsibilities of the community partners, and that ensure smooth transitions between and among service delivery partners. The issue of building community service delivery and system capacity is a local priority currently, in alignment with current MOHLTC funding and policy direction. • The development of protocols that ensure smooth transitions between acute and specialized hospitals. • The integration of components of community services with institutional services where the sharing of resources can increase our capacity/efficiency, such as staff education/training. Examples include continuing cross-sectoral multi-agency and cross-sectoral participation in dual diagnosis education/training, and expansion of an existing, successful model of psychogeriatric consultation clinics which provides access to the expertise of a geriatric psychiatrist to support all organizations who provide care to the elderly with mental health needs. An additional initiative would focus on knowledge transfer about mental health issues, mental health wellness, and recovery to mental health agencies, and to sectors such as police, physicians, the education system, and long term care facilities. Other potential areas of coordinated endeavor, such as the use of videoconferencing could also be identified. • The development of a more systematic and effective approach to meeting the needs of people with dual diagnosis across the MOHLTC and MCSS sectors • Pursuing the development of an effective public awareness, education, and advocacy strategy aimed at eradication of stigma, that builds on existing mental health initiatives, but that brings together local, LHIN-wide and ideally, inter-LHIN partners in the development of key messages, public education materials and other educational resources. • Expanding the capacity of community services including LTC facilities for the assessment and treatment of elderly persons with complex geriatric and psychogeriatric needs to avoid use of acute care or premature institutionalization. Coordinated models of specialized geriatric services will expand the strengths of the WR Community Geriatric Services, the W/D Seniors Mental Health 	

Clinic, the CCACs and the Psychogeriatric Resource Consultants in Waterloo Region and Wellington County.

- The better coordination/integration of services for people with mental illness who are also in conflict with the law. A service model needs to include access to: prevention strategies; mental health services supported by access to specialized assessment, consultation and clinical services; secure beds, protected/integrated beds, and step-down capacity; early diversion of low risk/minor offenders; community capacity to deliver forensic services; and collaboration and formal agreements among MOHLTC, MCSS, MCS, MAG, MSG.
- Continuing to streamline access to intensive case management through enhanced coordination/integration opportunities.
- Continued participation with MCY, MCSS, MOE and the developmental services sector in the challenging task of developing a multi-sectoral coordinated/integrated children’s mental health system. These efforts need to also include a focus on increasing the smoothness of the transition between the children’s and the adult mental health systems. For many years, the Child and Youth Mental Health Planning and Advisory Committee has been operating in this district as a multi-sectoral body concerned with system coordination/integration issues.
- Continued and greater local coordination of the employment programs funded by MOHLTC, MCSS, and HRDC/SD in order to better direct clients to appropriate services, to ensure that services meet local need, to reduce duplication of programming, and to increase the capacity of local employment programming. Presently the programs offered by each sector would benefit from greater coordination, a more streamlined approach to service provision, a minimization of duplication in programming, and the building of system capacity.
- As a precursor to requesting CritiCall’s facilitation of transfer of mental health patients, the coordinated development of a LHIN-wide inventory of available hospital resources (including beds and physicians), with defined agreements for access to service (referral protocols) as exist for other medical specialties (eg. trauma, neurology, burns, etc.)
- The development of a LHIN-wide integrated “hub and spoke” model for identifying and treating people experiencing their first episode of psychosis, that builds on the strengths of the partnering agencies and services.

Some service coordination issues will require Inter-LHIN consultations, eg. where an organization provides service in more than one LHIN area. Some Wellington organizations provide service to Dufferin, for example, and some specialized mental health services are provided to Waterloo and Wellington by St. Joseph’s Hospital, London.

In addition to increasing the coordination/integration of LHIN-wide mental health system and service components, mental health stakeholders within our LHIN, in conjunction with those of other LHINs, could form an alliance of experts that focuses on province-wide opportunities, such as providing advice to the MOHLTC on issues related to

- Policy development
- Standards, targets and benchmarks
- Priority resource needs
- Potential province-wide initiatives, such as the one referred to earlier with respect to stigma.

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

Two long established and successful networks currently exist in this planning District: the Waterloo Region Mental Health Planning and Advisory Committee and the Wellington Dufferin Mental Health Planning and Advisory Committee. Membership includes both hospital, medical (psychiatric) and community representatives. Numerous system-wide coordination/integration initiatives have been undertaken under this structure. Our recommendation is to continue network-based mental health coordination/integration efforts within the LHIN.

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

- The network is a successful umbrella mechanism for undertaking mental health planning and development activities
- The network mechanism is a successful model for harnessing the leadership required to achieve desired results in implementing mental health reform activities
- Expert planning skills are required to navigate the complexities of system planning
- Adequate resources at all levels of the system are required to deliver coordinated/integrated services
- Adequate resources are required to allow agencies and individuals to participate in the planning process
- Key system players need to be actively involved in the planning process for it to be successful
- The province has a role to play by developing policy around important issues, and by developing province-wide standards for level and quality of service.
- Where a single integrated program consists of components provided by a group of agencies (eg. Mental health crisis response) there should be funding and accountability mechanisms in place that permit consideration of the program as a whole, rather than at the level of each agency’s role, i.e. funding and accountability mechanisms that support integration.

Lead contact person:

Name: Harriet Lenard, Senior Planner
 Telephone: 519-836-7440, Ext. 229

Name: Carolyn Skimson, Executive Director
 Telephone: 519-843-5331 ext. 200

Organization: Waterloo Region Wellington Dufferin District Health Council
 Email address: hlenard@wrwddhc.on.ca

Organization: Groves Memorial Community Hospital
 Email address: cskimson@gmch.fergus.net

3. Priority Setting of Integration Opportunities

3.1 Overview

Members of the Steering Committee considered the criteria for ranking that was provided in the Resource Guide. The consensus among the members was that it would be prudent to take a strategic approach in ranking the priority integration initiatives. As some of the initiatives were “enablers” in achieving other initiatives, the Steering Committee saw merit in ranking those initiatives relatively higher than others. Most of the enabling initiatives were administrative initiatives. Many of the patient care initiatives could only be achieved if some of the administrative initiatives were in place first. With this philosophy in mind, the Steering Committee supported the following ranking of its top priority administrative and patient care initiatives.

	Name of Integration Initiative	Category
1.	Integrated Electronic Health Record [ENABLER]	Admin
2.	Admin support other than IT [ENABLER]	Admin
3.	Regional Care Maps [ENABLER]	Admin & Patient Care
4.	LHIN – wide Health Human Resources Plan including Recruitment & Retention [ENABLER]	Admin & Patient Care
5.	Discharge Planning and Integrated Case Management	Patient care
6.	Mental Health Service and System Integration Opportunities	Patient care
7.	Use of Existing Service Networks	Admin
8.	Integrating Community Health with Mental Health and Addiction Programs	Patient care
9.	Integrated Performance Measurement and Public Report Cards	Admin
10.	Role of Community Support Agencies in Health Services	Patient care
11.	Developing Models of Service that Empower Individuals to take responsibility for their Health	Patient care

3.2 Template C

I. Patient Care/Services Integration Opportunities		
	Priority Opportunity	High-Level Action Plan
1.	Integrated Electronic Health Record	<ul style="list-style-type: none"> • advocate for support and implementation from the LHIN for the electronic health record project • work with provincial and federal processes on integrating electronic health information processes (e.g., e-Health Council, SSHA, Canada Health Infoway, etc.) • define project outcomes and scope for the short/medium and long term • inventory of current applications and infrastructure relevant to the electronic health record • strategic IT plan for the implementation of the electronic health record as the driver for any future technology investments/planning • acquisition process by LHIN partners • initiate the phased implementation plan to address the needs of patients, providers and LHIN strategic directions
2.	Admin Support Other than IT	<p>Develop a list of potential Admin. and Support Services for integration between Acute Care and Rehabilitation Hospitals and Long Term Care Facilities.</p> <ul style="list-style-type: none"> • LHIN wide CEO's of Acute Care and Rehabilitation Hospitals and Long Term Care Facilities have completed a template of potential service integration opportunities. • Once the above list is finalized the LHIN CFO's to discuss feasibility of integration Admin and Support Services. • Contact John Callum from Toronto's "Back Office" project to discuss the process and challenges they encountered during their implementation. <p>Develop a list of potential Admin. and Support Services for integration between hospitals and CCACs and other Community Agencies.</p> <ul style="list-style-type: none"> • LHIN wide CEO's of Acute Care and Rehabilitation Hospitals and Long Term Care Facilities to share their final integration document with LHIN CCACs and Community Agencies for further integration opportunities. • LHIN wide CFO's to discuss feasibility of integration services with CCAC and Community Agencies. <p>Develop a list of potential Admin. and Support Service for integration between other Ministries's such as Education.</p> <ul style="list-style-type: none"> • The LHIN CEO should contact the Ministry of Education

		to discuss potential of integrated services. For example, integrating school power and heating plants with local hospitals.
3.	Regional Care Maps	<ul style="list-style-type: none"> • Complete an inventory of current Regional Care Maps within our LHIN and outside of our LHIN. • Determine key factors of successful care maps. • Organize a forum of key stakeholders to: educate people about care maps and how these assist in the continuum of care; describe some of the successful care maps e.g. Coordinated Stoke Strategy; clarify roles and opportunities of different health care sectors; and identify priorities. As part of the education process it will be important to create opportunities for key stakeholders to share not only what they do today but also what they feel their role could potentially be within the context of the Regional Care Maps. • LHIN to review the information from the stakeholder forum and set priorities using specific criteria. • Set up a team of front line providers from the different health care sectors: To review successful care maps and the lessons learned. To build a best practice model on how Regional Care Maps should be developed. To develop the LHIN identified priority Regional Care Map. To develop an implementation plan and a tool to evaluate the success of the Care Map. • Measure and evaluate the success of the Regional Care Map and build upon what has been learned to apply to other care maps.
4.	LHIN-Wide Health Human Resources planning with an emphasis on recruitment and retention.	<ul style="list-style-type: none"> • To enable effective HHR Strategic Planning, establish stable, multi-year funding for organizations funded by the LHIN, thereby reducing the erosion of critical human resources. • Identify planning partners – numerous community stakeholders have HHR concerns, and identifying the appropriate mix of partners for strategic HHR planning will require careful consideration and input from the field. It will be important to look beyond the traditional health services sector to health education and training, and include such perspectives in our approach to strategic HHR planning. • Develop linkages with existing HR collaborative planning tables, such as the physician recruitment committees in Waterloo Region and Wellington County, with a view to including representation from these groups at the LHIN HHR strategic planning table.

		<ul style="list-style-type: none"> • Establish the HHR Strategic Planning structure and develop terms of reference with clear objectives for the steering committee along with a workplan that identifies planning activities. An important component of this activity will be to establish a communication mechanism that is as inclusive as possible of the many providers with HHR concerns in Waterloo-Wellington. • An early workplan activity could include an environmental scan of local HHR activities and strategies, providing information that will help identify planning priorities. • Another early workplan activity will be to identify priority opportunities for collaborative HHR activities – While some suggestions were given during the LHIN Workshop, planning will have to include canvassing the field and prioritizing activities according to selected criteria. <p>This high level action plan will allow the LHIN to make recommendations regarding HHR strategic planning priorities and determine the process for addressing the identified priorities.</p>
<p>5.</p>	<p>Discharge Planning and Integrated Case Management (known as Integration of Access, Assessment, Case Management, Case Service Management and Discharge Planning in Section 1.3)</p>	<ul style="list-style-type: none"> • Rationalize the functions of case management and discharge planning between hospitals and CCACs in the LHIN area. • Establish a forum or group that will monitor the above initiative and share information on best practices • Evaluate new practices as they are adopted and monitor best practice/research information to be incorporated into practice as appropriate. • Conduct a survey of consumers/clients in order to ensure that the right problems regarding access and client transition are being addressed. • Advance networks of support and teams of interdisciplinary professionals to provide Specialized Geriatric Services. • Support the Community Health Information Network, or similar connectivity solution, to enhance the ability to share information electronically in a secure format. • Develop a multi-disciplinary steering committee that can take responsibility for establishing the scope and priorities and will assume accountability for deliverables and outcomes of these initiatives <p>NOTE: The projects/initiatives identified represent broad system issues that are complex and composed of several sub-projects.</p>

<p>6.</p>	<p>Continuing the network model of mental health planning and development to achieve further coordination/integration of the mental health system across the LHIN catchment.</p>	<ul style="list-style-type: none"> • The Waterloo Region and the Wellington/Dufferin Mental Health Planning and Advisory Committees to advise the LHIN on the best mental health network structure for moving forward within the LHIN (eg. one, versus two geographic committees, or a two-tiered structure such as a single overarching committee with geographic working groups as required). • LHIN to confirm the preferred network model as the principal collaborative mechanism for continuing mental health service/system planning within the LHIN. • LHIN to develop Terms of Reference for the new network(s). • LHIN to mandate the new network(s) to provide advice on the top priorities for mental health coordination/integration within the context of government/LHIN policy and the corporate priorities of the LHIN. LHIN to mandate network(s) structure to identify final priorities and an action plan to implement these priorities.
<p>7.</p>	<p>Use of Existing Service Networks</p>	<p>Conduct a complete inventory of networks in place within and across the LHIN and explore opportunities for integration and consider where integration is not appropriate</p> <ul style="list-style-type: none"> • Survey DHC and other key stakeholders to complete the inventory. • Ask about opportunities for integration vs. need for local focus (e.g. community-based) • LHIN to confirm the preferred models. • LHIN to facilitate development of revised Terms of Reference for the new network(s). • LHIN to mandate the new network(s) to provide advice on the priorities for coordination/ integration within the context of government/LHIN policy and the corporate priorities of the LHIN. LHIN to mandate network(s) structure to identify final priorities and an action plan to implement these priorities. <p>Identify LHIN priorities best addressed through network structure</p> <ul style="list-style-type: none"> • Review government transformation priorities in light of local network activity • Review local priorities with existing health providers to determine other network opportunities • Review service utilization data to determine high cost/high usage areas that may be seen as priorities • If possible, seek input from the general public about opportunities for improvement in the health system

		<ul style="list-style-type: none"> • Determine network approach and structure to address priorities and implement <p>Determine, fund and implement structure to support network activity</p> <ul style="list-style-type: none"> • Staffing is required to support and advance network activity. • LHINs need to determine the staffing needs of existing networks. This includes an understanding of current agency staff who function as network support and those networks (e.g. Wellington County Hospitals Network) who have funded staff support. • Once staffing needs are understood LHINs need to allocate resources to agencies or networks to support network activity.
<p>8.</p>	<p>Investigate opportunities for integration of community health, mental health, and addiction services.</p>	<ul style="list-style-type: none"> • Ensure that the mental health and addictions service sectors are given a high profile within the LHIN planning and management structure, with adequate resources allocated for concurrent disorder training and. staffing and program delivery. • Building on the established mental health and addictions networks in Waterloo-Wellington, identify partners to participate in the planning process, including public health and community health partners. • Ensure that resources for consumer and family member participation are adequate. • Engage planning partners in determining the best structure for LHIN mental health and addictions planning. Establish an integrated Mental Health and Addictions Strategic Planning structure and develop terms of reference with clear objectives for along with a workplan that identifies integration activities. Build on recent mental health, addictions and concurrent disorders planning that has taken place in the district. • An early workplan activity could include an environmental scan of local MH/Addiction activities and strategies, providing information that will help identify planning priorities. • Another early workplan activity will be to identify priority opportunities for collaborative Mental Health and Addictions activities – While some suggestions were given during the LHIN Workshop, planning will have to include canvassing the field and prioritizing activities according to selected criteria. • Ensure communication mechanisms with the provider sector are transparent and timely, especially during the transition phase from DHCs to LHINs

		This high level action plan will allow the LHIN to make recommendations regarding HHR strategic planning priorities and determine the process for addressing the identified priorities.
9.	Public Reporting and Scorecard Measurement	<ul style="list-style-type: none"> • Convene working group representing key stakeholders in the Waterloo-Wellington LHIN community to investigate and identify a common, preferred set of core performance indicators and related standard definitions, in the context of a “balanced” scorecard framework. Integrate the work to-date undertaken by District Health Councils on their Local Health System Monitoring Project as one starting point for the Working Group. • To ensure consistency of action and results, link with the work and expectations of the Information Management initiative (Adalsteinn Brown, Information Systems Lead with the Health Results Team), to build on current knowledge and best practices e.g. linking health system input indicators with population health outcomes. • Propose similar working groups and shared objectives with other LHINs so that performance measurement can be compared within and between LHINs in terms of provincial standards. • LHIN to consult with the broader Waterloo-Wellington community on its proposed public reporting framework to ascertain the type of health information (performance measurement and other indicators) that is most relevant and meaningful to the consumers of health care.
10.	Community Support Services are an integral component of the Health Care System and need to be recognized and supported in the development of LHIN #3	<p>Planning and Integration of Services:</p> <ul style="list-style-type: none"> • LHIN to establish a Board Member Role that holds the Community Support Services portfolio to ensure that these services remain pivotal in the LHIN in providing maximum access to services with the greatest cost efficiency (See Diagram on Template A) • LHIN to establish a Community Support Services Advisory Committee representative of already existing Community Support Service Networks established in the LHIN geographical area. <ul style="list-style-type: none"> ○ Support this committee by financial and practical assistance needed in the absence of the District Health Council offices. ○ Establish an integrated Strategic Planning Structure with clear terms of reference which build on the work already completed by the existing networks in the community. ○ Ensure that resources for consumer and family member participation are adequate

		<ul style="list-style-type: none"> ○ Ensure communication mechanisms with the provider sector/service networks are transparent and timely, especially during the transition phase when the DHC are closing and the LHIN structure is being established <p>Access and Service Coordination/Delivery:</p> <ul style="list-style-type: none"> ● LHIN to establish a navigator mechanism within the Community Support Service system to ensure appropriate and flexible access to services from the community level. This will ensure maximum access with the greatest cost efficiency. Similar navigation mechanisms currently exist such as Drug and Alcohol Registry of Treatment (Provincial Resource), Peel Crisis Capacity Network etc... <p>Intra-LHIN Continuity:</p> <ul style="list-style-type: none"> ● Ministry to establish similar plans of action across the 13 LHINs for Community Support Services in order to ensure continuity for access by clients, family and service providers.
11.	<p>Developing Models of Service that Empower Individuals to take responsibility for their Health</p>	<ul style="list-style-type: none"> ● LHIN area-wide process to define geographic boundaries for Local Health Hubs process should bring together a broad range of local stakeholders from the community, government and health services school boards etc. ● Within newly established Local Health Hub areas identify planning partners (e.g., including physicians, nurse practitioners, mental health supports, health education programs, community support agencies, etc. ● Identify priority community health issues for each Local Health Hub area ● Confirm and customize the program logic model for each Local Health Hub based on identified priorities. ● Establish a 3-year action plan with evaluation benchmarks ● Identify and implement a process to establish the Local Health Hub

4. Capturing Unique Characteristics of LHIN #3

4.1 Template D

LHIN Template D: Capturing Unique Characteristics of each LHIN

What role do Academic Health Science Centres and voluntary networks play within LHIN #3?

The Waterloo-Wellington LHIN (LHIN #3) does not have any Academic Health Science Centres within its boundaries. However, there are service, administrative and academic relationships between Waterloo-Wellington health services and AHSCs in other jurisdictions.

- Residents of Waterloo and Wellington historically and currently access tertiary services in Hamilton, London and Toronto. These services generally include trauma, neurosurgery, cancer and cardiac tertiary services, and level 3 neonatal programs.
- There has been and remains some utilization of primary and secondary hospital based services in the hospitals affiliated with the AHSCs in these areas, but it has been minimal. Waterloo-Wellington hospitals generally provide 80-90% of Waterloo-Wellington residents' primary and secondary hospital-based care. This pattern of geographic access is reflected in the LHIN #3 Localization Index of 82.2 (the average for all LHINs is 83).
- Several hospitals in LHIN #3 have physicians that have academic relationships with some of these AHSCs for teaching, education and research purposes.
- The hospitals affiliated with the AHSCs in Hamilton and London are participants in rehabilitation and stroke services planning and development.

Stakeholders in Waterloo and Wellington have a long history of using voluntary-based networks as mechanisms for service coordination, planning, and the ongoing development of services and service relationships. The list below identifies current networks that are active within the Waterloo-Wellington community.

- Waterloo Region Mental Health Planning and Advisory Committee
- Wellington-Dufferin Mental Health Planning and Advisory Committee
- Community Health Information Network (CHIN)
- Wellington County Hospitals Network - Network #3
- Wellington County Hospital Network- Rehabilitation Services Committee
- Network #18 (Headwaters Health Care and William Osler Health Care)
- Waterloo Wellington Dufferin Addictions Services Group
- Waterloo Wellington Emergency Services Network
- Waterloo Region Mental Health Crisis System Working Group
- Wellington-Dufferin Crisis Intervention System Steering Committee
- Waterloo Region Dementia Network
- Waterloo Region Wellington Dufferin Dual Diagnosis Committee
- Waterloo Wellington Dufferin Child and Youth Planning and Advisory Committee
- Wellington County Dementia Network
- Waterloo Region Hospice Palliative Care Network Steering Committee

- Wellington-Dufferin Hospice Palliative Care Steering Committee
- Waterloo-Wellington District Stroke Centre Steering Committee
- Grand River Hospital Regional Cancer Advisory Committee
- Waterloo Region Specialized Geriatric Services Group
- Wellington-Dufferin Specialized Geriatric Services Reference Group
- Physician Recruitment Committee - Waterloo Region
- Physician Recruitment Committee - Wellington County
- Community Health Centre Southwest Executive Directors Planning Group
- Wellington-Dufferin Community Heart Health Network
- Waterloo Region Choices 4 Health
- Wellington Dufferin Seniors Services Network
- Central West Eating Disorders Network

Describe any unique characteristics/features of your LHIN that impact this process and/or future Integrated Health Services planning activity.

- Waterloo Region and Wellington County comprise a mix of small-medium urban centres, small villages and hamlets, and rural-dispersed farm-based communities. The population density for Waterloo Region is 344.7 persons/square kilometer, and for Wellington County it is 76.4 persons/square kilometer. Rural service delivery is an ongoing challenge.
- High population growth rates of 1.5-2.0% annually are projected for the next 20 years. The population is also aging such that by 2016 the largest cohort in Waterloo and Wellington will be the 50-59 age cohort. This will have ramifications for increasing demand on most health services, as increasing age is the predominant correlation of increasing demand.
- Waterloo and Wellington have reached a population threshold (~700,000) that is now conducive to the development of specialty regional programs and services. Three recently established programs are the Regional Cardiac Program (St. Mary's General Hospital), the Regional Cancer Centre (Grand River Hospital) and the District Stroke Centre (Grand River Hospital). Additional specialty regional programs may be possible in the future as the population continues to grow.
- If Health Services Restructuring Commission (HSRC) directives regarding the dispersion of tertiary/specialized adult mental health beds from Regional Mental Health Care-London (previously London/St. Thomas Psychiatric Hospital) are implemented, Waterloo Region will have available the full spectrum of mental health services (from community treatment and support, through acute inpatient and tertiary/specialized inpatient programs).
- Wellington County was not issued HSRC directives concerning the distribution and supply of adult mental health inpatient beds. Consequently, Wellington County is currently under-bedded with respect to acute adult mental health beds and is the only jurisdiction in Ontario that will not have any designated tertiary/specialized adult mental health beds once the programs in London are dispersed to Waterloo and Windsor. The same issue exists for the supply of rehabilitation beds. Wellington County is still below HSRC benchmarks for this resource.

- Homewood Health Centre is located in Guelph (Wellington County). Homewood is unique in that they are a publicly funded but private mental health facility with specialty programs that have provincial catchment areas and acute mental health programs that serve residents of Wellington and Dufferin counties.
- Several community-based programs that serve Wellington County also currently serve Dufferin County (which has been allocated to LHIN #4 – Central West). Planning and integration activities for these services may be challenging due to their falling into the catchment areas of two LHINs. Some of these agencies are:
 - Community Care Access Centre- Wellington/Dufferin;
 - Community Mental Health Clinic
 - Canadian Mental Health Association – Wellington/Dufferin Branch;
 - Homewood Community Alcohol and Drug Services

5. Transformational Thinking and Process (Template E)

5.1 Approach and Process

The Waterloo Wellington Local Health Integration Network undertook the completion of the LHIN Resource Guide with a view to striking a balance between the need for meaningful consultation and the realities of an aggressive time line. In the end, the Planning Leads on the Steering Committee employed a variety of methods to secure stakeholder input at different points along the LHIN Work Plan’s critical path, culminating in the completed Resource Guide.

The LHIN Steering Committee held its first meeting on December 3th, 2004. At that meeting Planning Leads agreed to adopt a Work Plan incorporating deadlines that would see the Resource Guide completed by January 19th, 2005. Members of the Steering Committee took the lead in completing Templates A or B for each of the thirty-one (31) Integration Initiatives identified at the Community Workshop in November 2004. While all 31 initiatives form part of the LHIN #3 Resource Guide, special attention was focused on the top eleven initiatives identified as “priority initiatives” by the 180 stakeholders at the Community Workshop.

It was around the top eleven Priority Initiatives that a two-stage consultation process was designed and implemented. Each pair of Planning Leads was responsible for completing Template A or B depending on whether the initiative was related to “patient care” or whether it was an “administrative support” initiative. In the process of completing the Template, each pair of Planning Leads consulted with Community Workshop participants who expressed an interest in the topic. This consultation and feedback process focused on ensuring that the content captured in the template was of a sufficient order of magnitude that it would enable the LHIN Board to take the next step to implement that particular integration initiative.

When the Planning Leads had a “sign off” from the participants at the Community Workshop, the completed Template was forwarded to the District Health Council. The DHC agreed to facilitate the next round of community consultations using the agreed upon process scoped out the LHIN #3 Steering Committee.

The District Health Council, established a consultation process around the top eleven (11) Integration Initiatives that would be much broader and more inclusive of the 180 participants who attended the Community Workshop in November 2004. The District Health Council posted the top eleven Integration Initiatives on its website and, using different links, asked for feedback on the templates from two audiences. One audience was the original 180 stakeholders who participated at the Community Workshop in November 2004. The second audience was much broader and took in more than 400 stakeholders from across the district. A LHIN#3 newsletter was sent out to these two audiences, explaining how, where and when to access the website. The website provided specific instructions on how to provide feedback. Stakeholders visiting the website and reading the eleven templates were asked to address the following question of each of the eleven integration initiatives: *“What are the critical success factors required to implement the integration initiative?”* The feedback related to this question will be included in the completed Resource Guide, to be conveyed to the LHIN #3 Board of Governors. Feedback was received on 6 of the 11 templates through the website. Stakeholder feedback is included in the relevant template and/or as part of issues related to the implementation of the “high level action plan”.

Members of the LHIN #3 Steering Committee ranked the eleven top initiatives that were prioritized by community stakeholders at the November LHIN Workshop. The Steering Committee agreed to score each integration initiative using a “1”, “2”, “3” score for “low”, “medium” and “high” against the criteria provided in the LHIN Resource Guide.

The Planning Leads on the LHIN #3 Steering Committee assumed responsibility for completing the High Level Action Plans for the top ranked initiatives. It is at this stage that, once again, community input was included in the development of the High Level Action Plans for each integration initiatives.

The District Health Council, because of its expertise in health systems planning, together with its knowledge about local mechanisms to facilitate planning, agreed to prepare the first draft of Template D. It was reviewed and approved by the Steering Committee at its mid-January meeting.

Template E was tackled by the Steering Committee as it summarized the process it employed in completing the Resource Guide. As well, Planning Leads had much to contribute as each reflected on “lessons learned” throughout the process.

5.2 Key Learnings

Key Learnings Coming out of this Process

- Planning requires the leadership of individuals with specialized skills who are able and willing to organize and implement an effective process for “getting the job done”.
- Key system players need to be actively involved in planning for initiatives to be successfully implemented. The specialized knowledge they hold is a paramount requirement for success.

- Existing networks and relationships are invaluable mechanisms that should be maintained and build upon. They represent the community’s history of success in working together to achieve coordinated and integrated system outcomes. As a community we have once again been reminded that we have already come a long way toward developing cooperative and integrated solutions to health system issues. At the same time, we acknowledge that the work ahead of us will require continued commitment and dedication.
- Adequate resources at all levels of the system will be required both for the planning and for the delivery of coordinated/integrated services
- There is great potential value in LHINs getting together to share their success stories, as they had an opportunity to do during the January conference.
- Information Technology, as an enabler of enhanced coordination and integration, is fundamental to ensuring the success of the directions we have mapped for the future.
- It was informative to learn of the great commonality of issues across the province.
- The following are lessons learned about the use of open space technology:
 - Open space technology as a method did lend itself to a quick and efficient initial identification of community needs.
 - Open space technology allowed for the rare coming together of individuals from across the province who are from different health sectors and have differing perspectives on issues. Great learning occurred as a result of this experience.
 - Open space technology as experienced (especially on the initial community workshop day) did not provide for the opportunity to review topics for redundancy (and hence combine topics) nor for the elimination of topics that were not integration-related. Further, the technology did not allow for more in-depth reflection on identification of topics or their relative priority. This last issue was particularly significant in our area, since we were “first-up”; as the process proceeded, communities had time to reflect on their issues prior to their workshop dates.
 - The process may have been more effective if participants had more information in advance, e.g., agendas, background material.
 - Open space technology may not have been the most effective means of discussing the issue of community engagement.
- Common themes are apparent across the list of key initiatives brought forth on November 19, 2004. As there was not time in the process that day to review the initiatives and to consolidate where appropriate, some of the votes were split between very similar topics. This may have resulted in some topics of concern not making the list of ten integration opportunities.
- Similarly there were common themes apparent across the 10 Identified Integration Topics. With the limited time lines available to the planning group it was not possible to

consolidate the overlap of ideas or concerns into a cohesive list of common themes, or approaches. Our recommendations to the new LHIN would include identifying these common themes prior to implementing or acting on the recommendations or Actions Plans as presented in isolation from one another.

5.3 List of Organizations Involved in Process

Addictions Ontario
Alzheimer Society of Guelph-Wellington
Cambridge Memorial Hospital
Canadian Red Cross
Care Partners
Caressant Care Nursing Homes
CCAC – Waterloo Region
CCAC – Wellington-Dufferin
Central Park Lodges
Centre for Addictions and Mental Health
Comcare Health Services
Community Rehab
COTA Health
CYG
District Stroke Centre – Grand River Hospital
Extendicare
Golden Years Nursing Home
Grand River Hospital
Grand River Hospital Community Mental Health
Grand River Hospital Withdrawal Management
Groves Memorial Community Hospital
Guelph General Hospital
Homewood Health Centre
North Wellington Health Care Corporation
November 19th Community Workshop Participants (180 people attended LHIN#3 Workshop)
Ontario Federation of Community Mental Health and Addictions Programs
Ontario Half Way House Association
Ontario Hospital Association
Ontario Physiotherapy Association
Pace Homecare
Saint Luke's Place Nursing Home
St. Joseph's Health Centre
St. Mary's Counselling Services
St. Mary's General Hospital
Stonehenge Therapeutic Services
Waterloo Region-Wellington-Dufferin District Health Council
Waterloo Wellington District Stoke Strategy Group

6. Concluding Comments

The most significant “take away” for our community, related to this process, is the importance of addressing our top ranked ‘enablers’ as a means of ensuring that all of our initiatives will, one day, be implemented. The community of Waterloo Region and Wellington County will want to work in partnership with the LHIN Board to implement its priorities. As our community has demonstrated its ability to work collaboratively in the pursuit of mutually held goals, we are predisposed to adopt a similar stance with the LHIN #3 Board and Chief Executive Officer.

Appendices

Appendix A Templates A/B for System Integration Opportunities (other than the top ten) as identified at November 19, 2004 Community Workshop

Title of patient care/service initiative: Communicable Disease / Infection Control		Type of integration (more than one box can be checked) <input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:
Existing or new initiative? <input type="checkbox"/> Initiated/existing integration activity* <input checked="" type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	List of partners involved: Hospitals Public Health LTC facilities Sexual Assault Treatment Centres Community Health Centres	
Please briefly describe the initiative: <p>Opportunity for system wide approach across LHIN regarding communicable disease surveillance, control and prevention. Includes: planning, resource allocation, standard setting, outbreak response, human resource allocation, policies (e.g., influenza immunization), communication planning, information sharing, access to services 24/7 including outreach, surveillance, emergency preparedness.</p> <p>Impacts us all across the sector. SARS showed us we are not integrated/prepared/seamless/coordinated. Need for education and access to services with a comprehensive view, and a view to prevention. Health care providers do not know standards of care consistently (e.g., protocols for treating STDs). Public health must do outreach to special populations to ensure they get the care they need (e.g., young people, marginalized people). Outreach is currently not 24/7 – after hour access to care needed. Don't want penalties in system detrimental to public health, e.g., penalty when teen goes to outreach for birth control when her own MD gets penalized since this is a rostered practice.</p> <p>Tracking of staff and patients as they go from institution to institution, e.g., patients transferred from LTC to hospital to LTC, or part time staff who work in multiple institutions. Need standards for health professionals to follow re: infection control. Inadvertent impact of economic drivers on communicable disease control (e.g., staff can only get part time hours so they work in many institutions – a problem during outbreaks); funding does not allow negative pressure rooms or private rooms and patients undergo bed bumping – another problem during outbreaks. Funding decisions should include consideration of impact on CD/infection control from system perspective. Human resources could be reallocated with system perspective in mind and benefit of infection control.</p> <p>Focus on prevention needs standardization (e.g., immunization policies, infection control procedures, environmental design. Need to think upstream on prevention. It will cost money – investment up front.</p> <p>Communication: sharing of patient information as it relates to CD control, sharing of standards, protocols, surveillance, data, reporting could be improved. Lack of coordination of communication in SARS. Note privacy issues need to be addressed. Need to do better with surveillance, monitoring, reporting, control of communicable diseases.</p> <p>Resource deployment decisions from perspective of system-wide impact on CD control.</p>		

“System is only as good as its weakest link”. In SARS we were thin on the ground. We need stable administration and stable trained staff. Succession planning is difficult. Success partly depends on established relationship between staff – need relationship building. Info technology is a building block but we also need staff collaboration, e.g., Public Health and Emergency Room staff during SARS.

SARS – every organization had its own outbreak team resulting in duplication, inconsistent practices. Could have one outbreak response team in a LHIN. Numbers of cases tracked were different fro different parties – what were the right numbers? Consistency of surveillance, monitoring, reporting needed.

Emergency preparedness and response could be standardized/coordinated in the LHIN, e.g., pandemic planning.

If this is an initiative/existing activity...

What is the current status?

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

Lead contact person:

Name: Dr. Liana Nolan

Title: Medical Officer of Health

Telephone: (519) 883-2240

Organization: Waterloo Region Public Health

Email address: nliana@region.waterloo.on.ca

Title of patient care/service initiative: Community Care Services Remodeling		Type of integration (more than one box can be checked) <input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:
Existing or new initiative? <input checked="" type="checkbox"/> Initiated/existing integration activity* <input type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	List of partners involved: All community care service agencies	
Please briefly describe the initiative: Community Care Services Remodeling. Community Care defined as all care and services provided in the community outside of acute hospital care. Preferred features: <ul style="list-style-type: none"> • Client-focused • Shared operational resources – IT, management, facilities, training, etc. • Funding model changes that provide flexibility to float \$\$ between community program • Programs focus on prevention/diversion/delay from acute care services • Easy efficient access for client/client families • Minimum standard of access and services • More consumer choice and involvement including appropriate funding • Increase flexibility in service options • Access to broad range of services • Access to broad range of services • Client’s situation (caregivers, environment, transportation, place – urban or rural etc.) drives the required services • Central information access (i.e., Telehealth model for client information) • Caregiver requirements for support, education, advocacy and emergency plan Why is it a priority: <ul style="list-style-type: none"> • To improve quality and quantity of direct service delivery • To improve positive health outcomes • To increase efficiency and effectiveness in order to provide more \$ for direct service delivery • To decrease waste and duplication • To support consumer responsibility and community accountability 		
<i>If this is an initiative/existing activity....</i> What is the current status?	What are the outcomes/lessons learned (if any)?	
Lead contact person: Name: Gayle Sadler Title: Telephone: (519) 824-1010 Organization: Homewood Email address: sadlgayl@homewood.org		

Title of patient care/service initiative:		Type of integration (more than one box can be checked)	
Accessing Services		<input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:	
Existing or new initiative?		List of partners involved:	
<input checked="" type="checkbox"/> Initiated/existing integration activity* <input type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>		All health care service providers	
Please briefly describe the initiative:			
<p>To change the language and approach when thinking about health care to get away from the traditional medical model and move to an integrated health model i.e., consumer services instead of patient care (health care / community service providers to be effective)</p> <p>The LHINs can provide a new opportunity to examine and resolve the following main issues that continually challenge consumers and service providers alike.</p> <ol style="list-style-type: none"> 1. LHINs can be responsible for the planning in a community – identify opportunities and gaps, identify existing resources and reallocate or shift resources. Examples of resources include financial, knowledge and information 2. Designate funds to the LHINs to be used for accessibility to health services for the community. This addresses interpreting costs (ASL, language), technical devices for providers to be accessible and for consumers to be able to live independently at home, physical modifications to building and their systems (i.e., phone systems) where services are provided, or to consumer’s homes so that they can stay at home. These funds should address issues for consumers who have sight, hearing, physical and developmental challenges and mental health. The funds should also be used to make all information in plain language. 3. LHINs have the opportunity to support and build on current successes and collaboration in the community, i.e., community health centres collaborate with hospitals to bring some services into the community – for example having a community-based diabetes clinic. 4. LHINs have the opportunity to create a consumer driven health care system where there is comprehensive and accessible information that consumers can use to make their choices. LHINs can be the navigating system that is user friendly, family, covers a broad spectrum, fully accessible and integrates both medical and community services. <p>Why is it a priority?</p> <ol style="list-style-type: none"> 1. This is a priority because the current system is not accessible. The system is fragmented. It is harder to get some services if you are accessing it from the community and not the hospitals (i.e., long-term care bed). Information is not clear or easy to find. Access to resources is limited for both consumers and providers. This includes transportation (especially rural areas), coordination of services, having the financial means to access services in a timely fashion, language barriers, information is not plain language or alternative formats (i.e., large print or Braille, physical access barriers, phones, communication, mobility, interpreters, etc.) 2. The current system is based on a medical model and often services can not be accessed without a physician’s signature – this requirement also takes away from physician’s time. Often consumers who need the services the most do not have a family physician. In the current system you have to be diagnosed with something to get services. 3. System barriers – the current system limits scope of practice for some professionals (i.e., hospital privileges) 			

are limited, access to hospitals, examples include nurse practitioners and mid-wives. Lack of knowledge in current system about what other professionals and services provide. Including community based services as part of the interdisciplinary team. Limiting hierarchy of health services.

4. De-listing of services has created some of these problems.
5. Lack of infrastructure in the broadest sense – human resources, community – formal and informal caregivers in the community. Consumer services are not accessible because they can not retain and train people to provide the services.
6. Paperwork and red tape is creating access challenges for consumers and service providers alike – there are too many forms that are too long to be filled out i.e., 60-page CCAC assessment – physicians having to fill forms out for consumers to obtain other services.

<p><i>If this is an initiative/existing activity...</i> What is the current status?</p>	<p>What are the outcomes/lessons learned (if any)?</p>
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Lead contact person:

Name: Susanne Gillespie
Title: Organization: Canadian Hearing Society
Telephone: (519) 886-6298 Email address: sgillespie@chs.ca

Title of patient care/service initiative: Seniors Health – Education of Services		Type of integration (more than one box can be checked) <input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:
Existing or new initiative? <input type="checkbox"/> Initiated/existing integration activity* <input checked="" type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	List of partners involved:	
Please briefly describe the initiative: <ol style="list-style-type: none"> 1. Develop an integrated coordinated education program about the services available in the community that support senior’s health 2. Develop a seniors’ single point of access to information about the community services available that support seniors’ health <p>Why is it a priority?</p> <ul style="list-style-type: none"> • The senior’s population continues to grow at a fast pace • There are many community services available; however, many seniors and their families are not aware of these services • Supports the transformation of health care in terms of providing community services to keep seniors out of hospitals and LTC as long as possible. • Assists in the identification of the community support needs of seniors • Eliminates duplication of individual organizations marketing their services 		
<i>If this is an initiative/existing activity....</i> What is the current status?	What are the outcomes/lessons learned (if any)?	
Lead contact person: Name: Marianne Walker Title: CEO Telephone: (519) 824-6000		
Organization: St. Joseph’s Health Centre Email address: mwalker@sjhh.guelph.on.ca		

Title of patient care/service initiative: Patient Care Service – incorrect terminology		Type of integration (more than one box can be checked) <input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:
Existing or new initiative? <input type="checkbox"/> Initiated/existing integration activity* <input checked="" type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	List of partners involved:	
Please briefly describe the initiative: The term “patient” is based on a medical model of health and not all consumers of the health system are patients. Health should be focused on wellness, well-being, quality of life, and choice – not focused on illness. Should be “individual”, “person”, care/service or client care/services. Equally cannot exist within the LHIN system if we focus solely on a medical model of care. We need to think beyond medical model and need to focus on individual capacity building rather than individual health deficits. We need a more holistic approach.		
<i>If this is an initiative/existing activity....</i> What is the current status?	What are the outcomes/lessons learned (if any)?	
Lead contact person: Name: Janice Paul Title: Executive Director Telephone: (519) 742-6502		
Organization: KW Friendship Group for Seniors Email address: kwfriend@golden.net		

Title of patient care/service initiative: Shift thinking from continuum of care to system		Type of integration (more than one box can be checked) <input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:
Existing or new initiative? <input type="checkbox"/> Initiated/existing integration activity* X New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	List of partners involved:	
Please briefly describe the initiative: To provide services in a holistic manner (vs. medical model) to meet individual and changing needs of persons to improve or maintain quality of life, borrowing from lessons learned from successes in coordination and integration in other sectors. <ul style="list-style-type: none"> • Incubation for innovation funding is required • Human needs do not follow a linear path • Client need not move through system, rather the system must move around the client Why is it a priority? Because it is fiscally efficient and person focused. It is the only way to make the system function effectively.		
<i>If this is an initiative/existing activity....</i> What is the current status?	What are the outcomes/lessons learned (if any)?	
Lead contact person: Name: Paula Bergeron Title: Executive Director Telephone: (519) 740-3235 x 101		
Organization: Cambridge Home Support Email address: chs@sentex.net		

Title of patient care/service initiative: Hard to serve clients – complex care needs		Type of integration (more than one box can be checked) <input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:
Existing or new initiative? <input checked="" type="checkbox"/> Initiated/existing integration activity* <input type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	List of partners involved: Wellington County Hospital Network, LTC Facilities, Mental Health and Wellness Network, Independent Living Centre,	
Please briefly describe the initiative: Given that about 10% of the population are considered difficult to serve, an initiative is required that assists providers in delivering a high standard of care to the most complex population across all sectors, and also maintains a high quality service to the other 90% when the smaller population uses the majority of the resources. There is an opportunity for providing integrated services and specialized care that could service the individuals in question in enhancing their quality of life while still serving the larger group effectively. The goal is to increase quality of life of the hard to serve individual with complex needs, and empower staff with enhanced knowledge o provide care.		
<i>If this is an initiative/existing activity...</i> What is the current status?	What are the outcomes/lessons learned (if any)?	
Lead contact person: Name: Cathy Donahue Title: Telephone: 519-843-2400		
Organization: Caessant Care Fergus Email address: cdonahue@caessantcare.com		

Title of patient care/service initiative: Integration of Rehabilitation for people with disabilities		Type of integration (more than one box can be checked) <input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:
Existing or new initiative? <input type="checkbox"/> Initiated/existing integration activity* <input checked="" type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	List of partners involved:	
Please briefly describe the initiative: There is no integration for people with physical disabilities into the health care system. This must be addressed. Need for a service navigator in a navigable system. There needs to be incentives in the system for providers and clients. General practitioner needs to be the common thread that overlaps acute, rehab and community services for each client/patient. Need for rehab providers to partner and better understand each others services. Need for leadership in this process. Why is it a priority? It is a priority because there is a lack of integration for people with physical disabilities into the main stream of health care.		
<i>If this is an initiative/existing activity....</i> What is the current status?	What are the outcomes/lessons learned (if any)?	
Lead contact person: Name: Bill Laidlaw Title: Telephone: 519-742-3536 Organization: CNIB Email address: bill.laidlaw@cnib.ca		

Title of patient care/service initiative: Utilization of the provincial bed and resource registry		Type of integration (more than one box can be checked) <input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:
Existing or new initiative? <input checked="" type="checkbox"/> Initiated/existing integration activity* <input type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	List of partners involved:	
Please briefly describe the initiative: Improved utilization of the provincial be and resource registry. <ul style="list-style-type: none"> • Secure online resource registry (www.criticall.com) available to all hospitals in Waterloo-Wellington • Reflects (among other things) medical, surgical and specialty bed availability, oncall physicians, ICU/CCU status, Perinatal status, ED status and “admit to no bed” patients • Numerous report capabilities available to hospital staff and administration which can assist in short and long term planning, decision-making and resource management • Various levels of hospitals “participation”, i.e., inputting and updating of resource information specific to that hospital • Information input by hospitals currently used by the Ontario CritiCall Program’s call center (as well as other resources at its disposal) for physician-to-physician consultations concerning critically ill patients – general transfers or consults from community to tertiary centres • Information can also be utilized by hospitals in the same region for the transfer or consult of non-critical patients (when the call center is not needed) – for example, who’s on call for what service at which facility for a non-urgent patient <i>Separate but linked issue:</i> <ul style="list-style-type: none"> • CritiCall’s call center cannot currently assist with mental health referrals for hospitals – there are no referral protocols, transfer processes or identification of resources in place to provide CritiCall with the information it would need to facilitate mental health referrals (unlike Trauma, Perinatal or Cardiology specialties for example) <p>Why is it a priority? The provincial bed and resource registry is an established resource readily available to hospitals in Waterloo-Wellington. The registry, when used effectively and efficiently by hospitals can help to bridge the knowledge gap of resource availability between acute care facilities (including availability of beds, specialties and physician specialists) as well as provide valuable planning, decision-making and resource management information. Accurate and timely information in the registry could help physicians to better manager patients within their own LHIN..</p>		
<i>If this is an initiative/existing activity....</i> What is the current status?	What are the outcomes/lessons learned (if any)?	
Lead contact person: Name: Trish Simmons Title: Communications Specialists, Central West Manager Telephone: (905) 575-6263		
Organization: Ontario CritiCall Program Email address: simmonst@hhsc.ca		

Title of patient care/service initiative: Integration of health care providers in the treatment of musculoskeletal problems		Type of integration (more than one box can be checked) <input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:
Existing or new initiative? <input checked="" type="checkbox"/> Initiated/existing integration activity* <input type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	List of partners involved:	
Please briefly describe the initiative: Integration of health care providers in the treatment of musculoskeletal problems. Why is it a priority? Musculoskeletal disorders are the 2 nd leading cost of illness in Canada, with the biggest portion of these costs going to back pain. Government and health care providers / payers must acknowledge that different professions / professionals have different strengths in the treatment of musculoskeletal disorders i.e., chiropractors, physiotherapists, etc. There must be a willingness of care providers to defer treatment to the professionals which have demonstrated through evidence-based research effectiveness and cost-effectiveness of care. This lack of understanding and cooperation is a major barrier to integrated health care, as is the lack of appropriate funding. One major barrier which has been identified in numerous discussions today is the extreme reluctance and/or ignorance of medical physicians to acknowledge and/or refer patients to the various treatment options based on the available evidence. The LHINs, in cooperation from the provincial professional health associations, must disseminate appropriate literature to their counterparts as a means of rectifying the apparent lack of understanding about the strengths of each profession. The LHINs must then provide the appropriate (full) funding to the professions / professionals for the treatment of musculoskeletal disorders based on the evidence. There is far too much emphasis on the utilization of extremely costly medical services; typically care rendered after musculoskeletal disorders have advanced beyond a preventable and easily manageable stage. The costs of preventative care must be thoroughly evaluated in relation to the costs of treating preventable disorders. The public should be made very clearly aware of the costs associated with treatment i.e., disclosure of medical and hospital fees as a means of educating people what burden their condition places on the health care budget – to be used as an educational tool for promoting better health, lifestyles and use of preventative services. Solutions: Acknowledgement of all evidence-based research and data regarding musculoskeletal disorders i.e., WSIB program of care for acute low back injuries – 2004 data regarding treatment costs and return to work statistics; the Manga Reports regarding the effectiveness and cost-effectiveness of chiropractic care; Archives of Internal Medicine (Oct. 2004) – <i>Comparative analysis of individuals with and without chiropractic coverage</i> . Conclusion: Systematic access to managed chiropractic care not only may prove to be clinically beneficial, but also may reduce overall health care costs.		

Funding absolutely must reflect this research with respect to treatment protocols and patient referrals i.e., chiropractic care for treatment and back pain and headaches.

Better access to funded diagnostic and laboratory testing must be made available to chiropractors in medical facilities. The presence of chiropractors on hospital staffs, in emergency rooms, FHNs and CHCs should be strongly encouraged and promoted. There are many examples from other jurisdictions of successful chiropractic integration into health care.

The chiropractic profession fully endorses an environment of health integration and cooperation with other health professionals / professionals and facilities.

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

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

Lead contact person:

Name: Dr. Gregory Bidinosti

Title:

Telephone:

Organization: Waterloo Region Chiropractic Society

Email address: drgreg@rogers.com

Title of patient care/service initiative: Integration of Hard to serve the younger adult into LTC		Type of integration (more than one box can be checked) <input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:
Existing or new initiative? X Initiated/existing integration activity* X New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	List of partners involved: LTC Facility representatives attended this session	
<p>Please briefly describe the initiative: Integrating younger adults into LTC communities. Clients with needs are currently being supported separately in the community and in LTC facilities. The opportunity exists to coordinate services to better meet their needs no matter where they live. Mechanisms need to be developed and put in place to share resources, to include dollars, specialized care and services, training of support staff and physical surroundings. Co-funding of programs would better meet the needs of these clients both in the community, group homes and long term care.</p> <p>The current funding for LTC clients does not support the diverse social and emotional needs of the younger client. The staffing ratios required and specialized treatment needs are different than those of the traditional LTC client.</p>		
<i>If this is an initiative/existing activity....</i> What is the current status?	What are the outcomes/lessons learned (if any)?	
Lead contact person: Name: Brenda Nadeau Title: Administrator Telephone: (519) 620-9512		
Organization: St. Andrew's Terrace LTC Community Email address: brenda_nadeau@snr.on.ca		

Title of patient care/service initiative: Representation for public input into LHINs		Type of integration (more than one box can be checked) <input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:
Existing or new initiative? <input checked="" type="checkbox"/> Initiated/existing integration activity* <input type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	List of partners involved:	
Please briefly describe the initiative: The public should not be considered as “looking in” but must be recognized as “being in”. It is their health care system. The people of Ontario have said that they want the system fixed. There are existing community advisor councils and community networks that have the knowledge and expertise required by the LHIN. The individuals that are on these committees have previously identified opportunities for integration and innovation, but have not been given the authority or opportunity. It must be mandated that client/community representatives are on these committees. Examples of such networks are: CCAC community council; CCAC long term care network committee; and a difficult to serve committee. Why is it a priority? There must be a formalized process of inputting knowledge to the LHIN. Converting or utilizing the present networks is a savings in resources. In other words, we are not re-inventing the wheel. This would also be leverage to the relationships in place and refresh mandates.		
<i>If this is an initiative/existing activity....</i> What is the current status?	What are the outcomes/lessons learned (if any)?	
Lead contact person: Name: Nancy Kaufman-Lambert Title: Administrator Telephone: (519) 653-5493		
Organization: Golden Years Nursing Home Email address: nancy@goldenyears.cambridge.com		

Title of patient care/service initiative: Funding for LTC services		Type of integration (more than one box can be checked) <input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input checked="" type="checkbox"/> Other, describe:
Existing or new initiative? <input type="checkbox"/> Initiated/existing integration activity* <input checked="" type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	List of partners involved: The participants in this discussion were from: Long Term Care Facilities	
Please briefly describe the initiative: LHINs should organize a more consistent, efficient ltc facility placement system funding mechanism that reflects the needs of individuals and thus eases the wait times and avoids unnecessary hospital admissions and lengthy stays. LHINs should create a consistent funding mechanism for LTC facilities that reflects current resident needs, through the adoption of the MDS system LTC facilities could develop specialties within their programs and human resources, maximizing the expertise available to LTC consumers. LHINs could assist with ensuring better interdisciplinary utilization of specialty services, leading to more efficient and effective use of scarce human resources. 1		
<i>If this is an initiative/existing activity...</i> What is the current status?	What are the outcomes/lessons learned (if any)?	
Lead contact person: Name: Blair Philippi Title: Administrator Telephone: (519) 848-3795		
Organization: Caessant Care Arthur Email address: bphilippi@cogeco.ca		

Title of patient care/service initiative: Role of Volunteers in the health care system		Type of integration (more than one box can be checked) <input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:
Existing or new initiative? <input type="checkbox"/> Initiated/existing integration activity* <input checked="" type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	List of partners involved: All organization utilizing volunteers	
Please briefly describe the initiative: The opportunity for the provincial government to listen and better understand the unrealistic expectation of the voluntary sector – are there sufficient volunteers to carry through on the LHIN model? Need the realization that volunteer management does cost money. Currently the shortfall in ministry funding in the sector is being picked up by volunteers. The process of rolling out the LHINs does not value volunteer participation. The Selection Committee process needs to be transparent and there needs to be sharing of the criteria for appointment, accountability, skill set, expertise, etc. Informal/volunteer sector are not valued in the consultation or development process and caregivers are invisible in the process (caregivers are all volunteers). There is an opportunity to benefit from several reports already produced on volunteerism either produced locally through the DHC or nationally. Service provision in the system is dependent on volunteers and there needs to be recognition of the values and contributions of volunteers. Why is it a priority? Health care dollars that go to the voluntary sector are the most cost effective and efficient dollars in the whole health system. It is a priority if the whole LHIN process is going to work. Volunteers made up the entire “net” of the system and hold the whole system in place; the medical model is a small portion of the entire system of health care. There needs to be clearly defined accountability and responsibility and expectations of the LHIN Board so that they can develop the vision based on the community needs, wishes and desires. This is critical for buy-in from the LHIN Board and the community stakeholders.		
<i>If this is an initiative/existing activity....</i> What is the current status?	What are the outcomes/lessons learned (if any)?	
Lead contact person: Name: Deb Gemmel Title: Executive Director Telephone: (519) 744-7666		
Organization: RAISE Home Support Email address: rhsdirect@golden.net		

Title of patient care/service initiative: Services delivery in LHINS: Better or worse?		Type of integration (more than one box can be checked) <input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:
Existing or new initiative? <input checked="" type="checkbox"/> Initiated/existing integration activity* <input checked="" type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	List of partners involved:	
<p>Please briefly describe the initiative: Currently, local, provincial and national organizations support special patient populations. Regional health authorities treat rural/urban populations, victims of violence, conditions with small volumes, often using committees, associations or advocate societies. Needs can be met through letter writing campaigns or special community efforts to fund special services or one time needs.</p> <p>Needs can be:</p> <ul style="list-style-type: none"> • Short term / long term • Inpatient or outpatient, community, long-term care, cross continuum of care • Often overlap or led by social service organizations • Can have representation or are driven by consumers • Staff often alone with patient, responsible for wide ranging referral, linkage to other community agencies <p>These patient populations want a voice in developing the LHINs and put forward to the LHIN executive that consumers should drive this process. Consumers in this context could be an Association for a particular condition, a patient, a member of the public or client. Ask us what we want and we'll tell you what we need, we have data.</p> <p>Concerns: A common model implemented across LHINs may impact special patient populations negatively. Funding envelope could be driven by consumer as per Britain model for community services; basket that they determine. Funding and services need to be flexible re: structure and expectations. Need to be accountable and patient/ consumer needs to be accountable.</p> <p>Suggested purchase / provider model principles:</p> <ul style="list-style-type: none"> • Accountability • Responsiveness • Driven by consumer <ul style="list-style-type: none"> • Consumers need to be mobile, vote with their feet. They want reasonable, affordable and available options for care • Consumers want one-stop shopping to find care • Info given immediately on identification of problem for consumer to make informed choices • Realize we need to do this within same overall funding • Need to build in outreach, effective access for rural populations <ul style="list-style-type: none"> • Move hospital to community care whenever possible • Link services in outreach clinics/buses • Priorities based on consumer needs analysis <p>Indicators of need</p> <ul style="list-style-type: none"> • Wait lists a crude indicator of need; are you measuring a need or a bottleneck? <ul style="list-style-type: none"> • For midwives, palliative care, there can be no wait. There is refusal. There is data. Special 		

populations associations/groups can give it to you.

- Some waits artificially generated from short term solutions to meet budget deficits, bed closures, equipment breakage, internal shrinkage, inefficiencies. Increasing accountability can save money.
- Define accountability across community organizations and link to funding.

Opportunities:

LHINs are a major shift in governance and will make a major shift on delivery. Seize the day, equalize power, identify conflicting funding models and resolve.

Common themes that repeat are the opportunity to:

- Create one-stop shopping to access referral to care. Follow up on referral with appropriate information for informed choice. Accountability to organizations is linked to evaluation that proves that choices provided are palatable, available, effective.
- Communication: on first call for help, consumers get information they need, translated, and interpreted. Special needs accommodated to be able to access information.
- Spend the time to ask consumers what they want:
 - CEOs and Senior team will not likely be in touch at grass roots level. Include a consumer representative on the Board that has used and continues to be a user of local health services.
 - Explore integration opportunities that provide efficiencies in administration and improve access across organizations to care; particularly when care is staged across organizations in the course of the patient's care. Integrated length of stay, integrated health outcomes across the patient interventions tell the true tale, not just at one organization.
 - Explore best practices from British model where consumer holds funds and directs and distributes to care
 - View eligibility and admissions criteria differently, currently impede flow of patient movement. Consider common entry point like the Telehealth model where all patients are served at some level because care need are explored and episode is not closed until they are satisfied or goals are reached
 - Reform current community system where patient is own care coordinator when needing complex services in the community. If CCAC is to assume this role, they must significantly broaden their eligibility requirements.

Some exceptions:

Some populations will be so small and needs to unique that it is likely that funding will need to be directed provincially or even nationally. Others have such large needs that they may need to be treated uniquely in a separate envelope. Examples are:

- Public health / health prevention
- Populations reluctant to come forward: assault / victims of violence

Governance Issues:

- Will special populations organizations still establish standards of care, or medical criteria?
- Will content expert groups still set standards of practice / forward best practices? They currently manage appeals as well.
- There is lots of data. We can help.
- Determine a rationale ratio of community and acute care funding envelopes and implement.
- Other than asking consumers what they want, go ahead and implement all the info we already have.
- Establish a rational wait time strategy and stick to it.
- Get physician buy in.

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

What is the current status?

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

Lead contact person:

Name: Laurie Hurley

Organization: Arthritis Society

Telephone:

Email address: lhurley@on.arthritis.ca

Title of patient care/service initiative:		Type of integration (more than one box can be checked)	
Cross Sector training		<input checked="" type="checkbox"/> Horizontal <input checked="" type="checkbox"/> Vertical <input checked="" type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:	
Existing or new initiative?		List of partners involved:	
<input type="checkbox"/> Initiated/existing integration activity* <input checked="" type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>		Organizations and sectors represented in this group: Addictions Ontario, Community Support organizations, Community Health Centre	
Please briefly describe the initiative:			
The engagement of the health and human service sectors in cross-sector training is an integration priority because it would build upon expertise resident within the health care system, increasing both system quality and capacity. The LHIN Website could include a portal with agency information, training, models, news, best practices, etc. LHIN could act as a clearinghouse for training information			
<i>If this is an initiative/existing activity....</i>		What are the outcomes/lessons learned (if any)?	
What is the current status?		Requires agency commitment to collaboration in providing training	
Currently a single vehicle through which cross sectoral training activities could occur does not exist.			
Lead contact person:			
Name: Jeff Wilbee		Organization: Addictions Ontario	
Title:		Email address: jeff@highonlife.org	
Telephone:			

Title of patient care/service initiative: Fair funding for Waterloo-Wellington	Type of integration (more than one box can be checked) <input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:
Existing or new initiative? <input type="checkbox"/> Initiated/existing integration activity* <input checked="" type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	List of partners involved: All MOHLTC funding agencies
Please briefly describe the initiative: Fair share of provincial health care resources for Waterloo-Wellington residents <ul style="list-style-type: none"> • Transparency and consultation in the development of a new funding formula (equitable basis for distribution of funds) • Population needs based (e.g., based on age, sex, socioeconomic status, etc.) • Supports a fair allocation of human resources (e.g., psychiatrists, techs, etc.) • Allow to address gaps in service • Allow reinvestment of savings from integration into LHIN priorities (to the extent that not over funded) • Query how funding formula will deal with vulnerable populations and may have to address on a province-wide basis • Require drilling down on the population characteristics and health needs • Encourage investment in prevention strategies to avoid downstream needs (needs to be supported and encouraged) Why is it a priority? <ul style="list-style-type: none"> • All people deserve access to quality care and information deemed worth providing by the provincial government • Without additional resources, there will be a tendency toward continuation of a silo mentality • Current inequities exist across the province and in Waterloo-Wellington (according to current funding formulas) • Public expectations • Provides an incentive to do things effectively and efficiently • Expectation that “delisted services” impact on government funded providers • Ability to attract and retain clinicians requires fair starting point • Because we are Canadians who value fairness and equity (as opposed to US where a well-insured community will have vastly superior services to one supported by medicare and medicaid) • Need resources to do preventive work (kick start it) • We are competing in a global marketplace and businesses expect support from local health care providers • Growth in our region has not been adequately addressed in past funding (also patient demographics) • Without fairness there will continue to be “have and have not” which will be perpetuated if not addressed early on 	
<i>If this is an initiative/existing activity...</i> What is the current status?	What are the outcomes/lessons learned (if any)?
Lead contact person: Name: Dennis Egan Title: CEO Telephone: (519) 742-3611 Organization: Grand River Hospital Email address: dennis_egan@grhosp.on.ca	

Title of patient care/service initiative: Rural Intersectoral Integration and planning for intersectoral collaboration for health promotion, disease prevention and service delivery		Type of integration (more than one box can be checked) <input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:
Existing or new initiative? X Initiated/existing integration activity* X New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	List of partners involved:	
Please briefly describe the initiative: Why is it a priority? Opportunities for rural and urban: <ul style="list-style-type: none"> • LHIN could bring together sectors beyond health – education, housing, income, public health – broad determinants of health focus • LHIN could place greater priority on health promotion • Cross-LHIN sharing of health promotion resources, materials, focus • LHIN can promote community-based / focused health promotion • New funding formula could be opportunity to support health promotion, to look for / support partnerships in home, businesses, community and build on existing • LHIN focus on “patient community” could support focus on unique patient groups (voluntary) organizations, resources, groups, etc. • Potential to combine small funded program to make better use of small dollars, more funds to service, combined admin. • Potential to coordinate, enhance transportation across sections (transportation is key to many services / access) • LHIN have role to help population for planning for space/location, admin. Support infrastructure for smaller health promotion-focused organizations to co-location, focus on service, not on looking for place to work • LHIN itself presents opportunity for community-based collaboration, ensure resources for collaboration to happen • Opportunity to promote “one stop” access to community-based resources, intersectorally • LHINs can share “wisdom” about existing models of intersectoral collaboration, sharing within LHIN and among LHINs • Potential to resource many different locations to deliver programs (smaller organizations not have to use resources to deliver services at many different sites) Risks/Challenges for Rural and Urban <ul style="list-style-type: none"> • Losing what has worked so far in cross-sector work; different Ministries are not doing this • Challenge of a new funding formula that will support/fund health promotion/illness prevention • Risk that funding formula is so restrictive that prevents responsiveness at individual LHIN level • LHINs focus on “incenting change” could be challenge/risk • Reliance on volunteers, in agencies and on LHIN Board, can be a risk; need to have paid positions to make sure that critical work gets done, need to support volunteers (training, volunteer management, etc.) – if not good support, could lose volunteers, not get needed work done 		

Rural-specific opportunities:

- Transfer / maintain rural health planning skills, resources of DHCs to LHINs
- Potential to enhance / better coordinate transportation; involved private services (e.g., taxis), have “critical mass” in rural areas for transportation
- LHIN could help promote/share info about availability of services in rural (small rural agencies have resources to provide services but not to promote services) (e.g., transportation)
- Potential for rural health planning/resourcing to be better addressed in LHIN, in context of community

Rural-specific risks/challenges:

- Risk losing access to rural health planning support for small, rural agencies
- Rural communities could “fall of the radar” if urban population “drives” LHIN decision-making

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

What is the current status?

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

Lead contact person:

Name: Denise Squire

Title: Executive Director

Telephone: (519) 664-3534 x 225

Organization: Woolwich Community Health Centre

Email address: dsquire@wchc.on.ca

Title of patient care/service initiative: Integrated Primary Care		Type of integration (more than one box can be checked) <input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:
Existing or new initiative? <input checked="" type="checkbox"/> Initiated/existing integration activity* <input type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	List of partners involved:	
Please briefly describe the initiative: Build on what we know in the community to bring together the right service by right people at the right time. Reach individuals who require minimum intervention before they require more costly services. Minimum intervention to include: <ul style="list-style-type: none"> • Access to family doctor • Coordination of service and support • Crisis response resource • Link existing community mental health and support services to professional services in a client focused manner; no referrals, just have staff that respond to client needs • Major issue is funding; current community resources are without the flexibility to change resources to respond to a need as their agency needs demand all available resources • Need to prove early intervention results in savings in health care • Funding formulas must support integrated broad-based primary care models that respond to variety of needs of clients including marginalized individuals • The distinction between family health teams for general populations and community health for marginalized must be challenged. Costs may not be factor if integration of existing services occur in family health teams • Let us build on existing best practices • Answer is to ensure community services receive priority funding Why is it a priority? <ul style="list-style-type: none"> • Without an integrated broad-based primary care system, integration of health care system will not be achieved 		
<i>If this is an initiative/existing activity....</i> What is the current status?	What are the outcomes/lessons learned (if any)?	
Lead contact person: Name: Joe McReynolds Title: Telephone: (416) 256-3010 x 224 Organization: OSCA Email address: joem@ocsa.on.ca		

Title of patient care/service initiative: Ensuring care in the community for people with ongoing chronic needs / conditions		Type of integration (more than one box can be checked) <input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:
Existing or new initiative? <input type="checkbox"/> Initiated/existing integration activity* <input checked="" type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	List of partners involved: <ul style="list-style-type: none"> • Community support service agencies • Canadian Hearing Society • March of Dimes • Independent Living Centre • CNIB • CMHA • Community based Mental Health and Addiction agencies • CCAC • AIB • Alzheimer Society 	
Please briefly describe the initiative: Provide information systems and resources to collect data that looks at the impact of care in the community for people with ongoing, chronic needs / conditions. Look at data from other jurisdictions. Use this information to allocate funds. The resources for care in the community currently support post acute, post hospital care or end-of-life care. The intent is to shorten the length of stay and reduce hospital costs. More resources should go into the pre-acute, pre-hospital care to divert people from hospital and institutions. The people with chronic needs/conditions are: Frail elderly (age related conditions, stroke, dementia, mental health issues, etc.; Children with chronic illness; Physically disabled adults; ABI; Multiple chronic conditions; mental health, addictions, etc. The Services that are available to these people are inconsistent (quality, level of service, accessibility) and are decreasing due to increased need (demographics) We do not have information needed to make decisions at the moment. Care for chronic, ongoing conditions is important: prevents premature institutionalization; diverts needs from acute care services; supports caregivers (respite and case coordination). Living at home is a value to our society: maintaining quality of life and control of life; promotes independence, self worth; community benefits from civic participation, volunteerism; it is the right thing to do.		
<i>If this is an initiative/existing activity....</i> What is the current status?	What are the outcomes/lessons learned (if any)?	
Lead contact person: Name: Susan Thorning Title: Telephone:		
Organization: OSCA Email address: susant@osca.on.ca		

Appendix B LHIN #3 Steering Committee: Planning Lead Contact Information

Identified Integration Opportunities	Planning Team Contacts			
ADMIN TOPICS				
LHIN-wide Health Human Resources Planning including Recruitment & Retention (both Admin & Patient Care)	<p>Susan Burns Executive Director WRWDDHC 251 Woodlawn Rd. W., Unit 118 Guelph, ON N1H 8J1 Tel: 519-836-7602 ext. 224 Fax: 519-836-7177 sburns@wrwddhc.on.ca</p>	<p>Suzy Young 911 Queen's Blvd. Kitchener, ON N2M 1B2 Tel: (519) 749-6578 x1953 syoung@smgh.ca</p>	<p>Cheryl Batty Sr. Health Planner WRWDDHC 251 Woodlawn Rd. W., Unit 118 Guelph, ON N1H 8J1 Tel: 519-836-7602 ext. 238 Fax: 519-836-7177 cbatty@wrwddhc.on.ca</p>	<p>Blair Philippi Administrator Caessant Care Nursing and Retirement Homes, Arthur 215 Eliza St. Arthur, ON, N0G 1A0 Tel: 519-848-3795 Fax: 519-848-2273 bphilippi@caessantcare.com bphilippi@cogeco.ca</p>
Integrated Performance Measurement and Public Report Cards (Admin support)	<p>Jim Whaley Executive Director Grey Bruce Huron Perth DHC 235 St. George St. P.O. Box 610 Mitchell, ON N0K 1N0 Tel: 519-348-4498 Fax: 519-348-9749 jwhaley@gbhpdhc.on.ca</p>	<p>Randy Peltz Director of Operations Regency Care Corporation 2140 Baronwood Dr., Lower Level Oakville, ON L6M 4V6 Tel: 1-866-469-8949 ext. 703 Fax: 905-469-6028 rpeltz@regencycare.ca</p>		
Integrated Electronic Health Record (Admin support)	<p>Grant Hollett Sr. Health Planner WRWDDHC 251 Woodlawn Rd. W., Unit 118 Guelph, ON N1H 8J1 Tel: 519-836-7602 ext. 234 Fax: 519-836-7177 ghollett@wrwddhc.on.ca</p>	<p>Glenn Kearns Chief Information Officer Grand River Hospital Corporation 835 King St. W. Kitchener, ON N2G 1G3 Tel: (519) 742-3611 Fax: (519) 749-4282 glen.kearns@grhosp.on.ca</p>	<p>Maureen Carli President, Hospice of Waterloo Region 209 Pandora Cres. Kitchener, Ont N2H 3E5 Tel: 519 743 2038 Fax: 519 743 7021 ecarli@sympatico.ca</p>	<p>Roberta MacDonald St. Mary's General Hospital 911 Queen's Blvd. Kitchener, ON N2M 1B2 Tel: 519-749-6578 Fax: 519- rmacdonald@smgh.ca</p>
Admin support other than IT (Admin support)	<p>Stewart Boecker VP and CFO Grand River Hospital 835 King St. W. P.O. Box 9056 Kitchener, ON N2G 1G3 Tel: 519 Fax: 519 stewart.boecker@grhosp.on.ca</p>	<p>Karl Ellis Corporate Services North Wellington Health Care 630 Dublin Street, Mount Forest, Ontario N0G 2L3 Tel: 519-323-3333 Ext 2279 Fax: 519-323-2096 kellis@nwhealthcare.ca</p>	<p>Mark Beadle Program Manager, Ambulatory Clinics St. Mary's General Hospital 911 Queen's Blvd. Kitchener, ON N2M 1B2 Tel: 519-749-6639 mbeadle@smgh.ca</p>	

Regional Care Maps (both Admin support and Patient Care)	Neil Barran Senior Vice President Saint Elizabeth Health Care 90 Allstate Parkway Suite 300 Markham, Ontario L3R 6H3 Tel: (905) 940-9655 X2103 Fax: (905) 940-9934 nbarran@saintelizabeth.com	Marianne Walker President & CEO St. Joseph's Health Centre Guelph 100 Westmount Road Guelph, Ontario N1H 5H8 Tel: 519 824-6000 Ext. 4403 Fax: 519-763-0264 mwalker@sjhh.guelph.on.ca	Susanne Gillespie Canadian Hearing Society Manager of General Support Services and Hearing Care Counselling Program C/o 511 Windjammer Way Waterloo ON N2K 3Y5 Tel: 519-886-6298 sgillespie@chs.ca	Kristine McGregor Profesional Respiratory 604 Belmont Ave West Kitchener, ON N2M 1N5 Tel: 519-886-0202 Fax: (519) 741-8505 kmcgregor@proresp.com
Use of Existing Service Networks (Admin support)	Nancy Dunbar Administrator Leisureworld Caregiving Centre 120 Barnswallow Dr Elmira, ON N3B 2Y9 Tel: (519) 669-5777 Fax: (519) 669-0928 ndunbar@leisureworld.ca	Ross Kirkconnell Executive Director CCAC – WD 450 Speedvale Ave. W., Unit 201 Guelph, ON N1H 7G7 Tel: (519) 823-2551 ext 2225 Fax: (519) 823-9270 ross.kirkconnell@wd.ccac-ont.ca		
PATIENT CARE TOPICS				
Discharge Planning and Integrated Case Management (Patient care)	Nancy Kaufman-Lambert Administrator Golden Years Nursing Home 704 Eagle Street North Cambridge, ON N3H 1C3 Tel: (519) 653-5493 Fax: (519) 650-1495 nancy@goldenyearscambridge.com	Toni Lemon Manager, Client Services Pace Homecare 450 Frederick Street Kitchener, ON N2H 2P5 Tel: 519-576-3570 ext 228 Fax: 519-576-9270 toni@pacehomecare.com	Kevin Mercer Executive Director CCAC – WR 800 King Street West Kitchener, ON N2G 1E8 Tel: (519) 883-5576 Fax: 519-883-5515 Kevin.mercer@waterloo.ccac-ont.ca	

Integrating Community Health with Mental Health and Addiction Programs (Patient care)	John Jones Executive Director Canadian Mental Health Association 5420 Hwy 6 North Orchard Park Office Centre RR #5 Guelph, ON N1H 6J2 Tel: 519-766-4450 x223 Fax: 519-766-9211 jonesj@cmhawrb.on.ca	Pam Gardiner Addiction Services Program Director House of Friendship 215 King Street South Waterloo, Ontario N2J 1R2 Tel: 519-745-4691 Fax: 519-745-2223 pamg@houseoffriendship.org		
Mental Health Service and System Integration Opportunities	Carolyn Skimson Executive Director Groves Memorial Community Hospital 235 Union St. E. Fergus, ON N1M 1W3 Tel: (519) 843-5331 x200 Fax: (519) 843-7288 cskimson@gmch.fergus.net	Harriet Lenard Sr. Health Planner WRWDDHC 251 Woodlawn Rd. W., Unit 118 Guelph, ON N1H 8J1 Tel: 519-836-7602 ext. 229 Fax: 519-836-7177 hlenard@wrwddhc.on.ca		
Regional Care Maps (both Admin support and Patient Care)	<i>Combined with admin support listing</i>			
Role of Community Support Agencies in Health Services (Patient care)	Joanne Klausnitzer Executive Director Meals on Wheels K-W 40 Shirley Ave. Kitchener, Ontario N2B 2E1 Tel: (519) 743-1471 Fax: (519) 743-1472 ed-mowkw@bellnet.ca	Heather Kerr Executive Director, Stonehenge Therapeutic Community 60 Westwood Road Guelph N1H 7X3 Tel: (519) 837-1470 ext.230 Fax: (519) 837-3232 hkerr@stonehenge.com		
Developing Models of Service that Empower Individuals to take responsibility for their Health (Patient care)	Katherine Soule Blaser Director of Program Development Independent Living Centre of Waterloo Region 127 Victoria Street S., Suite 201 Kitchener, ON N2G 4B2 Tel: (519) 571-6788 Fax: (519) 571-7590 Katherine@ilcwr.org	Konnie Peet Executive Director Guelph Community Health Centre 1-176 Wyndham St. N. Guelph, ON N1H 8N9 (519) 821-5363 x 310 (519) 821-5834 kpeet@gchc.on.ca		

Appendix C Distribution List for Final Report to LHIN #3 Board

All WRWDDHC Stakeholder Committees

All WRWDDHC Stakeholder Contacts LTC Facilities / LTC agencies / Mental Health agencies /
Addiction agencies / Hospitals / Emergency Services / Primary Care organizations
(Waterloo Region-Wellington-Dufferin area)

All Municipalities in Waterloo Region-Wellington-Dufferin area

Attendees at November 19th Community Workshop Participants (180 people attended LHIN#3
Workshop)

Addictions Ontario

Alzheimer Society of Guelph-Wellington

Cambridge Memorial Hospital

Canadian Red Cross

Care Partners

Caressant Care Nursing Homes

CCAC – Waterloo Region

CCAC – Wellington-Dufferin

Central Park Lodges

Centre for Addictions and Mental Health

Comcare Health Services

Community Rehab

COTA Health

CYG

District Stroke Centre – Grand River Hospital

Extendicare

Golden Years Nursing Home

Grand River Hospital

Grand River Hospital Community Mental Health

Grand River Hospital Withdrawal Management

Groves Memorial Community Hospital

Guelph General Hospital

Homewood Health Centre

Members of Provincial Parliament (Waterloo Region-Wellington-Dufferin area)

Members of Parliament (Waterloo Region-Wellington-Dufferin area)

North Wellington Health Care Corporation

Ontario Federation of Community Mental Health and Addictions Programs

Ontario Half Way House Association

Ontario Hospital Association

Ontario Physiotherapy Association

Pace Homecare

Saint Luke's Place Nursing Home

St. Joseph's Health Centre

St. Mary's Counselling Services

St. Mary's General Hospital

Stonehenge Therapeutic Services

Waterloo Region-Wellington-Dufferin District Health Council

Waterloo Wellington District Stoke Strategy Group

