

## Mississauga Halton Local Health Integration Network (MH LHIN)

### Health Service Providers Forum - May 5, 2009

*The LHIN invited health service providers and other providers/partners from the LHIN to discuss the proposed strategic and integration priorities and enabling strategies to be included in the LHIN's Integrated Health Service Plan for 2010–2013. The session was one of a number of focused consultations planned with groups of stakeholders over the next month. This report provides a summary of the dialogue and feedback from the Health Service Providers (HSPs) and partners in attendance. Staff and members of the Board of Directors of the LHIN have been attending these sessions and listening closely to the feedback. The stakeholders' perspectives will also be an important part of the discussion with participants in the Citizens' Reference panel this June.*

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## Mississauga Halton LHIN Health System Update

The session began with an overview of progress in the LHIN on priorities from the first (current) IHSP:

- Achievements in seniors' health, wellness, and quality of life centred on initiatives to make daily living easier for seniors and on bridging the gap between hospital and home care. For example, the strategy for "hard to serve" seniors dramatically reduced the number of days these patients spent in acute care, and specifically, ALC days.
- Progress on the integration of acute care clinical services included creation of 24/7 capacity in Trillium Health Centre's Cardiac Care facility and initiatives in integrating vascular surgery and neurosurgery services.
- Wait times for six key procedures were significantly reduced over the last three years.
- The LHIN made progress on provincial targets for emergency room wait times, but more needs to be done in this area, particularly in treatment within eight hours for admitted patients (the only target where results were lower than the provincial average).
- LHIN staff presented demographic figures and prevalence statistics on diabetes and mental health and addictions in the LHIN.

LHIN leadership also reviewed the criteria for setting priorities for the IHSP. LHIN leadership emphasized that in order to be successful, a few top priorities need to be identified based on:

- Core commitments
  - Is there a direct link to the LHIN and Provincial Health System Priorities?
- Achievability
  - Do we have direct influence and can it be executed with 3 years?
- Benefits
  - Will there be a positive impact on health outcomes and improved accessibility, quality and safety?

- Severity and Prevalence
  - How severe is the problem and where do we have influence?
- Feasibility
  - Can health service providers and LHIN staff do what is proposed?
- Costs and Risks
  - Can it lead to a sustainable system?

Examples of the work the LHIN carries out were described, included health system planning, funding health service providers who deliver health services, and monitoring how well health services are being provided through a set of performance measures. It was also noted that the LHIN does not have a mandate in some other areas of the health care system, including providing direct patient care, oversight or management of physicians, and oversight and management of certain areas of the health care system such as public health IHSP or ambulance services.

The importance of the current priorities was highlighted in a pre-session survey of the participants. Sixty per cent said that the first IHSP had “very much” influenced their work. Most reported that it had helped to shape priorities in their organization, and that new initiatives flowing from those priorities have increased collaboration among service providers and reduced duplication of effort. Several mentioned specific improvements in capacity, transportation systems, workflow, and general administration.

Participants had also been asked about emerging trends in health care utilization that would help in planning for the next IHSP. During the session, they considered those trends in light of the proposed IHSP priorities:

- Improving access, quality and sustainability of the health system
- Enhancing seniors' health, wellness and quality of life
- Integrating mental health and addictions services
- Prevention and management of chronic conditions

Participants also discussed the three broad categories of enabling strategies:

- Primary health care
- eHealth strategy
- Health human resources

The following is a summary of their comments and ideas, grouped by the proposed priorities and strategies, further grouped by major themes emerging from the discussion. *Some of the issues raised do not fall within the work of the LHIN, but they are recorded here to fully capture the participants' views.*

## General Discussion

The wide-ranging discussion about priorities for the LHIN also touched upon the health care system itself and particular issues related to health service providers. Thus, some of the comments in this section do not relate to the proposed priorities for the new IHSP. Again, those comments are recorded here to fully capture the participants' views for the LHIN to consider along with outcomes from all of the other community engagement sessions.

### *Priorities*

- Health care for children and youth, health and wellness promotion, and palliative care should be added to the list of priorities.
- Articulating priorities should not create new "silos" that could make integration across sectors more difficult. For example, mental health and palliative care cut across the proposed priorities, and care should be taken that the funding process does not impede development of inter-sector programs.

### *Implementation of initiatives*

- There seems to be a welcome move from ideas to implementation in the LHIN. The focus should be on implementing what is manageable and can be done well, rather than trying to implement too many initiatives at once.
- There is a need for analysis of how things really work now, and for making sure everyone understands how the collection of health services works together as a system.

- It will be difficult—but necessary—to keep all of the priority concepts in mind at once, examining their effect as a whole. The approach should be systemic, keeping in mind what might be impacted by specific improvements in the priority areas.
- Implementation plans should be specific, and they should clearly address what the system will look like after implementation. Each action should be examined from the patient's perspective, not only from the service provider's point of view.

### *Funding for the LHIN*

- Health service providers are feeling the effect of the economic downturn, particularly in the loss of jobs in the auto sector. Agencies are seeing increased use of their services and decreased revenue from fundraising. They are under pressure to do more with less. Meanwhile, per capita funding in the LHIN is not on par with other LHINs. The LHIN should allocate resources to developing business cases for funding.

### *Administration*

- Health service providers are responsible for a great deal of paperwork, reporting, and attendance at meetings. The LHIN should look for ways to ease the administrative burden, such as simplifying forms, reducing duplication, and making it possible to submit forms electronically. To give health service providers more time for patient care, it may be possible to assign clerks to do at least some of the paperwork.
- Collecting the data the LHIN needs to make decisions is sometimes difficult for small organizations. One agency offered to collect and input information from a number of other community support services for a small fee. The efficiency gains from this informal integration initiative made resources available that would otherwise have been spent on administrative tasks.
- Administration related to patient assessments could be made more efficient through standardized assessment forms, used across disciplines and shared among services—preferably on line.
- The integration of back office functions will require some funding, especially for smaller agencies, to cover the capital cost of the infrastructure needed.
- Agencies should be able to use savings from cost-efficiencies to enhance services within the organization (rather than cutting their budgets accordingly).

## *Sharing methods and resources*

- Integrated programs have been effective, but there is a need to further reduce duplication of services, especially in areas such as geriatrics, palliative care, diabetes centres, outreach, and co-morbidities. In many cases, these gaps could be filled through cooperation between hospitals and community-based services. Funding should follow the service when functions shift from hospitals to community services.
- Health service providers are enthusiastic about integrating services and moving toward a shared care model. With common goals or directives as an impetus to get people working on it, they are capable of executing integration programs. For example, it would be useful for hospital administrators to have fixed targets set by the LHIN, with their input.
- There should be mechanism for sharing information about successful initiatives among LHINs.
- In many cases, improvement in services may be a question of simply using existing resources more effectively. Many community agencies have excellent resources that are not well known to other agencies. A central place for information on agency resources, and partnerships to share resources, would help to take full advantage of what is already available. The LHIN could play a role in facilitating opportunities for service providers to meet to share information and resources and form partnerships.
- Informal networking is a crucial element of integration. The LHIN could bring Community Support Services representatives together in forums where they have the opportunity to make the connections that will ease integration. This is already working in other areas, where networking has enabled Community Support Services in Mississauga Halton to establish common definitions and vocabulary to prevent confusion.
- Administrators often get together to discuss issues, but the LHIN should also bring frontline workers together for this purpose. Such a forum would enable frontline workers to advise the LHIN on what would make their work easier and give them the opportunity to learn about other services.
- There is a need to build trust between hospitals and community agencies. Shared programming can help to build that trust. Shared programming could mean developing links between services rather than sharing the same space, but co-location as well as clinical integration could be useful in some instances.
- Developing trust between agencies also means coming to trust patient information from other agencies so that agencies can build on patient information rather than starting a new record. This would require building shared languages, intake processes, and other tools. There is also a need for communication and trust among the health care disciplines.

- Currently, community mental health and addictions agencies cannot compare data because there is no centralized data collection. Agencies would need more staff support to collect data themselves. These agencies should meet with a view to working together and sharing data.
- Hospitals should have a line of communication with post-discharge services to ensure that patients have appropriate follow-up care. Often, the ER or hospital cannot discharge a patient because of the lack of services available in the home. CCACs may have the capacity to follow up with discharged clients, and hospitals might consider establishing a referral unit to ensure that patients see someone knowledgeable about community services before leaving hospital. Follow-up processes could be similar to the model for nurses contacting new mothers.
- There should be a better flow of information between the ER and nursing homes. The ER should share patient information with long-term care facilities and with hospital staff at each shift change. Follow-up information should go to the patient's family, and to the physician and staff at the long-term care facility.

## *Outreach and information*

### Public outreach

- In many cases, patients are not aware of the services available to them. In particular, too few people are aware of the role and function of Community Care Access Centres. Information about the resources available could be made more accessible in a number of ways:
  - Brochures distributed to locations where people already go (libraries, places of worship, recreation centres, seniors' centres) would raise awareness and provide information to people with no computer access. Agencies could also work with clergy to help them recognize needs in the course of pastoral visits and make appropriate referrals.
  - Single locations could serve as central hubs for agencies to make information available, and sometimes have representatives on site (as the United Way of Peel has already begun to do).
  - Seniors' buildings or affordable housing buildings could have "service nights," where service providers are invited to inform residents about their services. Smaller-group sessions could focus on specific topics, such as diabetes management.
- It is important to find out how people in target groups prefer to receive information. For example, brochures may not be appropriate for many people. Targeted information should also be made available in other languages and alternative formats such as audio and Braille.

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- In considering outreach, several questions should be answered: Who are the target groups? Should outreach be done at the community level or throughout the LHIN? Who should undertake outreach—the LHIN or individual services? How can ancillary groups help improve communications? Should the message be treatment or wellness?
- Outreach should be planned with the realistic availability of services in mind.

## Information for service providers

- Organizations have an urgent need for quick access to information about the resources available to their clients. Many do not know where to get information on other service providers. An online directory of agencies would be most useful. It could contain information such as services, capacity, waiting lists, maps, and contacts. The site could also provide forms, preferably with the ability to complete and transmit them on line. With such a directory, a referral would more often lead directly to service. The same site could prove a venue for sharing resources. The public could have access to information on the services provided, the main numbers, maps, and certain forms. ServiceOntario would be a useful model. An 800 number providing the same information could serve people with no computer access. A system-wide site could be updated by individual providers.
- Family doctors and other health professionals should be involved in referrals to community agencies.
- Community Care Access Centres should have better connections for information and referrals to all of the resources in the community, not only the organizations under contract.
- Frontline staff should receive training in making referrals.
- A centralized patient information system (under the eHealth strategy) would help in providing seamless services and avoiding duplication of records. For the patient, this could take the form of a "health passport" or smart card that travels with the patient.
- Services to people with disabilities should be a specific focus. For example, one in four Canadians will become deafened, which can lead to isolation and depression. Service agencies need to develop cross-sector relationships to prioritize services in areas such as prevention, screening, outreach, and referrals.

## *Performance measures*

- In addition to ER issues and wait times, performance measures should be developed that reflect longer-term objectives and how health service providers delivery quality care. Providers could work together, and with the LHIN, to identify indicators based on existing accepted measures, such as symptom-reduction scales and recidivism rates.
- The underlying meaning of the data collected should be analyzed, and a data strategy should be in place to use information as productively as possible. Targets should also be examined for appropriateness. For example, in the United Kingdom, the health system successfully reduced wait times, but the mortality rate rose at the same time.
- Analysis should include examining the linkages between the indicators and patient behaviour. For example, for some immigrants, the hospital is the primary health resource. Turning to a hospital first may have been routine in their country of origin, or they may not have a family doctor or know about community resources. The LHIN might need to consider ways to change “health-seeking” behaviour.

## Proposed Priority: Improving access, quality and sustainability of the health system

- The wording could be changed to more fully reflect a patient-focused approach, such as “to create a system that provides better health outcomes.”
- The priority should be expanded to specifically include non-hospital services and community services.
- The concept of sustainability should be explained in the IHSP. For example, does it mean sustaining the status quo or sustaining changes, made now, into the future?

## *Facilities and infrastructure*

- In integrating services, the LHIN should consider the “one stop shop” concept, where services and information are available to the patient in one place.
- For the patient, ideally all doors to health care should be the right door. Health service providers should all be hubs leading to all health-related services and capable of making seamless referrals.
- Better access will require an infrastructure plan. The plan set out in the Acute Care Services Study should be incorporated into the IHSP.

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- More specialized facilities and services are needed in the LHIN to avoid having to transfer patients to other areas for specialized care or treatment. However, there is also a tendency among service providers to send patients to specialized facilities outside the LHIN, even when they could be treated locally.
- Creating centres of excellence is a good strategy. Other services will be necessary to make them as effective as possible, such as transportation and ways to link people back to the supports in the community once they are discharged. Virtual centres of excellence may be one way to increase access to specialized services throughout the LHIN when it is important to provide care closer to home.
- In considering off-hospital urgent care options, it is important to bear in mind that they may not be appropriate if they do not have diagnostic and other necessary facilities. However, more physiotherapy and other non-acute services could be offered outside of hospital.

### *Wait times*

- To track wait times more accurately, the term needs to be defined so that the starting point of the waiting period is clear. Wait times should capture situations where the patient is waiting to be moved elsewhere or the occurrence of patients listed on two or more waiting lists for the same service. In addition, wait times should reflect the wait for actual services, not the time required to get onto a waiting list.
- Wait times should be monitored across the continuum of services (long-term care, community services, psychiatric assessment, palliative care beds, and community mental health beds).
- Wait times for specialized services should be addressed specifically. Waiting time for specialists and treatment is currently seen as a more serious issue than wait times for non-urgent care in hospital emergency rooms.
- A mechanism is needed to ensure that patients on waiting lists actually require the services for which they are waiting. It may be that some of patients could be treated more quickly in other ways.
- The Alternate Level of Care and Ageing at Home strategies could serve as models for addressing wait times within the community.

### *Health and wellness promotion and education*

- Health promotion and disease prevention are related to the continuum of services, and essential to the sustainability of the health system. There should be more support for a healthy lifestyle and the prevention of disease.

- More research is needed into prevention and health promotion. The focus should be on early prevention measures.
- Healthy lifestyle information should be circulated through schools and youth groups, using existing networks.
- Initiatives in education are effective and should be more widely available. Policy-makers should place a greater emphasis on this long-term strategy versus early successes.
- A program of “health literacy” would help patients make the most of their time with their physicians, explain when they should go to the ER, and teach them how to get more information about disease management.
- Physicians and the public need education on the palliative process.
- Investing in seniors’ wellbeing is important, but investment in wellness for the young could prevent chronic illness later in life and make the health system more sustainable.

### *Navigating the system*

- The health system is complex and extremely difficult for many patients to navigate without help. Service providers need to be able to provide patients with the information they need to navigate the health system once they are discharged from a service. Learning the networks and making informal contacts is time-consuming for service providers, and the central information source mentioned above would help them in serving patients.
- There may be a role for a community worker specifically to help patients through the system. The role would be separate from that of a case manager. More social workers in nursing homes could also help patients and families through the system.

### *Transportation*

- For many patients, transportation difficulties continue to be a significant barrier to accessing health services. Through partnerships, the health system could build on existing resources to improve transportation for patients.

### *Cultural diversity*

- Responding to the needs of diverse cultures should be included as a criterion related to quality and access.

- Cultural competency training programs should be offered to all health service providers. Organization policy should incorporate cultural competency and sensitivity. For example, hiring policy should aim to reflect the ethnic composition of the community.

## *Palliative Care*

- The need for palliative care is increasing. Palliative care developed on a volunteer model, but now needs appropriate resources. The sector needs funding for staff and hospices now, but also needs data on current capacity and future need for planning purposes. The business case for more support for palliative care is that the cost of palliative care beds is significantly lower than the cost of Alternate Level of Care accommodation.
- “Palliative” should be defined (using the prognosis indicators from Canadian Hospice Palliative Care Association definition).
- Patients and their families and caregivers need education and supports for daily living. Funds should also be allocated to support during periods of transition between facilities.
- More residential hospices are needed, but flexible alternative supports should be available to patients who wish to stay at home. The goal should be to increase patient choice, and the emphasis should be on a patient-centred, holistic approach.
- There is a need for public education about palliative care and for encouraging end-of-life planning, integrated into all levels of the health care system. Planning of this kind would also help to avoid conflict in times of crisis.
- Hospitals, CCACs, and palliative care facilities should develop protocols to ensure smooth transitions between facilities. The eHealth strategy could help with seamless transition by reducing paperwork.
- Palliative care should be sensitive to cultural needs, diversity, age, and level of support services required. Shared care should have proper support in community.

## Proposed Priority: Enhancing Seniors’ Health, Wellness and Quality of Life

### *Service planning*

- To plan for the future, data is needed on what today’s 40-to-60-year-old population is planning for the senior years.

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- “Senior” should be defined. The age group is extremely broad, and people will have very different needs at age 65 and at age 95.
- Data is needed on seniors’ current living arrangements in order to assess how many are isolated. Then, services could be provided to isolated seniors in partnership with building managers or condo boards. The data may also show that it is advisable to shift funding from acute care to long-term care. Socio-economic factors affecting health should be acknowledged and should be considered in planning. For example, the number of seniors living in high-risk environments because of these factors would affect the need for day programs.
- A model for specialized geriatric services should be drafted, based on data to identify needs and service gaps. Drafting the model could start with joint strategic planning by the LHIN and service providers. All services should work toward developing an adequate body of knowledge of seniors’ needs. Ultimately, the LHIN should have a geriatric centre of excellence.
- The LHIN does a good job at bringing service providers together and should do more of this. For example, there is a great deal of support for a shared care model, and the LHIN could work with service providers and the community to look for opportunities to integrate services for seniors or provide services collaboratively.
- To improve access to services for seniors, the LHIN should examine the issue of exclusionary criteria based on primary diagnosis.

### *Prevention and wellness*

- More information is needed on seniors’ quality of life, and there should be more emphasis on it. In long-term care, for example, quality of life seems to depend on individual existing social and financial supports.
- There should be more focus on prevention and promotion of a healthy lifestyle so that seniors can manage their own health. One particular focus should be the prevention of falls and other programs to keep seniors mobile.

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- People should be encouraged to plan early for their care, and planning should be integrated into the system. For example, in BC, when adults enter certain parts of the system, they are asked whether they would like to discuss their care later in life. A seniors' starter kit is already available in Ontario, but it could be improved and more widely distributed. It might be helpful to provide a flowchart for thinking about the course life in old age, showing options at each stage.
- Programs for adults should include early testing for Alzheimer's and dementia.
- Centralized, accessible community service centres for seniors could focus on prevention and reducing the need for long-term care. The centres could include social programs, mental health services, and day programs, as well as a variety of services, such as dentists and hairdressers. This would contribute to wellness and also help to alleviate transportation problems. The transportation difficulties mentioned above can isolate seniors and exacerbate their health problems because they cannot get to medical appointments or shop for food.
- A "village" model has been suggested, where seniors could help take care of one another. The hub could be an existing long-term care facility, with outreach to seniors in the neighbourhood around it. This could be the site of a centre of excellence for senior care that would also be supportive to well seniors in the neighbourhood.
- More activities, day programs, and social activities (but not "forced" activity) would contribute to seniors' wellness—possibly including programs to bring seniors together with youth. Bearing in mind that many seniors are on fixed incomes, some funding will be required for this and volunteerism should be encouraged as well.
- Crisis prevention should be an important component of services for seniors. Intervention before seniors need to access the health care system will require both health-related and social measures. More post-discharge support would also contribute to preventing a crisis requiring re-admission.

### ***Outreach and information***

- More programs should be based on outreach rather than office visits.
- Online solutions for seniors' access to health information will not work for the many seniors who do not have computer access or computer literacy. Likewise, telephone options will not work for many of the elderly. The LHIN should examine alternative ways to provide information.

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- Family physicians should be kept informed of local services available to seniors so that they can make referrals.
- Seniors should be provided with the information and education they need in order to increase their ability to advocate for themselves. However, many seniors are vulnerable and alone and need someone to act as their advocates. The CCAC role could be enhanced to fill this gap.

### *Support for caregivers*

- Senior's adult children are often their caregivers. Many caregivers have to change or quit their jobs to care for elderly relatives. This is a great cost to society in loss of productivity. Caregivers often end up in hospital themselves, and more respite opportunities could help to prevent this.

### *Long-term care issues*

- More capacity for long-term care is urgently needed. Ontario added 20,000 long-term beds, but people are still waiting. Wait times across services should be monitored and plans should be formulated accordingly.
- There is an increasing need for dialysis units in long-term care facilities, but no one is funding them. This need should be integrated in long-term planning.
- As well as more beds, a greater variety of long-term care facilities is needed to respond to different needs and cultural diversity.
- A long-term care bed is not the appropriate solution for every patient. Helping seniors stay at home when possible is a good strategy. Many will require increased home care (both medical and practical assistance) and a means of transportation.
- Long-term care facilities are increasingly serving as psychiatric facilities. The implications for staffing and funding need to be considered. There is also a need for better communication between hospitals and long-term care facilities. For example, patients with mental health problems are often moved to long-term care and staff at the facility are not informed and prepared. Hospital and long-term care staff should receive cross-training.
- Seniors often end up in the ER because families believe that long-term facilities do not have the skills and resources needed. To address this, there may be a need for specialized emergency services for seniors.

- Community supports are needed for the spouses of seniors admitted to hospital or long-term care who suddenly find themselves alone.

### *Case management*

- Complications due to misuse of medication are common. In many cases, when the cause of hospitalization is coded as a fall, the underlying cause was incorrect use of medication, sometimes because multiple doctors have prescribed various medications. There may be room for a specialized role for managing medication in a geriatric setting. Related education for seniors' caregivers could also help prevent many admissions. Admissions and falls due to medication errors should be tracked as an indicator of improvement after implementation of related strategies.
- Ideas for improving case management include having one case manager with expanded duties, or two case managers, each covering certain areas. There could also be different types of case managers, depending on whether the senior is high-risk or low-risk. CCAC's care coordination role should also be enhanced.
- More partnerships between organizations that share clients would allow case managers to be assigned to clients across those organizations. If a client accesses three service organizations, one case manager would coordinate the client's care across the organizations, rather than a different case manager at each.

### *Seniors' mental health*

- Seniors may have mental health and addiction problems interacting with medical problems, often triggered by grief over the loss of partner, retirement, or loss of mobility due to illness or injury.
- Seniors in long-term care often experience a cycle of crisis, emergency room visit, and return to the long-term care facility. Without attention to the root cause of the crisis, the cycle repeats. Hospitals could have specialized units for seniors with behavioural problems, separate from psychiatry and medicine departments. Long-term care staff, doctors, nurses, and others who work with seniors need specialized training in the psychiatric problems most common in the elderly. The LHIN should look at the funding model for St. Joseph's Health Centre's mental health and addiction program.

## Proposed Priority: Integrating mental health and addictions services

### *Access to services*

- All age groups need better access to services related to mental health and addictions. In these services, there is a strong correlation between funding and results. Based on more data on needs, the LHIN should examine the allocation for mental health and addictions services.
- Expanded services are needed in a number of areas. At the moment, many patients are waiting up to six months for a psychiatric assessment, the lack of designated beds is placing stress on other services, and it can take up to three weeks to attend to a patient in crisis. Access to comprehensive mental health and addictions services can take two years or longer. Wait times are also long for cognitive and behavioural assessment. Methadone maintenance programs are needed for opiate addiction.
- The diabetes strategy could serve as a model for improving access to mental health and addictions services. Mental health and addiction could have a designated advocate to advance the issue.
- As with other health services, mental health and addictions services should be provided through the “no door is the wrong door” model, in which all services have the ability to make seamless referrals. This is especially important in mental health, because a patient turned away from one door may not seek help elsewhere.
- The tendency to send patients to CAMH removes people from their own community supports. The LHIN needs a dedicated facility in the region.
- Mental health service providers have noticed that the age range for psychosis is shifting to younger people. The 15–22 age group is especially vulnerable. For example, anxiety disorders are often followed by substance abuse and addictions. Services for children and youth are fragmented. Children are treated differently by different agencies as they age through the system, often because different laws come into play and apply to different agencies. Peel and Halton are both studying service gaps, and that information should be brought to the LHIN. One hospital in the LHIN could serve as a centre for paediatric mental health services.
- The Alternate Level of Care (ALC) policy should be eliminated with respect to mental health and addictions services. ALC is currently keeping these patients from accessing the services they need.

## *Integration*

- Integration of mental health and addictions services is a good strategy, since the vast majority of patients are dealing with both issues. Separate services will still be necessary were the two conditions do not coexist. Integration should not preclude specialized services that address cultural and language issues, specific age groups, and outpatients.
- Mental health and addictions services should be integrated with the health system generally, since mental health problems lead to a great many emergency room visits. Integration with other health services would also acknowledge the link between physical and mental health and could help to remove stigma, which is a significant barrier to accessing services. Integration is especially important where depression is related to a chronic condition or disability. Mental health and addictions should be viewed as chronic conditions.
- Co-location of services is an innovative idea presenting great opportunities, and a pilot program has already begun on which services can build. It is important to concentrate on connecting the related services at the same time as locating them in the same place.
- Communication between mental health and addictions services and other health service providers (including family physicians and family health teams) is crucial. Collaboration with organizations outside of the health sector (such as the police and settlement workers) should also be encouraged.
- Service providers need a detailed plan for undertaking integration. In particular, the issue of who should be sharing patient information needs to be addressed. A pilot integration project involving a coalition of agencies would be instructive.

## *Education and information*

- Education and access to information is critical to the success of integrating mental health and addictions services. Efforts should be concentrated in key areas:
  - Family physicians and others on family health teams need more education in dealing with mental health and addictions. All service providers need better access to mental health expertise. CAMH workers have undertaken some instruction, and services in the LHIN should draw on that resource more often. The LHIN should also encourage other knowledge transfer opportunities, such as job-shadowing, mentorships, and training activities.

- The public requires education to accept mental health and addiction problems as a health issue. More public education should be directed at removing stigma. Special attention should be paid to cultural views of mental illness. The campaign could build on existing CAMH materials, customized for the LHIN, and should emphasize personal stories of ordinary people. Funding should be available for anti-stigma campaigns, working with an existing survivor network.
- Specific prevention, early intervention, and screening programs should be tailored for youth and seniors, with special outreach to high-risk groups.
- The LHIN needs a centralized information and referral system for mental health and addictions. With such a service, anyone with a mental illness or addiction could get assistance with one phone call, and service providers could make appropriate referrals quickly.

### *Emergency and acute care services*

- One of the objectives under this strategy is to “Improve community mental health supports to ensure appropriate use of Emergency Room services and reduce re-admissions to hospitals.” “Re-admissions” should be changed to “re-visits,” since admission does not result from every visit to the ER.
- Relapse and return to the ER less than 30 days after the previous visit is endemic. The LHIN should look for innovative approaches to reduce ER visits and re-visits.
- Service providers should have better access to the Crisis Outreach and Support Team (COAST) or similar mobile crisis units.
- A greater variety of specialized mental health and addictions services in the LHIN would reduce costs to the system through fewer emergency room visits. Similarly, withdrawal/detox centres would be more cost-effective than using acute care resources for patients who need that service.
- The CAMH model would be an appropriate starting point for a mental health and addictions centre of excellence within the LHIN. A governance structure and needs assessment would be the first steps. Prevention and education programs would be a major component, along with clinical services and evaluation of results based on clinical outcome indicators and other factors such as the relapse/re-visit rate.

## Proposed Priority: Prevention and management of chronic conditions

### *Education*

- Health promotion and prevention of illness through public education, especially related to children, is of paramount importance to a sustainable health system. It is the underlying issue in all of the proposed priorities. The focus should be on keeping people healthy rather than on health care. There is a need to determine who has the time, knowledge, and resources to undertake education effectively, and who should be responsible for it. Public education is outside the mandate of the LHIN, but the LHIN could play a health partnership role.
- One of the objectives under this priority is to “empower residents to manage their chronic conditions.” The objective should be expanded to include health teaching for patients and caregivers. This could include “lifestyles groups” on diet, physical activity, and other factors in wellness. The Stanford Chronic Disease Self-Management Program (a group-based model) may be appropriate for many patients. Nurse practitioners could undertake some of the education for managing chronic conditions. Following education, there should be continued monitoring and audits to assess effectiveness.
- Obesity is becoming a major challenge for the health system. Again, the focus should be on education and early intervention.
- Education should also focus on the management of medications to reduce the need for hospital visits.

### *Reliable data*

- An effective prevention/education program would first need data on risk factors and information on when and why chronic disease begins. Epidemiological data on chronic disease is also needed, and socio-economic factors that compound chronic diseases should be highlighted. Reliable data on the current system of treatment for chronic disease is also needed, along with meaningful measures of improvement in services.

### *Integration of services*

- For co-morbidities, patient care should be integrated among services, such as between diabetes care and cardiac care or between mental health services and diabetes care (schizophrenics often develop diabetes, but may have difficulty in accessing diabetes clinics). Where possible, comprehensive chronic care services should be co-located. This would be especially helpful to people with multiple chronic conditions.

- Adolescents with a chronic condition often experience depression or anxiety, which lead to drug use, which escalates health problems. Services for young people should be coordinated with mental health services.
- Chronic care for seniors should also be linked to mental health services.

## Enabling Strategies

### *Primary health care*

- There is a need for more information on existing services. One solution may be to better inform family physicians on all of the community and specialized services available.
- The responsibility to provide information to CCACs and patients should be clearly defined.
- For many patients, transportation continues to be a major barrier to accessing primary care.
- There is a need for better integration and cooperation among allied health professionals as part of the implementation strategy.
- The shortage of family physicians continues to be a serious impediment to access to health care. As one measure to help address this, it was suggested that the relevant law and regulations should be changed to allow qualified professionals other than physicians to diagnose and treat patients.
- The lack of physicians is especially acute in small communities. Better communication with universities and incentives such as tuition rebates for doctors willing to work in small communities could help to alleviate the shortage.
- The Ministry of Health should re-examine primary care strategies to better reflect the values articulated in the original primary care planning document.

### *eHealth strategy*

- The eHealth strategy has great promise, but many health service providers have experienced frustration with implementation to date. A governance structure, decision-making structure, and critical path need to be put in place, along with detailed planning for infrastructure and hardware integration among agencies.

- Privacy issues are the main hurdle in implementing the eHealth strategy as a means of recording and accessing patient information. This issue needs to be worked out, because access to patient information would be the most useful feature of the strategy for many health service providers. Once the strategy is fully implemented, patients could have a “health passport” or smart card that travels with them, containing information such as history, allergies, and medications. Hospitals could also use the system to share discharge information with community services.
- Sharing information among service providers is important, but using eHealth to share information with patients should also be considered.
- A networking system associated with eHealth would be helpful for receiving information on events and for sharing resources.
- Widespread use throughout the health system is necessary to make the strategy successful. For example, implementation of the OneMail system is incomplete and many services are not using it at all, and CCACs continue to send information by fax.
- An important aspect of eHealth should be the ability to accomplish administrative tasks like submitting forms and reporting electronically. A “One Form” model to complement OneMail would assist in managing referrals. Again, however, a blueprint for action is required.

## *Health human resources*

- Health human resources should be approached strategically and centrally. Employment equity and models of care issues need to be addressed in light of the fact that LHIN boundaries overlap with other administrative units.
- The Ministry of Health should provide more funding to LHIN offices for human resources. LHINs are trying to do too much with too few people.
- Higher pay may be necessary to address the shortage of health care staff. However, there is a need for careful balance, because repeatedly raising salaries could shrink the system as a whole.
- Generally, pay is higher in hospitals, which makes the shortage of community workers more acute. There should be an equalization formula for frontline community workers.
- There is a serious shortage of Personal Support Workers. Their duties have been expanded, but their wages have not increased accordingly. PSWs should be regulated, with the regulations setting out standards and mandatory training.

- There is a shortage of health professionals in some specialized fields. Better sharing of human resources between hospitals could help to address this.
- Volunteers have an increasingly important role in the health system. Volunteerism should be encouraged and promoted, particularly in youth, but volunteers should not be relied upon for core services.
- Agencies need training in recruiting, training, and managing volunteers. They also need assistance with issues such as police checks, insurance, and liability.

## Performance Measures and Success Indicators

Participants were asked to contribute their ideas on how to measure performance in delivering health services in the LHIN and to suggest indicators of success in implementing initiatives under the proposed priorities.

## Improving access, quality and sustainability of the health system

### *Improving access to services*

- Measure occupancy and utilization to determine system capacity.
- Develop indicators for the quality of services provided.
- Measure the quality and efficiency of services by conducting a survey to determine the number of clients who received the services they needed.
- Monitor success in providing specialized services within the LHIN by tracking the number of people transferred out of the LHIN.
- Track the percentage of patients with an integrated service plan (rather than a service plan for each service they use).
- Track the number of patients accessing a variety of services to measure improvement in the ability to navigate the system.

### *Wait times*

- Clearly define "wait time," (e.g., the starting point).
- Monitor wait times across the continuum of services (including long-term care, community services, palliative care beds, community mental health beds).

## *Palliative care*

- Track distribution of deaths by location (hospital, home, hospice) to plan for future needs, including the number of hospice beds required. To ensure that tracking is accurate, the patient and other decision-makers would be required to work with their health service providers at each point in care.
- Track patients' choices of location and compare with distribution of deaths.
- Track the use of home care, hospice care, and other specific areas to measure the demand for and success of providing palliative care services.
- Track success of education regarding palliative care through documentation/coding at every point in the health care system.

## *Education*

- Monitor the effectiveness of health education programs by linking them to health statistics.
- Measure the degree to which education programs are responding to the multicultural community tracking the ethnicity of participants compared with the population and the number of referrals to those programs from multicultural agencies/faith groups.
- Monitor the frequency with which information for health service providers is updated.

## *Transportation*

- Determine current needs to establish a baseline:
  - Transportation utilization (percentage of patients using transportation service, aggregated by age and other factors)
  - Vehicle occupancy rates (overall, and throughout the LHIN)
  - Average duration of transport
- Suggested indicators of success in improving access to transportation:
  - Higher percentage of clients whose transportation needs are met (survey-based)
  - Greater client satisfaction (overall, and related to transportation)
  - Greater caregiver satisfaction (overall, and related to transportation)
  - Reduced patient tardiness for appointments

- Reduced patient wait times attributable to transportation difficulties
- Timely patient pickup
- Timely patient arrival

### *Cultural competency*

- Track the ethnicity of service users versus the prevalence of that particular need.
- Determine whether staff composition in health service agencies reflects the community served.
- Establish a target for cultural competency training (e.g., by 2013 all new hires will receive cultural competency training).

### **Integrating mental health and addictions services**

- Track the number of re-visits to ER to ascertain whether patients are being diverted to appropriate services.
- Assess the availability of services in specific target categories:
  - Geographic location
  - Adolescent and senior care
  - Specialized services
- Capture quality indicators:
  - Resources used per patient
  - Time spent on resources per patient
  - Time patients enrolled in program
- Develop clinical outcome indicators.
- Conduct qualitative surveys on public perceptions of mental health.
- Track wait times for actually receiving specific services.
- Compare per-capita funding for mental health and addictions services in the LHIN with funding in other LHINs.

- Suggested indicators of success in improving mental health and addictions services:
  - Access to a mobile mental health crisis unit
  - Response to crises within 24 hours
  - Increased public awareness and decreased stigma regarding mental health issues and addictions
  - Reduction in related visits to hospital (bearing in mind that increased awareness may lead to increased admissions)
  - Fewer patients going to ER
  - Fewer patients relapsing and returning to the ER within 30 days
  - One hospital serves as the lead for pediatrics
  - More non-psychiatric health professionals are trained in dealing with mental health
  - Wait times for mental health and addictions services are reduced by 10% annually
  - Patients have access all mental health and addictions services through one telephone number

## Enhancing seniors' health, wellness and quality of life

- Track the number of medication errors, falls, and other events leading to ER visits.
- Conduct a province-wide "quality of life" survey to determine what people the 40–60 age group will be looking for when they are seniors
- Track the number of clients referring other clients to services as an indicator that services are addressing seniors' needs.
- Track ER admissions in relation to education programs.
- Develop indicators to measure wellness.
- Track admissions and falls due to medication errors and use this data as an indicator of the effectiveness of related initiatives.
- Track appropriateness of referrals (e.g., through surveys of community organizations)

- Suggested indicators of success in enhancing seniors' health:
  - Increased number of clients accessing community support services
  - Higher average age of institutionalization
  - Clients are linked with a variety of service providers (an indicator that seniors are navigating the system successfully)
  - Increased partnerships between organizations that share clients
  - Case managers are assigned to clients across organizations (rather than a case manager at each)
  - CCACs are referring clients to more agencies (including organizations with which they do not have contracts)
  - CCAC has increased capacity to follow up with discharged clients
  - Reduction in number of patients revisiting the ER after discharge by CCAC
  - Seniors have access to more activities and programs, including those that are culture-specific
  - Increase in volunteerism related to seniors
  - Increased interval between seniors' hospital visits and reduced duration of stay

## Prevention and management of chronic conditions

- Measure the effectiveness of education and healthy living initiatives by tracking participation in those programs by people at risk for developing chronic conditions. Then, compare the prevalence of chronic conditions in participants and non-participants.
- Track the effectiveness of programs to improve medication management by the number of related hospital visits.

## Primary health care

- Develop LHIN-wide measures to determine a baseline for access to primary health care.
- Determine the degree to which physician's assistants and nurse practitioners are used now as a baseline for tracking initiatives to increase their role in primary health care.

## eHealth strategy

- Determine current use throughout the system as a baseline for monitoring implementation.
- Suggested indicators of success in implementing the eHealth strategy:
  - Health care providers have online access to patient records
  - Pharmacists are linked to the system to enabling monitoring of duplicate prescriptions
  - Standardized assessment forms are used across disciplines and shared among health service providers
  - The system is used to manage CCAC referrals

## Health human resources

- Ascertain the current number of education programs/training sessions for health care providers as a baseline for initiatives in this area.
- Track the number of audits performed.
- Track the number of health care professionals working with seniors to assist with planning for future needs.
- Survey frontline workers before and after holding a forum for them to discover the range of what they learned about services available in the LHIN.

Closing remarks were made by Bill MacLeod, Chief Executive Officer for the Mississauga Halton LHIN. He reiterated that the MH LHIN is looking closely at the information and ideas generated at all of the IHSP Refresh Community Engagement sessions. Bill pointed out that the LHIN would not necessarily take the lead role in some of the ideas and areas of work raised at this and other sessions. Instead, the LHIN could partner with other agencies or organizations that have a clear mandate and role in that area (i.e., partnering with Public Health units on health promotion and disease prevention initiatives). Bill concluded by thanking everyone again for taking the time to share their views and ideas.