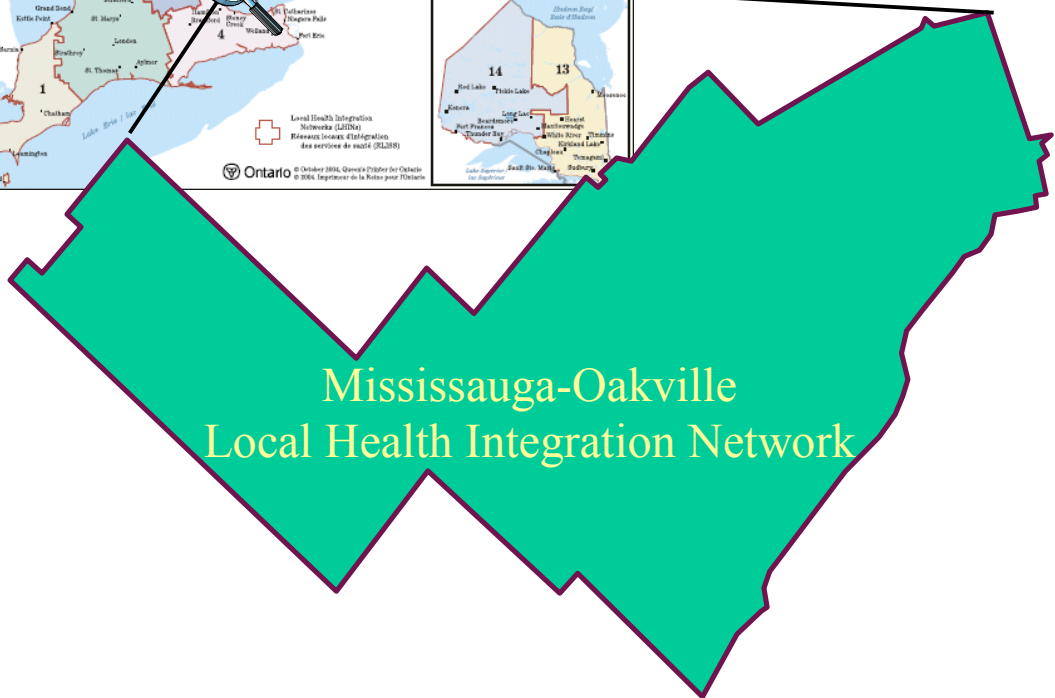
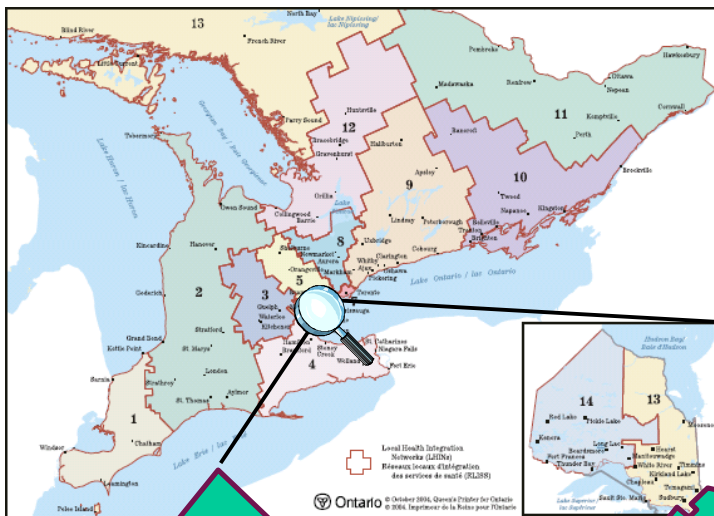


Local Opportunities for Health System Integration



Summary Report from the Mississauga-Oakville Local Health Integration Network Steering Committee

Local Opportunities for Health System Integration

February 16, 2005

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Acknowledgements

This consensus report is the result of the effort and commitment of numerous individuals from the Mississauga-Oakville Local Health Integration Network (LHIN) area. The individuals listed below represent those who volunteered to act as co-leads and local champions of the 10 priority integration opportunities identified at the LHIN workshop held in Mississauga on December 3rd, 2004. They have made a significant contribution towards completion of this report and their assistance through all phases of the planning process and under tight timelines is truly appreciated. It is anticipated that this document will become the foundation for planning and a starting point for the LHIN CEO and Board of Directors as the Mississauga-Oakville LHIN develops and will help to ensure its success.

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Laurie Ridler, Supportive Housing in Peel
David Rowe, The Credit Valley Hospital
Maria Sewell, Independent Living Halton
Eshan Sharif, Integrated Mobile Crisis Programme of Peel
Jacqie Shartier, Hope Place Women's Treatment Centre

The Members of the Steering Committee would also like to express their thanks and appreciation to the following staff of the Halton-Peel District Health Council who provided significant and professional leadership throughout the process, and particularly during a difficult and challenging time.

Chris Altmayer, Epidemiologist
Jane Richardson, Senior Health Planner
Elaine Kachala, Senior Health Planner

1.0 Setting the Context

The Ontario Ministry of Health and Long-Term Care (MOHLTC) has undertaken a major health system transformation agenda with the goal of making the health system more patient-centered and responsive to local needs. A key enabler of this transformation is the creation of 14 Local Health Integration Networks (LHINs) across Ontario. LHINs are being established as the principal organization responsible for planning, coordinating, integrating, funding and evaluating the delivery of health care services within their geographic areas.

In preparation for the transition to LHINs, the MOHLTC developed and managed a process to engage the full spectrum of providers across all sectors in each LHIN area to come together to identify current and new opportunities for integration. Beginning in late November 2004 and through mid December 2004, the MOHLTC planned and facilitated one-day workshops in each of the 14 LHIN areas. Full details on the workshops process, materials and results can be obtained from the MOHLTC websites. (www.health.gov.on.ca and www.prioritysetting.ca)

The workshops were designed to “kick-start” the process of communities self-organizing and to begin preparing the necessary ground work for the transition to LHINs.

1.1 Mississauga-Oakville LHIN Workshop


The Mississauga-Oakville LHIN Workshop was held on December 3, 2004 in Mississauga. Over 175 participants from across the health sector participated in the workshop.

The Open Space methodology employed at the workshop enabled participants to create and manage their own agenda of concurrent working sessions around the central theme of identifying current and new integration opportunities. A total of 29 distinct initiatives were identified at the workshop (see Table 1 below for a summary). These initiatives along with a brief description of the discussion were recorded. Participants at the workshop subsequently identified 10 top priority integration opportunities. Two individuals volunteered to develop each of these ideas further using a prescribed template as well as participate on a LHIN Steering Committee charged with the task of developing this summary report.

Table 1 – Integration Opportunities identified at the Work Shop

#	Integration Opportunity
1	We must remember that the individual is key to any integration model. Be “people” centred.
2	Safety and security and health
3	Vertically integrated multidisciplinary hospice palliative care teams/ Continuum of Hospice Palliative Care
4	FAIR FUNDING: A Population, Needs-based Funding Formula to ensure Equitable Funding for LHINs
5	A continuum of care that ensures the right care at the right time in the right place
6	In order to achieve effective and efficient integration, the LHIN boundaries for Halton Region must be changed and Halton Region must be contained within ONE LHIN.
7	Incorporating population health into the transformation agenda
8	Electronic Health Record to promote service delivery and self care
9	Standardization of expected outcomes
10	Integration of and links to primary health care services
11	Enhanced partnership between LTC, Hospitals, CCAC and clients/families
12	System’s Navigation/Access to Information
13	Creating of Culture of common knowledge
14	Addictions and Mental Health integrated through innovative client centred care models focusing on the mental health and addiction needs of our community
15	Mental Health and Addiction service delivery enhanced through an integrated seamless cross sectoral approach
16	LHIN Community Advisory Committee
17	Identification of available health care resources
18	Imputabilite Envers Les Services De Sante En Francais

#	Integration Opportunity
19	Access to transportation for both Community Services and Clients
20	Shared Administrative Services
21	“Bridging” health care delivery from hospitals to community care and support services
22	Innovation In Service Delivery Models to Maximize Human Resources Across the Continuum
23	<i>No report assigned</i>
24	Integration of Children’s Health Services Across the Full Continuum (from prenatal, health promotion, and early identification to protection, justice and tertiary care)
25	Co-ordinated Emergency Preparedness Plans across LHIN and Regional boundaries
26	Functional Ability Data System
27	Access to services – cultural sensitivity and equity
28	Health Human Resources: Who do we need, how many do we need, how do we recruit/retain them?
29	Long-Term Community Support for Adults with Cognitive Behavioural Needs

 Denotes those ideas that were the top 10 priorities

1.2 Purpose of the Report

This consensus report has been prepared to summarize and record discussions that the Mississauga-Oakville LHIN Steering Committee had regarding:

- The Steering Committee process and transformational thinking
- Guiding principles and common themes across integration opportunities
- The demographic profile of the population within this LHIN
- The unique characteristics of this LHIN
- The priority integration opportunities and action plans
- The important role of Networks in enabling integration

The report provides the founding Board and CEO of the Mississauga-Oakville LHIN an excellent foundation to inform the transformational journey of the LHIN.

2.0 Steering Committee Process and Transformational Thinking

2.1 Steering Committee Process

At the conclusion of the LHIN Workshop on December 3rd, the individuals who volunteered to act as local champions with respect to the 10 priority integration opportunities met briefly and agreed to become the Steering Committee charged with developing this report within the 75 day time frame. A tentative meeting schedule was established and, at the request of the Steering Committee Members, the Halton-Peel District Health Council (DHC) agreed to provide facilitative leadership for the process.

The Steering Committee's first meeting following the Workshop was held on December 16, 2004. The agenda for this meeting focused on reaching a consensus and understanding of:

- The role of the Steering Committee
- Deliverables from the individual co-leads and the Steering Committee
- The principles, assumptions, process, templates and level of consultation for achieving these deliverables
- A detailed work plan for completing the deliverable

This first meeting also provided an opportunity for each of the co-leads to share the progress to date as well as their individual plans to finalize the work. This first meeting was important in that it established consensus on the approach and how members would work together to share the responsibility for completing the deliverable.

Table 2 includes a high-level summary of the work plan that was developed to complete the task. The agendas, minutes and presentation materials for these meetings are attached in Appendix 1.

Table 2 – Work Plan for the Mississauga-Oakville Steering Committee

Task	Lead	Schedule
<p>Description of each Patient care and Administrative Support initiative (Template A and B) (excluding 10 priorities)</p> <ul style="list-style-type: none"> ➤ Cut and past content developed at the work shops into the templates ➤ Circulate to originator to add / confirm ➤ Originator to review and sign off 	<p>DHC</p> <p>DHC Originator</p>	<p>Dec 17 - Jan 10</p> <p>Jan 10</p> <p>Jan 10 – Jan 21</p>
<p>A high level work plan for each of the prioritized integration opportunities (Template C)</p> <ul style="list-style-type: none"> ➤ Develop consolidated template based on input from Steering committee ➤ Circulate template to Planning leads ➤ Leads complete template and consultation as required ➤ Completed Templates due back ➤ Templates are presented to the Steering Committee as they are completed 	<p>DHC</p> <p>DHC Planning Leads</p> <p>Planning Lead</p>	<p>Dec 16 – Dec 21</p> <p>Dec 22</p> <p>Dec 22 – Feb3</p> <p>Feb 3</p> <p>Jan12 – Feb 3</p>
<p>Description of unique characteristics of the LHIN and existing networks (Template D)</p> <ul style="list-style-type: none"> ➤ Obtain demographic data and develop profile ➤ Confirm unique characteristics ➤ draft a “straw dog” of the what are voluntary networks and their important role in the LHIN 	<p>DHC Steering Committee</p> <p>DHC / Steering Committee</p>	<p>Dec 1 – TBA TBA</p> <p>Dec 22 - Jan 12</p>
<p>Description of the transformational thinking and process that the guided the group (Template E)</p> <ul style="list-style-type: none"> ➤ Summarize and discuss at the last meeting of the Steering Committee 	<p>Steering</p>	<p>February 3</p>
<p>Assemble final report</p> <ul style="list-style-type: none"> ➤ Pull all components together ➤ Circulate to steering committee for review ➤ Submit final report 	<p>DHC</p> <p>DHC Steering</p>	<p>Feb 4 –11</p> <p>Feb 14 – 16</p> <p>Feb 16</p>

2.2 Key Learnings / Transformational Thinking

In completing the deliverable, the Steering Committee was requested to identify key learnings and the transformational thinking used to create this report. The following represents overarching themes and thoughts provided by the Steering Committee.

- **DHC leadership facilitated a quality process** - The Halton-Peel DHC was vital in facilitating completion of the task. The staff resource and planning / facilitation expertise provided by the DHC was invaluable to the process. Spending time up front to define the process, assumptions, expectations and having mechanisms to review status and time frames were also important.
- **Efficient meetings led to an efficient process** - Timing of meetings was also critical to task completion. Fewer but longer meetings were most effective. Rather than scheduling many short meetings over the course of the 75 days, there was consensus that much of the work should be completed “off-line”, thereby allowing the Steering Committee to focus on reviewing and providing suggestions for enhancing draft materials.
- **Integration as a goal is not a new concept** – Providers in the Mississauga-Oakville LHIN area fully understand and appreciate the importance of integration. The goal of integration is something that numerous organizations have already been working on and are committed to achieving. They believe that the introduction of LHINs needs to result in real progress and integration.
- **Build on the work that has been completed to date** – Most of the integration opportunities identified are not new. In some cases, there has been considerable research and planning already completed. It is important that we continue to build on this work and not lose sight of the achievements already achieved.
- **Integration opportunities have begun** - The LHIN process (Workshop and Steering Committee) encouraged creative and broad thinking; it brought a group of dedicated providers together in a way that encouraged individuals to look more broadly for solutions. The process also created an opportunity to gain a better appreciation and understanding of each other’s roles, challenges, and opportunities.
- **Channel the expertise and energy of the Steering Committee constructively** – The process generated renewed commitment, energy and resolve toward achieving integration. This excitement needs to be capitalized upon and used to engage the full system. Steering Committee members have high expectations of the LHIN system, and could help engage others in getting ready for this change.

It is important for local providers to face the challenge and become part of the process and solution.

- **Clear information leads to a better process** - Having a greater and more complete understanding of LHINs would have made completion of the task easier. While the Steering Committee appreciates that the development of LHINs is evolutionary, the process (and possibly its outcomes) would have been better serviced if there had been more information and sharing of additional details relative to this task.
- **Meaningful community engagement is essential** - As the LHIN system is implemented and begins the process of planning, integration and coordination, it will be essential to have a meaningful community engagement process in establishing local priorities. Given the timeframes for completing the action plans for the priority integration initiatives, broad community consultation on ideas was not possible, but is necessary.
- **Change management support is essential** -The transformation agenda will create a level of uncertainty, confusion, and instability within the health system. It is essential that greater attention is given to managing the transition and change process providing support and reassurance to individuals and organizations going through change.
- **There are many integration opportunities beyond the 10 priority initiatives identified in this report that should be considered by the LHIN** - While it is recognized that the “process is the process” and resulted in identifying the 10 priority integration opportunities, there are other integration initiatives that should be considered. This report should be considered as one source of advice.
- **Integration alone will not address all of the challenges in the health system** – In high growth communities such as those within the Mississauga-Oakville LHIN, integration alone will not address all of the challenges of providing high quality, comprehensive and patient/client-focused health care; **adequate funding and resources must be made available to meet the need and increasing demand in high growth communities.**
- **Integration will not be achieved without significant transformation within the Ministry of Health and Long-Term Care** – Local community providers and planners are committed to the goal of integration; however, without fundamental transformation of how the Ministry fulfills its mandate, integration will not be achievable.

3.0 Guiding Principles and Common Themes

The Mississauga-Oakville Steering Committee supports the principles adopted and published by the Ministry of Health and Long-Term Care for the LHINs:

- Patient Focus
- Clarity of Roles
- Strategic Partnership Role
- Stakeholder Engagement
- Evidence-Based Balanced Approach
- Transparency
- Fostering Changes through an Incentive-Based Approach
- Voluntary Boards
- Partnership of Equals

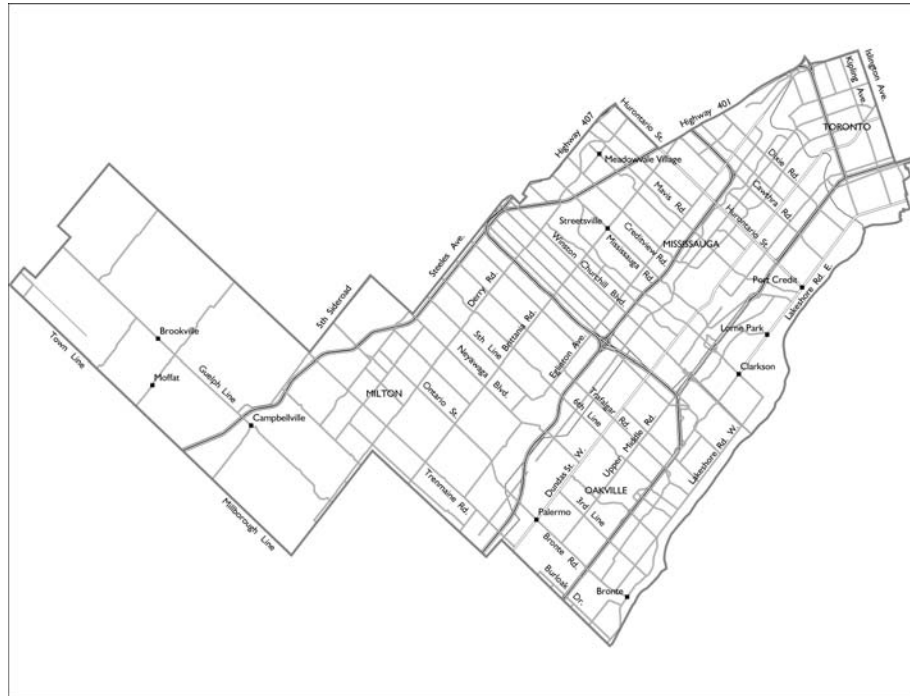
Many of these were echoed as guiding principles and common themes by members of the Steering Committee as they developed the priority integration opportunities. The following principles and themes were identified through the process and further validate the Ministry's published LHIN Principles.

- Integrate a **population health approach** (as defined by Health Canada, July 2001) as a cornerstone value and policy. The approach to preventative, curative and rehabilitative service delivery, coordination and integration through publicly funded health services will cross the life span within the LHIN.
- Recognize: a) the critical role that **voluntary networks** will play in developing the foundation for integration and, b) that the LHIN must work together with the voluntary networks, including the sub-groups within networks, as these are vehicles for achieving different levels of integration (governance, administrative, clinical). To this end, the Mississauga Oakville LHIN must: conduct an inventory of existing networks (including local, regional and provincial; identify their roles, functions, deliverables; build on the substantial work achieved to date; and support these networks to ensure their sustainability.
- **Recognize the potential of human resources partnerships** across the health care continuum in the Mississauga-Oakville LHIN:
 - Recognize, utilize and build upon the expertise employed and the knowledge generated by the Steering Committee through this priority integration process.
 - Build on existing integrated health care teams / systems
 - Acknowledge and trial innovative approaches / new roles for person-centered care in the Mississauga-Oakville LHIN (i.e. Navigator, healthcare professional internships)

- **Utilize and build on existing work** by the District Health Councils and other organizations. The research, methodologies developed and findings will be of significant value to the Mississauga-Oakville LHIN.
- Recognize the **significant achievements** community organizations have already made towards integration.
- Rely on **evidence-based planning and implementation** to drive the LHIN work. The changing demographics will have a significant impact on the volume and mix of services required in the LHIN.
- Conduct **data collection on the population within the new Mississauga-Oakville LHIN boundaries** and analyses of the impact of population growth/demographics on health services. These are essential next steps for the LHIN in order to facilitate local planning.
- Work with **bordering LHINs and their recommendations**, as many service providers will be working in more than one LHIN.
- Utilize **information technology** to effectively and efficiently manage information and facilitate integration.

4.0 Mississauga Oakville Demographic Profile and the Challenges We Face

4.1 Mississauga-Oakville LHIN Boundary Description



The Mississauga-Oakville LHIN borders have been defined by Upper and Lower-Tier Municipality borders, although parts of the LHIN boundaries remain defined by the original ICES methodology and are represented by major roads.

Northern Border:

From the west, the northern border runs eastward including the Town of Milton, and continues along the Mississauga / Brampton municipal border to Hurontario Street. At Hurontario Street it runs south to Hwy 401. It continues westward along Hwy 401 to Islington Avenue.

Western Border:

From the north, the western border includes the Town of Milton and the Town of Oakville.

Southern Border:

The southern border runs eastward along the lakeshore from the Burlington/Oakville municipal boundary to Islington Avenue in Toronto.

Eastern Border (Defined by local roads)

From Lake Ontario, the border runs north along Islington Avenue (south of the Gardiner Expressway, Islington extends along '7th Street') to Eglinton Avenue West.

(Note: South of the Gardiner Expressway the eastern border bends east slightly to accommodate an entire Statistics Canada Census Dissemination Area. This area is sparsely populated and adjacent to the QEW / Islington intersection. The actual border should continue to be defined by Islington, although for analysis purposes the entire DA has been left intact).

Data Challenges Related to the Boundaries

The following section is focused on providing information to help understand population growth and demographic changes in Mississauga-Oakville set within the provincial context. Most information is presented at the LHIN level. However, where information was not available at the LHIN level, comparable District Health Council, regional or municipal level information has been presented. Furthermore, although information presented at the sub-LHIN level would help identify unique population demographics within the LHIN, these data were not available to produce a complete analysis. Despite this limitation, several within-LHIN population differences are identified in the following text.

4.2 Population Growth

Population counts from the Statistics Canada 2001 Census indicate that 860,000 residents live in the Mississauga-Oakville LHIN area. However, after accounting for population growth over the past 4 years (10.1%)¹, and under-counting (missing dissemination area level information ~ 0.2%; and net census under-coverage ~ 3.8%), an estimate of 985,000 residents is likely more reflective of the LHIN's population in 2005.

From 2001 to 2016, significant population growth is projected to continue in all areas across the Mississauga-Oakville LHIN, in contrast to a provincial growth rate of 21%. Table 3 demonstrates projected population growth for selected census divisions (counties/regions) and census sub-divisions (municipalities) located in Mississauga-Oakville. Of note, Milton's relative population growth (>200%) is considerable. Clearly, Mississauga Oakville's health care system will have to adapt and expand to handle increased pressures from high population growth.

¹ Represents average GTA (Halton, Peel, York and Durham) projected population growth from 2001 to 2005 (Ministry of Finance Population Projections, 2000)

Table 3. Population Growth by Selected Census Divisions and Census Sub-Divisions, 2001 to 2016

Census Divisions	Population Estimates 2001	Ministry of Finance Projections 2016	Absolute Population Growth 2001 to 2016	Relative Population Growth 2001 to 2016
Peel	1,047,000	1,419,000	371,000	36%
Halton	383,000	520,000	136,000	36%
Census Sub-Divisions	Population Counts 2001	Planning Dept. Projections 2016	Absolute Population Growth 2001 to 2016	Relative Population Growth 2001 to 2016
Mississauga	613,000	699,000	86,000	14%
Oakville	145,000	215,000	70,000	48%
Milton	31,000	94,000	63,000	203%

Sources:

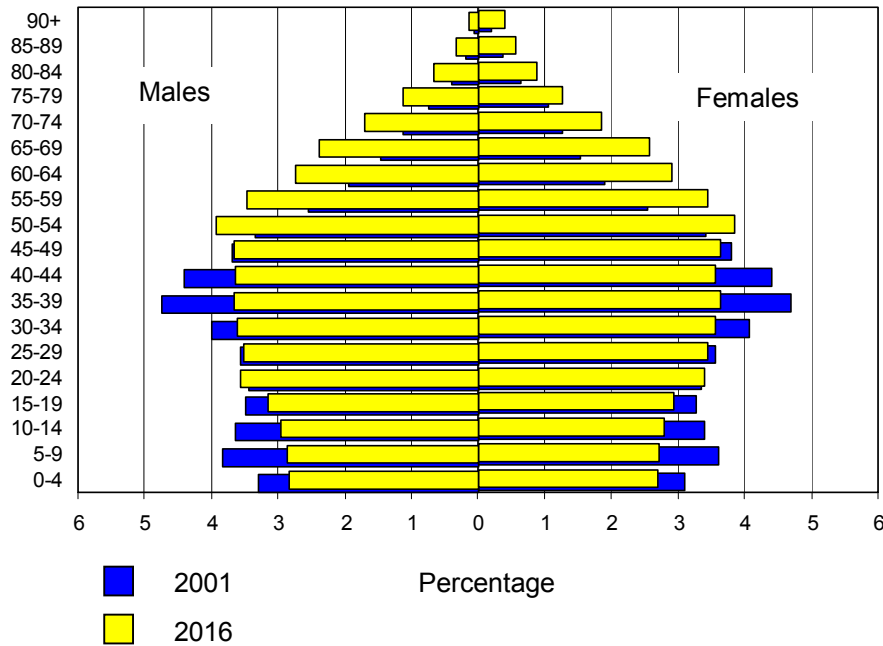
- Ministry of Finance Population Projections, 2000
- Statistics Canada 2001 Census
- 1997-2016 Best Planning Estimates of Population and Occupied Dwelling Units, The Regional Municipality of Halton
<http://www.region.halton.on.ca/ppw/PlanningRoads/Planning/planinfo/projections/halton.htm>
- Population Growth and Forecast 1996-2021, Region of Peel.
<http://www.region.peel.on.ca/planning/stats/1996/popproj.htm>

Note: South west Etobicoke is also located within the Mississauga Oakville LHIN. Unfortunately this level of population data is not currently available

4.3 Population Aging

Figure 1 demonstrates the changing population composition of Mississauga-Oakville residents. Due to difficulties in accessing age and sex specific data, information is only presented for Halton-Peel. The most notable trend is the aging of the population. The population pyramid indicates a significant percentage increase in older age cohorts from 2001 to 2016. This is important as the prevalence of certain illness increases with age, as does the use of particular health care services. Although it is not absolutely clear what the increased demand will be on the health system, it is clear that the health system will need to adapt and expand to meet the needs of an older population.

Figure 1. Population Pyramid, Halton-Peel, 2001 and 2016



Source: Statistics Canada, obtained from Ministry of Health and Long-Term Care Provincial Health Planning Database, 2005

4.4 Ethnicity and Language

Mississauga-Oakville represents a culturally diverse population. Table 4 demonstrates the cultural diversity, as measured by respondent ethnic origin. Ethnic origin refers to the ethnic or cultural group(s) to which the respondent’s ancestors belong. Ethnic or cultural origin refers to the ethnic “roots” or ancestral background of the population, and should not be confused with citizenship or nationality. In 2001, 48% of Mississauga-Oakville residents indicated a single ethnic origin other than British or Canadian, compared to 36% in Ontario. However, it must also be noted that most of the ethnic and language diversity occurs largely in Mississauga and Etobicoke. Oakville and Milton have substantially lower ethnic and cultural diversity in their populations. This may be explained by their much lower immigration rates.

Table 4. Population by Ethnic Origin, Mississauga-Oakville and Ontario, 2001

Mississauga-Oakville		Ontario	
Multiple responses	33%	Multiple responses	39%
Single responses	67%	Single responses	61%
Ranking of single responses (top five)		Ranking of single responses (top five)	
British	10%	Canadian	14%
Canadian	9%	British	11%
Italian	5%	Italian	4%
Chinese	4%	Chinese	4%
Polish	4%	East Indian	3%

Source: 2001 Census, Statistics Canada

Notes:

- All percentages are calculated using total population as the denominator
- British includes English, Scottish, Irish, British (not included elsewhere) and Welsh

To effectively plan for growing populations with increasing cultural diversity, health care services must have a significant focus on cultural sensitivity. In addition, recent immigrants may have different health care needs and may have more difficulty accessing health care services due to lack of familiarity with the health care system and cultural or language barriers.

Population by mother tongue also reveals the diversity in Mississauga-Oakville (Table 5). Mother tongue is defined as the first language learned at home in childhood and still understood by the individual at the time of the census. In 2001, 37% of Mississauga-Oakville residents indicated a non-official language as their mother tongue, compared to 24% in Ontario. The top-ranked non-official language response was Polish among Mississauga-Oakville residents.

Table 5. Population by Mother Tongue, Mississauga-Oakville and Ontario, 2001

Mississauga-Oakville		Ontario	
English	62%	English	72%
French	1%	French	4%
Non-Official Languages	37%	Non-Official Languages	24%
Ranking of non-official languages (top five)		Ranking of non-official languages (top five)	
Polish	5%	Chinese	4%
Chinese	4%	Italian	3%
Portuguese	3%	German	1%
Italian	3%	Portuguese	1%
Tagalog	2%	Polish	1%

Source: 2001 Census, Statistics Canada

Notes:

- All percentages are calculated using total population as the denominator
- Chinese includes Chinese, Mandarin, Cantonese and Hakka

However, mother tongue may not reflect the languages spoken at work, at school, with friends etc., (i.e., may not reflect the overall language habits of respondents); therefore, knowledge of official languages is another useful indicator. Knowledge of official languages is defined as the ability to conduct a conversation in English only, in French only, or in both English and French. Table 6 demonstrates that 2% of Mississauga Oakville residents cannot conduct a conversation in neither English nor French; however, this percentage may still underestimate the true need. Clearly, effective communication is essential in receiving health prevention messages and adequate health care.

Table 6. Population by Knowledge of Official Languages, Mississauga-Oakville and Ontario, 2001

Official Languages	Mississauga-Oakville	Ontario
English only	89%	86%
French only	<1%	<1%
English and French	9%	12%
Neither English nor French	2%	2%

Source: 2001 Census, Statistics Canada

4.5 Income and Education

A population's health is strongly linked to socio-economic indicators such as income and education. Populations with higher incomes have greater health (e.g., less morbidity, greater life expectancy) than those with lower incomes. Individuals with higher education are also healthier than those with lower education. Although this effect is likely to be related to income, increased decision making skills, coping skills and locus of control – which are all primarily associated with education – are important determinants of health.

Mississauga-Oakville has a lower proportion of residents living below the low-income cut-off point (11.5%) than Ontario (14.4%) (Table 7). Similarly, 35% of Mississauga Oakville residents reported university education, compared 26% for Ontario (Table 8).

Table 7. Low-Income Rates, Mississauga-Oakville and Ontario, 2000

Indicator	Mississauga-Oakville	Ontario
Percent of low-income population (of total population in private households)	11.5%	14.4%

Source: 2001 Census, Statistics Canada

Table 8. Population by Education, Ages 20+, Mississauga-Oakville and Ontario, 2001

Education Level	Mississauga-Oakville	Ontario
Less than grade 9	7%	9%
Grades 9 to 13	26%	31%
Trades certificate or diploma	9%	10%
College	24%	24%
University	35%	26%

Source: 2001 Census, Statistics Canada

5.0 Unique Characteristics of the Mississauga-Oakville LHIN

Over the course of completing this report, members of the Steering Committee identified a number of characteristics that are unique to the Mississauga-Oakville LHIN. These characteristics will have important implications for planning and service delivery within the LHIN.

Capacity / infrastructure pressures

While all hospital corporations continue to work towards achieving Health Services Restructuring Commission directions, some cannot be achieved without major redevelopments that have yet to be approved or started. As a result, hospital capacity continues to be a major issue for hospital corporations in the Mississauga-Oakville LHIN.

In order to facilitate a longer-term vision for hospital infrastructure, in January 2003, the Halton-Peel DHC in partnership with 5 hospital corporations completed and released the *Regional Hospital Infrastructure Plan for Halton and Peel*. The deliverable from the project was advice and recommendations on where and when additional hospital capacity should be added to meet current and future needs. Recommendations from this report specific to Mississauga-Oakville include:

- A new hospital constructed in north-west Peel to accommodate the significant growth in communities adjacent to it and to relieve pressure on existing hospitals
- A new replacement hospital located in north Oakville to accommodate the high rate of growth and to replace the lack of capacity and poorer aging infrastructure at the existing site
- Redevelopment at the Milton District Hospital, Trillium Health Centre, and The Credit Valley Hospital

Delays in proceeding with the planned expansions and redevelopment of facilities consistent with the Regional Hospital Infrastructure Report at Credit Valley Hospital, Halton Healthcare Services Corporation and Trillium Health Centre will continue to put pressures on the acute care system.

Additional recommendations included major redevelopments in the neighbouring Central West LHIN including a new hospital in Brampton and a major redevelopment of the existing Lynch Street, Georgetown and Etobicoke Hospital sites.

Transportation is an important enabler of health service integration. The 3 hospital corporations in the Mississauga-Oakville LHIN along with William Osler Health Centre (in the Central West LHIN) collectively participate in a shared model for non-urgent patient transport. For community-based transportation, the

Region of Peel funds TransHelp, the Region's para-transit system. There is not an equivalent region-wide service in Halton.

Health Care Funding

Per Capita funding across all health sectors in Mississauga-Oakville is consistently and significantly below the provincial average. While the health status of residents is generally high and may account for a lower rate of utilization of health services, it is unlikely that it can account for the large gap in per capita funding in all sectors. While there has been a significant infusion of new and much welcomed resources in some sectors in recent years, most notably the acute care and long-term care home sectors, the funding has not kept pace with inflationary or growth pressures. In sectors such as Community Mental Health, Addictions and Community Support Services per capita funding remains below provincial averages.

Emergency service pressures

Emergency departments at the hospital corporations in Mississauga-Oakville (Trillium Health Centre, The Credit Valley Hospital, Halton Healthcare Services) continue to experience considerable pressures as a result of continued lack of acute care inpatient capacity coupled with population growth and demographic change. As a result, it is not uncommon, particularly during the winter months, for many, and sometimes all, of the stretchers in these hospital emergency rooms to have a patient waiting for an inpatient bed. Consequent to this is long waits for patients to see a physician, and significant ambulance offload delays, whereby paramedics are waiting long periods of time to transfer patients to hospital care. This results in patients leaving the emergency department without being seen by a physician, and reduces the number of ambulances available to respond to emergencies which increases overall response times.

Capacity within the long-term care home sector

Until recently, a long-standing issue in Mississauga-Oakville was the lack of beds in long-term care (LTC) homes. However, as a result of the Government of Ontario announcement in 1998 to build 20,000 new LTC beds across Ontario, 2,027 were awarded to the Mississauga-Oakville LHIN area. Before this investment, there were 2,098 LTC beds. As a result, there are now 3,920² LTC beds in the Mississauga-Oakville LHIN, representing an 87% increase over the 6-year investment period. The significant increase in supply has exceeded, temporarily, the demand for LTC home beds. While this presents significant challenges, it also creates unique opportunities in the short-term (approximately 2 –3 years) to ensure the sustainability of local LTC home capacity as well as

² This takes into account the "closure" of Lyons Lane Centre, Oakville in 2003.

address other pressures in the health system. This was recognized by providers in Mississauga-Oakville, many of who participated in a planning process facilitated by the Halton-Peel DHC in January 2004. The resulting report, ***Local Opportunities for LTC Facility Capacity (April 2004)***, provides an overview of the process and numerous opportunities that individual organizations continue to explore and that should be considered by the LHIN with respect to utilizing LTC home capacity.

Health Human Resources

Recruitment and retention of health professionals and physicians will continue to be a challenge across many LHIN areas. Locally, these challenges are compounded by pressures of population growth. Even when there are increases to health human resources, population growth is such that the rate of these resources to the population actually decreases. Furthermore, while it might be possible to attract additional health human resources given the significant population growth and demand, there is a lack of additional capacity within the system to facilitate further development of services and supports.

Specific to physician resources, Milton is currently designated as an under-serviced area (USA) for family physicians, according to the MOHLTC's benchmark of one physician to a population of 1,380 individuals. Mississauga is also technically under-serviced when this ratio is applied. However, currently the USA does not generally capture urban area needs. This is because Regional Municipality projections are more sensitive to local development than are Statistics Canada projections. Some communities within the Mississauga-Oakville LHIN also have an under-supply of specialty physicians.

Recruitment and retention of nurses (RNs and RPNs) as well as personal support workers (PSWs) / health care aides is also challenging across most sectors and organizations.

No academic teaching centre, including affiliated programs such as Regional Geriatric Programs

The Mississauga-Oakville LHIN does not have an academic teaching centre located within its respective geography. As such, it will be important to maintain and foster planning, coordination and integration of tertiary-level services across larger geographic networks and with neighbouring LHINs (such as Central West Toronto Central and Hamilton, Niagara, Haldimand, Brant).

Low localization index

The localization index for Mississauga-Oakville is 77.5, one of the lowest in Ontario. This indicates that for every 100 Mississauga-Oakville residents discharged from a hospital, only 77.5 will be from hospitals located in the LHIN. 22.5 resident discharges will be from hospitals outside of the LHIN. Despite

this, the community hospital corporations in Mississauga-Oakville continue to provide highly specialized services and supports, with an ever-increasing proportion of these procedures being offered locally (i.e. Regional Cardiac Care Centre at Trillium Health Centre and the Carlo Fidani Peel Regional Cancer Centre at The Credit Valley Hospital).

Designation under the French Language Services Act

The City of Mississauga is designated under the French Language Services Act (FLSA). As such, the following 10 organizations and / or regional programs have been identified for formal designation under the FLSA.

- Alzheimer Society of Peel
- CCAC of Peel
- Canadian Mental Health Association
- Centre for Addictions and Mental Health
- Erinoak
- Healthy Babies/Healthy Children Program (Region of Peel)
- Ontario March of Dimes
- Preschool Speech and Language Program
- The Credit Valley Hospital³
- Violence Against Women Program (Trillium Health Centre)

Each of these organizations are working toward formal designation.

Unique facilities

There are several unique provincial resources located within the Mississauga-Oakville LHIN:

- E.C. Drury High School in Milton is one of four provincial schools for the deaf in Ontario.
- Milton is also home to Maplehurst Correctional Complex, the largest provincial correctional facility in Canada (1,550 beds), and the Vanier Centre for Women (124 beds). In addition to specific health services delivered on-site to the correctional population, inmates are not able to access other community-based services and supports, thereby putting increased pressure on local hospitals.
- Rose Cherry's Home for Children, Ontario's first pediatric residential hospice and respite care home, is located in Milton.
- Erinoak, one of 19 children's treatment centres, is located in Mississauga.
- Oaklands, a non-profit organization providing residential and other support services to individuals with developmental disabilities, is located in Oakville.

³ Provision of French-language services at The Credit Valley Hospital was expected to occur incrementally over time. The Genetics program was a suggested starting point.

Alignment with regional and municipal boundaries

While the LHIN boundaries reflect where people receive hospital care, these boundaries do not necessarily reflect how and where people access other health programs and services or how they are currently organized. A number of our local community based providers will need to work with up to 3 LHINs to plan and deliver services. It is imperative to understand and explore the potential impact this will have on service delivery and access to services by our local population.

Regional cancer centre

In May of 2005 the long awaited Carlo Fidani Peel Regional Cancer located at the Credit Valley Hospital is scheduled to be opened. The addition of this cancer treatment centre will have a significant impact for residents of Mississauga-Oakville and surrounding LHINs requiring specialized cancer treatment.

Population Projections

The Statistics Canada methodology for projecting population growth at the Census Subdivision (CSD) level has historically underestimated the projected population growth in Milton and overestimated the projected population growth in Mississauga. The Regional Municipalities of Halton and Peel also project population growth at the CSD level. Their projections have proven to be more accurate as they are more sensitive to local development at the municipal level. For this reason, the Halton-Peel DHC has recommended the uses of regional planning projections for local health system planning.

The accuracy of the population projections have significant implications for population-based planning and funding methodologies. It will be important for the LHIN Board and CEO to understand the population projections adopted by the Ministry of Finance and the Ministry of Health and Long-Term Care and to determine what impact these may have for local planning.

6.0 Priority Integration Opportunities and High-Level Action Plans

A key deliverable from the Steering Committee is the completion of the description and high-level action plan for each of the priority integration initiatives identified at the LHIN Workshop. A summary of the priority integration initiatives and the individuals who championed the completion of each is outlined in Table 9. (Note – the opportunity number corresponds to the number assigned at the December 3rd LHIN workshop) Each of these templates were completed using the guidelines below and were presented and discussed at the Steering Committee.

Table 9 Priority Mississauga-Oakville Integration Opportunities

#	Integration Opportunity	Pg	Idea Champion
4	FAIR FUNDING: A Population, Needs-based Funding Formula to ensure Equitable Funding for LHINs	25	Allan Halls, Halton Healthcare Services Corporation Ron Noble, The Credit Valley Hospital
5	A continuum of care that ensures the right care at the right time in the right place	28	Lynn Harrett, Etobicoke & York CCAC Lawna Paulos, Nucleus Independent Living
8	Electronic Health Record to promote service delivery and self care	30	Jasmin Earle, Saint Elizabeth Health Care Scott McLeod, Halton-Peel District Health Council
10	Integration of and links to primary health care services	32	Natalia Lishchyna, Mississauga Physical Rehab Centre Chris Power, Trillium Health Centre
11	Enhanced partnership between LTC, Hospitals, CCAC and clients/families	34	Cathy Hecimovich, CCAC of Halton David Rowe, The Credit Valley Hospital Carmen DiMauro, Extendicare Mississauga

#	Integration Opportunity	Pg	Idea Champion
13	Creating a Culture of Common Knowledge	37	Raymond Applebaum, Peel Senior Link Maria Sewell, Independent Living Halton
14	Addictions and Mental Health integrated through innovative client centred care models focusing on the mental health and addiction needs of our community	40	Darlene Holowachuk, YMCA Greater Toronto Eshan Sharif, Integrated Mobile Crisis Programme of Peel
15	Mental Health and Addiction service delivery enhanced through an integrated seamless cross sectoral approach	42	Laurie Ridler, Supportive Housing in Peel Jacqie Shartier, Hope Place Women's Treatment Centre
21	"Bridging" health care delivery from hospitals to community care and support services	43	Angela Brewer, VON Halton Cindy McDonnell, Halton Healthcare Services Jannine Bolton, RNAO
22	Innovation In Service Delivery Models to Maximize Human Resources Across the Continuum	46	Janet Doering, CCAC of Halton Marg DiCesare, Saint Elizabeth Health Care

The Steering Committee members developed and applied the following principles and approach in completing the templates for each of the priority initiatives:

- Completion of the initiative description should remain true to the work done at the workshop – the idea description developed at the workshops should be used as the starting point.
- The Planning Leads have some license to edit / tighten up / enhance the workshop summaries as long as it continues to remain true to the workshop discussion.
- The action plan (Template C) and the description of the integration opportunity (Template A and B), will be linked together.
- Be brief and concise.
- Use bullet points.
- Try to limit each completed template to two pages.

- Use the questions in each of the sections of the template to guide your thinking and organization of your initiative.
- In developing the high-level action plan, describe the action oriented steps/ tasks needed to be done to move the initiative forward – you are not implementing the initiative.
- Look to surrounding LHINs with similar priorities and share information / approaches.
- The level of additional consultation regarding the initiative and high-level action plans should at a minimum include the individuals who were involved in the discussion at the LHIN workshop. Given the time lines for completing the initiative, broader input / consultation is at the discretion of the planning contacts.

Integration Opportunities Not Prioritized

Consistent with the commitment at the LHIN Workshop, members of the Steering Committee wanted to ensure that all the integration ideas were included in the final report. All of the ideas that were not prioritized at the Central West LHIN Workshop were reformatted into the new template and forwarded to the originator to review and add any additional information or details missing. While the originator was encouraged to add any new information they were requested to remain true to the original discussion at the Workshop.

Appendix B includes all of the “non prioritized” integration initiatives.

Title of initiative:		Type of integration (more than one box can be checked)	
#4 Fair Funding: A population, Needs-based funding formula to ensure equitable Funding for LHINs		<input type="checkbox"/> Horizontal <input 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 <small>* Note initiated / existing activities do not need to be confined within LHIN boundaries</small>		Divina Jalea, Diversicare Jane Sanders, RNAO Jannine Bolton, RNAO Jennefer Morris, Independent Diagnostic Clinics Assoc. Joanne Fluker, Erinoak John Oliver, Halton Health Care Julie Wong, Northridge LTC Paolo Giacco, Credit Valley Diagnostic Centre Dr. Shelly Fine, Credit Valley Hospital S. Font, TCSO Sue Fedun, Northridge LTC Gerald Park, VON Halton Gayle Burse, Peel Region CCAC Chris Altmayer, HPDHC Tariq Asmi, GTA 905 Healthcare Alliance Jim Armstrong, OACCAC Scott McLeod, HPDHC Donna Rubin, OANHSS Karen Sullivan, OLTC David Kelly, OFCMHAP Alan Halls, Halton Health Care Ron Noble, Credit Valley Hospital Shirlee Sharkey, Saint Elizabeth Health Care Ken White, Trillium Health Centre Sandra Henderson, Halton CCAC	
Brief description of the initiative			
<p>Description</p> <p>The purpose of the initiative is to develop a population, needs-based equitable funding formula for the Oakville Mississauga LHIN. It is not to develop individual funding formula for the various types of provider agencies in the short term. The long term strategy will also look at ways to ensure equitable funding between providers to service the LHINs population base. This approach will require a provincial strategy and the development of a framework for local implementation.</p> <p>Rationale:</p> <ul style="list-style-type: none"> • Equitable and population needs-based funding supports and sustains collaboration and partnerships across the care continuum – health promotion, community care, hospitals, CCACs, LTC. • Equitable funding increases public support for LHINs • Equitable funding creates the ability to confidently plan for future care needs (multi-year funding) • For integration to maximize benefits to patient care LHINs must have enough services and resources to bring together. • Population-based funding supports client and consumer-based planning • Equitable funding based on population needs allows for expansion of services in the community • Equitable funding allow for increased focus on quality of care <p>Importance:</p> <ul style="list-style-type: none"> • Mississauga-Oakville is one of the fastest growing regions in Ontario but is second lowest funded 			

region in Ontario. In recent years this funding gap has grown disproportionately to changes in population demographics.

- Mississauga-Oakville does not have enough services to meet patient/client needs
- Equitable funding fosters inter-LHIN cooperation
- Equitable funding reduces wait times
- Equitable funding brings care closer to home
- Population-based funding is about client-centred care
- Equitable funding improves outcomes
- Equitable funding fills gaps in services and infrastructure (e.g. IT, facilities)
- Equitable funding is consistent with the principle of funding following the patient/client
- Equitable funding helps with recruitment and retention of scarce health human resources
- Equitable funding allows health care services to focus on their mission and mandates

Assumptions and Risks

- MOHLTC is committed to development of population, needs-based funding formula to ensure equitable funding for LHIN's
- Work to-date from other organizations (JPPC, OACCAC, ONHA, etc) is available for analysis
- Equitable formula will result in a redistribution of healthcare funding from around the province with the provision of one-time limited transitional funding to ensure a smother transition and how the profile compares t other LHIN's and/or provinces
- Strategic alliances (eg. JPPC, other LHIN's, Provincial Associations etc.) will be formulated where appropriate to capitalize on work completed to date
- LHIN's will develop a long term strategy to ensure equitable funding allocation from within the LHIN
- Knowledgeable resources will be retained within the LHIN to lead, implement and evaluate funding methodologies.

Current Status (If this is an initiated/existing activity)		Outcomes / lessons learned (if any)	
Activity has been occurring at the JPPC level for equitable hospital funding.			
Lead contact person			
Name	Alan Halls	Ron Noble	
Title	Senior Vice President	Vice President	Organization: Halton Healthcare Credit Valley Hospital
Telephone	905 815 5098	905 813 2433	e-mail address: ahalls@haltonhealthcare.on.ca moble@cvh.on.ca

High Level Action Plan

#	Description of the Tasks / Actions
1.	Attain MOHLTC commitment to a provincial strategy and the development of a framework for implementation of a needs-based, equitable funding formula. Oakville-Mississauga LHIN to advocate for a leadership role.
	Through the development of a provincial strategy and local framework ensure the following:
2.	Survey existing organizations (local and provincial) to determine level of funding formula work completed to date.
3.	Analyze existing MOHLTC, JPPC and other geographical methodologies for funding allocations and need analyses. Analyze current funding by health sector and analyze weighted funding on a per capita basis using age weighted population statistics.

4.	Conduct a literature search to determine methodologies utilized in other jurisdictions.
5.	Develop a working group to evaluate and provide ongoing feedback to MOHLTC.
6a.	Determine population, needs-based profile of Oakville-Mississauga LHIN.
6b.	Establish a working group of cross sector representation (with supporting budget) to develop funding allocation methodologies.
7.	Evaluate various funding allocation methodologies.
8.	Recommend and achieve consensus of various health sectors on preferred methodologies.
9.	Trial and evaluate the preferred funding methodologies.
10.	Assess potential for this work to apply to other sectors.

Title of initiative: # 5 Building a continuum of care that ensures the right care, at the right time, in the right place.		Type of integration (more than one box can be checked) <input checked="" type="checkbox"/> Horizontal <input checked="" type="checkbox"/> Vertical <input checked="" type="checkbox"/> Intersectoral <input checked="" type="checkbox"/> Other, describe: Inter - LHIN
Existing or new initiative? <input type="checkbox"/> Initiated / existing integration activity* <input checked="" type="checkbox"/> New integration opportunity <small>* Note initiated / existing activities do not need to be confined within LHIN boundaries</small>	List of Partners involved Angela Brewer, VON Halton; Bob Haig, Ontario Chiropractic Assn.; Carole Jones, Canadian Red Cross Peel; Donna Schell, Alzheimer Society of Peel; Elizabeth Gill, Peel Cheshire Homes Inc.; Geraldene Adams, Peel Cheshire Homes Inc.; Helen Brent, Wellspring Cancer Support Foundation; Hugh Stewart, Independent Living Halton; Jennifer Morris, Independent Diagnostic Clinics Association; Joanne Fluker, Erinoak; Lydia Wong, Carefirst Seniors and Community Services Association, Lynn Harrett, Etobicoke and York CCAC; Marianna Kreppi, Peel Halton ABI Services; Maureen Lynn, Yee Hong Centre; Nora Paradis, COTA; Paolo Giacco, Credit Valley Diagnostic Centre; Wendy McBride, SENECA Senior's Day Program Halton; Wendy Shelley, Chelsey Park Streetsville LTCF; Lawna Paulos, Nucleus Independent Living	
Brief description of the initiative		
<p>What is the idea? To enhance the quality of care of patients by:</p> <ul style="list-style-type: none"> ➤ Eliminating fragmentation, duplication and silo approaches to health care ➤ Ensuring the infrastructure is in place to support the continuum of care, e.g. Information Systems, Electronic Client Chart, Back-office Support e.g. human resources, training ➤ Building accountabilities, best practices, protocols, incentives and rewards that support the continuum of care rather than individual organizations ➤ Provide consumers with a say and a choice in the provision of service taking into consideration cultural and linguistic needs and preferences. i.e. who provides the service, where the service is provided and how the service is provided <p>Why is this important? This initiative is at the foundation of LHINs and supports the building of a sustainable health care system by:</p> <ul style="list-style-type: none"> ➤ Refocusing health care on population, health and people, not disease management ➤ There will be a shared vision, values and standards amongst support service agencies ➤ Improving the quality and timeliness (decreasing waitlists) of client care ➤ Supporting client choice ➤ Maximizing health care resources by improving cost effectiveness and efficiency ➤ Eliminating existing obstacles to accessing services, i.e. literacy level and languages of some service brochures <p>This initiative can be achieved over time, first through short and medium term projects and then, in the longer term, through organizational and structural change.</p> <p>Assumptions and Risks:</p> <ul style="list-style-type: none"> ➤ Existing organizations, networks and staff will need to change their practices and organizational restructuring may be needed. This may require legal, contractual changes and paradigms shifts in thinking ➤ There is a need to focus on the future, not past experiences. 		
Current Status (if this is an initiated/existing activity)		Outcomes / lessons learned (if any)
Ad hoc cross-organization inter-agency projects Long Term Care, Housing and Community Care Networks Partnerships for quality and standards of care		N/A
Lead contact person		
Name: Lynn Harrett Title: Manager, Public Affairs & Community Development Telephone: 416 780 7892 Name: Lawna Paulos Title: Executive Director, Nucleus Independent Living Telephone: 416 620 0333 ext. 21		Organization: Etobicoke and York Community Care Access Centre e-mail address: Lynn.Harrett@etobicoke-york.ccac-ont.ca Organization: Nucleus Independent Living e-mail address: lawna@nucleushousing.org

High-level Action Plan

#	Description of the Tasks / Actions:
1.	Form a Steering Committee/group to enable community involvement in the implementation of the action plan
2.	Form a Continuum of Care Network to ensure this is evident and is as seamless as possible
3.	Assess future demographics and service implications, e.g. culturally and ethnically diverse populations, aging population, increase in population
4.	Develop an inventory of all health and community services and providers in the LHIN
5.	Develop a high-level process map of the continuum of care across organizations, focusing on heavy systems users and complex disease management
6.	Assess the current capability and capacity of organizations to provide services, e.g. Wait lists, client satisfaction, service blocks; this will require development of standards, common language, benchmarks, etc.
7.	Engage broader community to influence change including marginalized communities (e.g. homeless people), ethnic communities, regarding expectations, available resources and challenges
8.	Identify services clients are accessing outside the LHIN
9.	<p>Create a vision and plan for building a continuum that provides care in the right place at the right time by:</p> <ul style="list-style-type: none"> • Developing accountability agreements that support shared patient responsibility and outcomes with family members and volunteers and provides bridging between informal and formal caregivers • Developing accountability agreements that support the agencies individuality and strengths • Developing cross-organizational care pathways and protocols, using best practices • Re-allocating funds to support and reward organizations that can provide cost-effective and quality care • Addressing non-performance issues • Providing client focused and cultural sensitivity training across the continuum of care • Developing incentives for the organization that enhance the continuum of care • Identifying areas for systemic change
10.	Reward and fund partnerships that result in increased in both quantity and quality of care.
11.	Develop an assessment tool that facilitates the consumer's awareness of the various options of care available and clearly identifies their personal choices.
12.	Opportunity to evaluate outcomes

Title of initiative:		Type of integration (more than one box can be checked)																													
# 8 Electronic Health Record to promote effective service delivery and optimize client self care		<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 <small>* Note initiated / existing activities do not need to be confined within LHIN boundaries</small>		Participants at the Workshop <table border="0"> <tr> <td>Carol Puri</td> <td>College of Physiotherapists</td> </tr> <tr> <td>Carole Beauvais</td> <td>Northern Diabetes Health Network</td> </tr> <tr> <td>David Rowe</td> <td>Credit valley Hospital</td> </tr> <tr> <td>Donna Leavens-Vanwest</td> <td>H-P Emergency Services Network</td> </tr> <tr> <td>Jannine Bolton</td> <td>RNAO Peel Chapter</td> </tr> <tr> <td>Julie Wong</td> <td>Northridge LTC</td> </tr> <tr> <td>Jasmin Earle</td> <td>Saint Elizabeth Health Care</td> </tr> <tr> <td>Nancy Berner</td> <td>MDS Labs</td> </tr> <tr> <td>Paul Gould</td> <td>Ontario Assoc of Medical Labs</td> </tr> <tr> <td>Scott McLeod</td> <td>Halton-Peel DHC</td> </tr> <tr> <td>Sharon Mills</td> <td>Halton Healthcare Services</td> </tr> <tr> <td>Shelley Fine</td> <td>CCO</td> </tr> <tr> <td>Sue Fedun</td> <td>Northridge LTC</td> </tr> <tr> <td>Tom Valentich</td> <td>MOHTLC Human Services Cluster</td> </tr> </table>		Carol Puri	College of Physiotherapists	Carole Beauvais	Northern Diabetes Health Network	David Rowe	Credit valley Hospital	Donna Leavens-Vanwest	H-P Emergency Services Network	Jannine Bolton	RNAO Peel Chapter	Julie Wong	Northridge LTC	Jasmin Earle	Saint Elizabeth Health Care	Nancy Berner	MDS Labs	Paul Gould	Ontario Assoc of Medical Labs	Scott McLeod	Halton-Peel DHC	Sharon Mills	Halton Healthcare Services	Shelley Fine	CCO	Sue Fedun	Northridge LTC	Tom Valentich	MOHTLC Human Services Cluster
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Sue Fedun	Northridge LTC																														
Tom Valentich	MOHTLC Human Services Cluster																														
Brief description of the initiative																															
<p>Development of a virtual client health record that integrates all client information from all members of the healthcare team and is accessible at the point of care by providers and consumers. A record, which addresses the access needs of specific populations such as the deaf, incarcerated and no fixed address communities. A record, which has different levels of security based on individual needs. Lock box provisions and which is jointly owned / managed (rules based)by consumers and providers and which:</p> <ul style="list-style-type: none"> ➤ facilitates client self management through health teaching and monitoring ➤ addresses privacy and consent concerns by giving the consumer direct control over access ➤ gives health care providers access to administrative and clinical information from all source services, 24/7 availability, remote access, e-charting capability, e-mentoring, access to knowledge/data repositories and care standards, trending data, tools to measure client/population health outcomes and share research ➤ allows health care organizations access to shareable applications, standards, Information Technology (IT) and Information Management (IM) infrastructure and interconnectivity to partner organizations and the Ministry leveraging existing interconnectivity projects and architecture ➤ gives system planners access to timely information to facilitate evidence based decision making and health system reform, access to an integrated information management system to measure and track/trend client/population health outcomes and drive effective health care reform ➤ supports MOHTLC goals to build an overarching IM/IT strategy that is scaleable, feasible and secure and allows all service provider practitioners and organizations to align existing infrastructure to an integrated E-Health strategy <p>While developing and implementing the necessary infrastructure and systems necessary for the fully comprehensive system envisioned may take a number of years, there is local support for proceeding and the investment is already quite significant. There are opportunities to maximize and leverage this investment as well ensure coordinated and strategic information management investments within the LHIN consistent with the broader Provincial e-Health strategy and other transformation initiatives such as primary care reform (FHT) and wait list management strategies. There is an opportunity for “quick wins” by completing partially developed projects ongoing provincially and locally (e-Health, e-CHN, OLIS, EHR, etc) or by identifying the LHIN as an ideal beta site for some key initiatives being considered Provincially.</p> <p>While there are opportunities to leverage existing financial and human resources directed to information management, development of a comprehensive information management system will not happen without continued and strategic investment in IT infrastructure. Without acknowledging and funding investment, at a rate similar in magnitude to other information dependent industries (8%-10% of Budget), achieving the long-range vision of a</p>																															

comprehensive, reliable, timely administrative and clinical electronic information management system will not be achievable.	
Current Status (If this is an initiated/existing activity)	Outcomes / lessons learned (if any)
Nationally, provincially and locally there has been a lot of work undertaken regarding development of electronic patient records including: Canada Health Infoway , Provincial E-Health Strategy, Smart Systems for Health (SSHA) and Halton-Peel Shared Services West –Regional IT Committee. Many providers within Mississauga Oakville have participated on the Shared Services West – Information Technology Committee which has been largely hospital, CCAC and Regional Municipality focused. In May 2004 the Halton-Peel DHC hosted a workshop which pulled together key stakeholders from across the region to gain an understanding of the National, Provincial and Local initiatives and to discuss the local opportunities and priorities to be pursued. In January 2005, the e-Health Office of the Ministry of Health and Long-Term Care also hosted a workshop to overview the provincial strategy, solicit regional input into the e-Health Strategy, showcase regional e-Health initiatives and begin a dialogue on how best to support and nurture integrated regional e-Health strategies within the context of the provincial strategy.	<ul style="list-style-type: none"> ➤ Consensus that the province must continue to take leadership in the development of a vision, IM/IT solutions, infrastructure, standards, shareable applications and coordination of the multiple interconnectivity initiatives already underway so as to maximize innovations already realized and leverage existing technologies. ➤ It is clear that a multi sectoral approach to coordinating the development of these systems is essential as is dedication of resources. ➤ Efforts should be made to ensure that the investments to date are maximized as we move forward.
Lead contact person	
Name Jasmin Earle Title V.P. Operations Telephone 905 940 9655x 2401	Organization: Saint Elizabeth Health Care e-mail address: jearle@saintelizabeth.com
Name: Scott McLeod Title: Acting Exec Dir Halton-Peel DHC Telephone: 905 814 5995x106	Organization: Halton-Peel DHC e-mail address: scott@hpdhc.com

High Level Action Plan

#	Description of the Tasks / Actions
1.	<p>Establish a regional multi-sectoral information technology network to lead, guide, support and enable local integrated IT planning within the LHIN</p> <ul style="list-style-type: none"> ➤ Identify key IT Leaders within the LHIN providers ensuring representation from each of the key health sectors, the regional municipalities, e-Health Strategy and other Ministries as appropriate ➤ Draft terms of reference for the role and deliverables for the network ➤ Begin meeting regularly to lead guide and support the work of developing the strategic priorities for local IT needs consistent with the overall vision for electronic information management ➤ Early priorities for the IT Network would include the key task below
2.	Develop and conduct an e-health “Readiness Inventory” to identify readiness of local providers to pursue local e-health strategies including assessment of IT infrastructure and IT utilization and cultural / HR assessment
3.	Establish a dedicated LHIN wide IT investment budget similar in magnitude to other information dependent industries (ie 8%- 10%)
4.	Develop a multi year plan based on the identified gaps and the overall vision, outlining the priorities and strategic investment required to move the health record agenda forward
5.	Identify and pursue opportunities for “quick information management wins” that are consistent with the overall vision but will have the potential to realize significant local impact. (Eg – secure e-mail for all providers)
6.	Develop a methodology for monitoring and reporting progress against the multi year plan

Title of initiative:		Type of integration (more than one box can be checked)	
#10 Integration of and links to primary health care services		<input checked="" 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 checked="" type="checkbox"/> New integration opportunity <small>* Note initiated / existing activities do not need to be confined within LHIN boundaries</small>		Natalia Lishchyna Chris Power Stephen Foreman Shirley Ha Sheila Burton Sandy Milakovic Russ Ford N. Neall Lynne Tintse Jacquie Shartier Howard Shapiro Donna Laevens-VanWest Claire McCullough Bob Haig Jean McKellar	
		Miss Phys Rehab Centre Trillium Health Centre WOHE SSW OAO VON Peel CMHA Peel Camp CHC MDS Labs The Arthritis Society Hope Place Centres Peel Health Halton Peel DHC Voluntaire French Svcs Ont. Chiro. Assoc Ontario Arthritis Society	
Brief description of the initiative			
<p>Primary health care is the foundation for and entry point to the rest of the system. Currently, primary health care services are provided by a variety of health care providers in diverse settings with inefficient and ineffective linkages among the providers, facilities and sectors. Better co-ordination and integration of primary health care services will facilitate the most effective use of the entire health care system and improve care to patients/clients and families.</p> <p>This is a priority because the majority of health care is primary based, thus it can potentially affect every citizen of the LHIN. Since primary health care providers are highly influential on health behaviours, effective linkages can facilitate the patient/client to receive the right health care at the right time and at the right place.</p> <p>Currently, there are several models that aim to converge the diverse components of primary care together. However, it appears that the linkages are not sophisticated enough to effectively integrate the system. There are a variety of reasons why this is the case including lack of communication and trust between care providers, inability to link health information, awareness of services provided in the community, etc. Given that the LHIN is more regionally based, effective linkages in the primary health care field are more likely to be successful.</p>			
Current Status (If this is an initiated/existing activity)		Outcomes / lessons learned (if any)	
-Gaps identified: publicly vs non-publicly funded services, knowledge of resources, many points of entry, need to bridge the public/private gap, need to access least costly services first, should the physician be the gatekeeper/case manager, differences between delivery models (eg. FFS vs CHC), English as a second language, cultural sensitivities, education, socio-economic status. -most primary health care providers practise independently which leads to a lack of continuity of clinical management -there is a shortage of certain primary health care providers		-LHIN needs to identify full spectrum of BARRIERS TO ACCESS and begin to address them -need to be patient-centred (inherent involvement of family) rather than patient-focused -need to redefine how public accesses primary health care services (not just one gatekeeper) - need to invest in health promotion and disease prevention by integrating public health as well	
Lead contact person			
Name Natalia Lishchyna / Chris Power Title Dr / Ms Telephone (905) 891-5300 / (905) 848-7683		Organization: Mississauga Physical Rehabilitation Centre / Trillium Health Centre e-mail address: nishchyna@cmcc.ca / cpower@thc.on.ca	

High Level Action Plan

#	Description of the Tasks / Actions
1.	Determine the current health status of the Mississauga/Oakville LHIN specific to primary health care services. Since the LHIN consists of residents from Halton, Peel and West Toronto, customized data extraction from already existing databanks should be performed.
2.	Design and conduct a survey of a representative sample of the LHIN to determine which primary health care services are utilised for common conditions (look for patterns of behaviour) and which services the health consumer would like better access to. The survey will be instrumental in further identifying the barriers to access. The survey should be developed and implemented by knowledgeable experts and results should be used by the LHIN for planning of integration of primary health care services.
3.	The LHIN should create an IT-based System Navigator. In order to do so, a primary health care service Registry should be created for each of the micro-communities within the LHIN. This registry would be the central component of the web site that could be accessed by all primary health care entry points to direct their patients/clients so that they receive appropriate services in a timely manner. The web site may contain links of existing resources for the patient/client to access (eg. link of CPSO database to family physicians accepting patients).
4.	Co-ordination of MOHLTC initiatives. The LHIN should serve as a catalyst for creating effective linkages between primary health care providers that can then be facilitated for establishing FHTs. Information from the registry can be used to build linkages in the communities within the LHIN by providing forums for health providers to be educated about it each other and build relationships. This task can be measured by the number of FHTs established over a pre-determined timeline.
5.	Under the auspices of the LHIN, establish a Steering Committee which includes primary health care service representatives who can provide insight and feedback on the tasks described above.

Title of initiative:		Type of integration (more than one box can be checked)	
#11 Enhanced partnership between LTC, Hospitals, CCAC and clients/families		<input checked="" 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 <small>* Note initiated / existing activities do not need to be confined within LHIN boundaries</small>		Florence Wong Carmen Dimauro Julia Baxter Evelyn MacDonald Lyette LaCroix Yumi Takahashi Scott Faraway Donna Levans-Van West David Rowe Cathy Hecimovich Allan Halls Amalia Aiello Bernard Soucha Brent Kerwin Dana Ellis Divina Jalea Julie Wong Elaine Russell Lorraine Ladha Sue Fedun Wendy Shelley	
Yee Hong Centre Extendicare Halton Geriatric Mental Health Outreach Program Highborne/ Extendicare Reseau Franco-Sante du Sud de L'Ontario Chartwell Seniors Housing Reit PHABIS Halton/Peel DHC Credit Valley Hospital CCAC of Halton Halton Healthcare Wenleigh/ Regency Care Baxter Corp. Chelsey Park Mississauga The Waterford/ Regency Care Diversicare North Ridge/ Central Care Wesbourne Manor Ontario Hospital Association NorthRidge/ Central Care Chelsey Park Streetsville			
Brief Description of the initiative			
<p>What is the Idea:</p> <ul style="list-style-type: none"> Our goal is to maintain residents in the LTC or community setting and avoid unnecessary visits/admissions to acute care settings and facilitate timely discharges either home or to an alternative care provider. <ul style="list-style-type: none"> Specific opportunities currently in place but requiring expansion/enhancement include IV therapy, tube feeding, palliative care, psychogeriatric care and mental health supports for persons in LTC and community settings. Additional specialties to be explored were: home dialysis, intensive assessment and stabilization services for severe behavioural and severely mentally ill residents, young adults (e.g. autistic or ABI, MS) post partum and neonatal home support, home support for select surgical patients and longer term rehab requirements. This initiative should have Ontario wide application. Services will need to be available in languages other than English as required (i.e. French, Hindi, etc) <p>Why is this important:</p> <ul style="list-style-type: none"> Will promote more efficient and effective use of limited multi-sector resources by appropriately prioritizing utilization according to need. Will foster greater accountability both within and between sectors. Will close some of the existing services gaps for these populations. Better quality of life, comfort, and greater convenience for LTC and community residents and families. Promotes a more holistic approach to care. Will enhance opportunity for better clinical outcomes. Will foster better understanding, partnerships and respect between the various sectors of healthcare. Will promote better understanding and utilization of healthcare resources by LTC and community residents and their families. 			

- Will create opportunities to support initiatives which address alternatives to hospitalization/institutionalization.

Assumptions & Risks:

Enablers include:

- Ongoing funding supports for training of acute care, community and LTC service providers.
- Ongoing funding supports for enhanced care levels in community and LTC settings.
- One time funding to enable changes to LTC facility infrastructure, equipment and enabling technology
- Use of remote technology for timely access to consultation to avoid the need for transfer to acute care for tests/evaluation.
- Willingness among sectors to engage in collaborative partnerships (acute care, community, LTC, and mental health)
- The development of a comprehensive geriatric program for this LHIN area would enable many of these changes to the service delivery model.
- Willingness of MoH/LTC and partners to revisit funding formulas and allocations to support key initiatives.

Barriers include:

- Public/family perceptions that acute care is the best setting for the elderly and other specialized populations (e.g. ABI).
- Ensuring that the needs of the elderly and other specialized populations are prioritized as important when competing for acute care/CCAC funding and supports.
- Lack of cross sectoral clinical protocols, policies, etc. that include the needs of the elderly and other specialized populations.

Current Status (If this is an initiated/existing activity)

Many of these individual initiatives are already in place to a limited extent.

Outcomes / lessons learned (if any)

Enhanced coordination and interagency/sector accountability required. Sufficient resources to address demand.

Not a substitute for increasing acute care bed capacity in high growth areas such as Halton and Peel, but does mitigate the magnitude of the additional capacity required.

Lead contact person

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Title
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High Level Action Plan

#	Description of the Tasks / Actions
1.	Under the auspices of the LHIN form a Steering Committee consisting of reps from acute care, CCAC, community providers and LTC.
2.	Develop a master work plan of initiatives to achieve this goal.
3.	Consult with broader sector as well as client/caregiver groups to confirm priorities from work plan for short, medium and long term action

4.	Identify leads for each determined action from the work plan.
5.	Secure targeted funding in order to pilot key initiatives and evaluate outcomes.
6.	Create funding incentives to promote wider adoption of successful pilot initiatives.
7.	Evaluate implementation of each initiative and modify as indicated by results.
8.	Track key outcomes over time to ensure continued success of initiatives.
9.	Incorporate key outcome indicators into accountability and reporting requirements for each sector.

Title of initiative: # 13 Creating A Culture of Common Knowledge and Appreciation For The Critical Role Of Community Support Services Amongst All		Type of integration (more than one box can be checked) <input checked="" type="checkbox"/> Horizontal <input checked="" type="checkbox"/> Vertical <input checked="" type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:
Existing or new initiative? <input checked="" type="checkbox"/> Initiated / existing integration activity* <input checked="" type="checkbox"/> New integration opportunity <small>* Note initiated / existing activities do not need to be confined within LHIN boundaries</small>	List of Partners involved Carmen Gauthier; Carole Jones, Canadian Red Cross; Chris McLean, CNIB; Diane Austin, SLEC; Heidi Canivet, SLEC; Jodi Perry Brinkert, Wellspring; Marion Bascom, Oakville Senior Citizens Residence; Maureen Davis, Alzheimer Society Peel; Paul Vanderhelm, Peel Senior Link; Steve Kavanah, Ontario March of Dimes; Yvonne Hodge, Nucleus Housing; Maria Sewell, Independent Living Hamilton; Raymond Applebaum, Peel Senior Link	
Brief description of the initiative To provide the Mississauga Oakville LHIN Governance Board, CEO, and staff, and all service providers/volunteers within the LHIN network, with a comprehensive understanding and appreciation for the critical role of Community Support Services within the broader health care system. Initially, as part of the LHIN orientation, a presentation will be provided early on (within 60 days of April 1, 2005) to the LHIN Governance Board, CEO, and staff by community support service providers (volunteers and staff), clients, and caregivers, along with written materials that will be shared with all service providers, networks, and community groups, operating within the LHIN's jurisdiction. To create a culture of common knowledge amongst all, a series of strategic actions will be taken initially and on an ongoing basis to ensure that all the service partners (hospitals, long-term care homes, and in-home and community support service providers) have a thorough understanding for the role of Community Support Services and how best to utilize these resources in the community, and communicate this knowledge to persons in the community. This priority initiative can and should be replicated throughout the province to achieve similar outcomes as identified for the Mississauga Oakville LHIN. The educational and support materials being developed will be created in collaboration with the Ontario Community Support Association and the Canadian Federation of Mental Health & Addictions, which represents over 500 community support service agencies, serving 14 LHIN communities. This integration priority is critical to the success of the Mississauga Oakville LHIN in achieving enhanced access and support for improved service provision through an integrated and coordinated system for clients, caregivers, volunteers, and service providers. As the LHIN develops its initial and annual plan, its imperative that everyone is operating from a common knowledge base. The enhanced utilization of community support services will result in reduced pressures on the acute care system and enable people to choose to live independently in the community, therefore, delaying and or avoiding the need for Long-Term Care placement. As well, working more closely with the community-based primary health care system through current and new initiatives such as Family Health Teams and Community Health Centres, the cost benefits of reduced hospitals visits will be further accrued, creating the potential for community support service enhancements and expansions to address growing needs, and a focus on community support. This priority initiative will provide benefits to both current and future clients/caregivers, and our new integrated and coordinated system in Mississauga Oakville. In achieving a culture of common knowledge amongst all service providers on a cross-sectoral basis, clients will be better served as community services are better understood and therefore, an increased number of appropriate and timely referrals should result. As well, clients/caregivers will have an increased appreciation and understanding of our motives, operational changes, values, and principles. More importantly, the community will be engaged in an education process with the Mississauga Oakville LHIN to achieve an understanding of and participation in helping to shape this LHIN. Community support service agencies operate in a highly flexible, accommodating, and adaptable environment, being responsive to changing community needs, and helping people avoid falling through the cracks in the system. This critical resource of community contacts and services can be further enhanced with support and recognition for their contribution and critical role within the broader health care system. Investments need to be made to provide these organizations/networks with the capacity to serve a growing population desiring in-home and community-based services for independent living and an enhanced quality of life.		
Current Status (If this is an initiated/existing activity)		Outcomes / lessons learned (if any)

<p>There are several networks of Community Support Services agencies that meet for information sharing and joint training/project opportunities, e.g. diversity training, and transportation. (The Change Foundation, Health Networks in Ontario, Nov. 2004)</p>		<p>Best practices and lessons learned have benefited these providers, and more importantly the people they serve in the community clearly benefit from these networking opportunities.</p>
<p>Lead contact persons</p>		
<p>Raymond Applebaum Executive Director Peel Senior Link ray@peelseniorlink.com 905-712-4413</p>	<p>Maria Sewell Volunteer Independent Living Hamilton msewell@designalpha.ca 905-875-2679</p>	

Creating the Culture Activities:

- Creating a better understanding of small agencies by achieving the priority
- Trust and respect in the region -> build on it
- Challenge -> opportunity
- Small amount funding, how to advertise, use the LHIN to facilitate
- ensure communities unique needs are recognized
- Opportunities to voice opinions, values
- Marketing availability of services
- Education-> knowledge of what is in the LHIN
- Recognition of **needs**
- Inventory of current service- -> address need for future service
- Research of CSS prevention (U of T -> relationship), transfer to all LHIN
- Connect to universities / colleges - DHC etc.,...for planning
- Knowledge base must include wait list
- Teach people where to find services, presentation of resource list (i.e. who to call for more info)
- Partnerships within the CSS sector and across sectors
- Sector participation in orientation of LHIN and CEO
- Links to colleges etc., -> for educating / training healthcare providers (volunteers)
- Clarification of geographic boundaries – Oakville / Mississauga / Etobicoke services
- Map out services to show gaps
- Flowchart – where to go to meet needs->patient, providers, referrals, discharge planner, case managers
- Info gets to right people, increased knowledge base
- **common language**, (i.e. home care -> community support services)
- What are the **incentives** for the referral agencies to **value** CSS and refer clients
- qualify / quantify what we do
- equal player in the system
- learn lessons from strategies that are working well e.g, best practices and strategies
- **educational strategies** -> CSS. on LHIN Boards
- learn lessons from strategies that are working well
- people with a knowledge base of CSS to offer to serve on the LHIN boards
- encourage those with leadership ability and aspirations to serve on LHIN's, put names forward
- LHIN board members should be aware of all the sectors
- Ensure that referrals happen and that people are referred to the services which prevent the need for acute care or institutional care
- Increased public awareness resulting in potential to increase access to CSS
- Clients will be better served, CSS more cost effective to the system
- Services add to quality of life

- Centralized referrals
- System to respond to what caregivers/client needs
- CSS sector is flexible, creative, and offers a variety of services and solutions to decrease people's limitations and focuses on their capacity
- Demographics, e.g. baby boomers will want to choose where and how they will be served in the community
- Good use of CSS takes pressure off the other more costly parts of the health care system
- Serve clients based on their needs
- Cross utilization of all players (networks)

High Level Action Plan

#	Description of the Tasks / Actions
1.	Local stakeholders to develop an orientation presentation package and site tour for the LHIN CEO, Chair, Board members and staff in collaboration with the Ontario Community Support Association, the Canadian Federation of Mental Health and Addictions, and community networks
2.	Establish an investment and related resources for initial and ongoing education for LHIN clients, caregivers, staff, service providers, and service system partners, e.g. common assessment form
3.	Develop a cross-sectoral action team within the LHIN with representatives from clients/caregivers, service providers and partners, and relevant community networks
4.	Develop a system wide community education/marketing campaign utilizing shared resources, and media opportunities for the public in collaboration with community networks
5.	Integrate caregivers/clients and providers in all aspects of LHIN decision making and development
6.	Ongoing acknowledgement and support for existing networks such as secretariat support and travel, as a key element for continuous learning and sharing environment to support integration, e.g. Community Support Services Group of Peel and the Halton Health & Community Support Services Network
7.	Providers and other stakeholders develop an ongoing tracking system with an initial baseline for Community Support Services, to determine increased referral patterns as a direct result of these actions
8.	Hold a social event early on (fall 05) for the LHIN CEO and Board to meet the service providers/partners as part of the orientation/learning process

Title of initiative:		Type of integration (more than one box can be checked)	
#14 Addictions and Mental Health integrated through innovative client centred care models focusing on the mental health and addiction needs of our community.		<input checked="" type="checkbox"/> Horizontal <input checked="" type="checkbox"/> Vertical <input 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 <small>* Note initiated / existing activities do not need to be confined within LHIN boundaries</small>	Peel Addiction Assessment and Referral Centre Supportive Housing In Peel Dixie Bloor Neighbourhood Centre SEHC CMHA – Peel Halton Health Care Services CAMH STRIDE Support and Housing Halton Community Services Mobile Crisis of Peel ADAPT Schizophrenia Society of Ontario - Halton Friends & Advocates Peel Ontario Hosp Association India Rainbow Com. Centre ABI Possibilities Inc CMHA – Halton Halton Peel DHC Summit House Halton Recovery House YMCA Employment Care Partners YMCA Youth Sub. Abuse Program Hope Place		
Brief description of the initiative			
<p>The Mississauga/Oakville LHIN will establish a horizontal integrated approach for all community Mental Health and Addiction services for client care. The development of a service continuum will address need and assist the individual, those that suffer from Mental Illness and Addiction.</p> <p>Appropriate and equitable funding will ensure that service providers work with a respectful manner to each other's individual philosophies and practices, which benefit the client population.</p> <p>We further advise that the Mississauga/Oakville LHIN take serious the following documents: Mental Health Implementation Task Force, CMHA Ontario Paper, Community Integration Planning Key Issues in Mental Health and Addictions, Joint Paper of CAMH, Best Practices, Making It Happen and Setting the Course, Federation and Canadian Mental Health Association. These documents were prepared in recent years and confirm the respective areas of need and legitimize the value of implementing initiatives to housing stock, provide a 'no wrong door approach' for access to service, address issues of culture, develop an 'integrated approach' to concurrent disorder treatment, review the integration of complimentary care service, implement priority needs for special populations and client/patient choice.</p> <p>These reports list a number of high priority areas yet to be realized in the Mississauga Oakville LHIN area.</p> <p>To that end, we the priority #14 representatives advise the Mississauga/Oakville LHIN focus on increasing the capacity of existing services and the development of new services that currently do not exist. We expand on the needs in the Mississauga Oakville HIN areas for Mental Health and Addictions under the High Level Action Plan at the end of this report.</p> <p style="text-align: center;">Importance</p> <p>The participants for Addictions and Mental Health, Priority #14 are confident that if the recommendations are addressed the following outcomes will be experienced.</p> <ul style="list-style-type: none"> • Reduced client time in the system • Reduced wait list time for clients which will result in movement through the system • Appropriate use of services by client (reduced ER use) • Timely, effective and coordinated client service for crisis, case management, housing and social rehabilitation • Improved client outcomes • Increased community relations and participation 			

- Improved quality of life for the individual and their personal support system
- Established egalitarian approach will be to all populations that exist within Mental Health and Addictions

Assumptions and Risks

Implementing the recommendations, which are supported through years of recommendations from the reports developed as described above.

Current Status (If this is an initiated/existing activity)	Outcomes / lessons learned (if any)
Mississauga/Oakville service providers have a credible and successful history, with a reputation for organizing collaborative services which enhance service delivery and have economies of scale (i.e. homelessness initiatives, space sharing, resource sharing (including staff,) cross-sectoral training, joint program planning, community support agreements, Region of Peel Street Outreach, shared consultation with full accountability to funding expectations.	The following documents: Mental Health Implementation Task Force, CMHA Ontario Paper, Community Integration Planning Key Issues in Mental Health and Addictions, Joint Paper of CAMH, Best Practices, Making It Happen and Setting the Course, Federation and Canadian Mental Health Association should be reviewed and applied in planning.
Lead contact person	
Name: Laurie Ridler Title: Executive Director Telephone: 905-450-0060 ext. 303	Organization: Supportive Housing In Peel e-mail address: Laurie@shipshey.ca
Name: Jacqie Shartier Title: Executive Director Telephone: (905) 875-3214	Organization: Hope Place Women's Treatment Centre e-mail address: jacqie@hopeplace.ca

High Level Action Plan

#	Description of the Tasks / Actions
1.	LHIN to form a steering committee consisting of representatives from Addictions and Mental Health specific to client service and program need which will:
2.	Implement adequate resources to all existing services to address extensive wait lists
3.	Implement an integrated access system for the client population with 'no wrong door approach' (clients can access the system through any of the available services) including all forms of access whether telephone, walk in, email or regular post.
4.	Review current service options, address gaps and enhance the service continuum for improved client choice, emphasizing value, outcomes and wellness.
5.	Increase housing stock and expand the continuum of housing options, with the provision of support service to the client which will optimize outcomes.
6.	Develop and implement a formalized 'priority need' process for specialized populations (i.e. concurrent disorder, dual diagnosed population, youth, seniors, diverse cultural population)
7.	Implement an integrated approach to concurrent disorder treatment
8.	Provide education and opportunity to ensure the value of complementary care services are integrated into Mental Health and Addictions Services (i.e. nutrition, chiropractic, naturopathic and alternative care interventions) which have a proven positive influence on client outcomes and wellness.
9.	Increase service options to include client 'supported' job opportunities throughout the community.

Title of initiative: #15 Mental Health and Addiction service delivery enhanced through an integrated seamless cross sectorial approach)		Type of integration (more than one box can be checked) <input checked="" 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 <small>* Note initiated / existing activities do not need to be confined within LHIN boundaries</small>	List of Partners involved STRIDE, Halton Recovery House, Support and Housing Halton, Table de Concertation Franco en sante, YMCA Employment and Comm. Svcs. Care Partners, Mobile Crisis of Peel, YMCA Youth Sub. Abuse Program, ADAPT, Hope Place Centers, PAARC, Friends and Advocates, SHIP, Ont. Hosp Association, Dixie Bloor Neighbourhood Center, India Rainbow Com. Cntr, SEHC, ABI Possibilities Inc, Halton Health Care Svcs, Halton Peel DHC, CAMH, Summit House, CMHA Halton and Peel.	
Brief description of the initiative This initiative is proposed to create a horizontal/cross-sectorial integration of all administrative aspects of community Mental Health and Addiction services in Mississauga Oakville LHINs. Establishment of a Central Network of Mental Health and Addiction will positively explore and utilize existing regional resources, management, housing human resources and information. This Central Network would identify gaps and overlaps in service delivery. It will bring all stakeholders together to identify the needs of community and develop a collaborative venture at regional level. The network will facilitate smooth access to tertiary psychiatric hospital and specialized outreach, consultation, safe beds and residential care. This initiative will provide continuum of services needed in Mental Health and Addictions, as well as a continuum of philosophies, with all equally valued. It provides an opportunity to develop a comprehensive mental health and addiction strategy within the health care system that will:		
<ul style="list-style-type: none"> ➤ Secure dedicated funding for mental health and addictions ➤ Increase system capacity, ensure the availability of core supports and services including Schedule One and tertiary levels throughout the Mississauga Oakville LHIN ➤ Foster integrated treatment of common mental health and addiction problems and ensure integrated approaches to other health issues which are superimposed by mental health and/or addiction. The Central Network of Community Mental Health and Addictions easily enables the system to: <ul style="list-style-type: none"> ➤ Identify program and service priorities within Mental Health and Addictions ➤ Provide Cross training of Mental Health and Addictions to develop needed skill sets ➤ Enhance/equalize per capita funding ➤ Honour and value what each service provider in the Mental Health and Addiction system does and promote collaboration between all sectors ➤ Stop discrimination and bias ➤ Educate and enhance awareness for different cultural groups ➤ Eliminate stigma and discrimination for Mental Health and Addiction ➤ Facilitate Accreditation/certification process for Mental Health and Addiction ➤ Improve compensation to attract and retain the best staff. ➤ Work smoothly with other LHIN's to encourage a national strategy for Mental Health and Addictions ➤ Address funding disparities in order to provide equitable access across LHIN's borders for Mental Health and Addictions ➤ Recognize the work already done in the Mental Health and Addictions system, ie. Implementation task forces, making it happen, setting the course etc ➤ Ensure equitable access to Mental Health and Addiction services for Urban and Rural population ➤ Define program and services priorities for special populations ➤ Increase services to those with mild and moderate mental health issues ➤ Promote joint management by agency agreement of infrastructure resources such as HR 		
Current Status (If this is an initiated/existing activity) Collaborative work attitude is evident among existing community mental health and addiction services. Partnerships and service agreements have been developed between services providers	Outcomes / lessons learned (if any) <ul style="list-style-type: none"> ➤ Decrease duplication of services ➤ Accountability ➤ Improved communication, coordination and continuity of care ➤ Improved economies of scale and 	

		<ul style="list-style-type: none"> ➤ credibility for the health system ➤ Cost-effective use of acute care services, bed utilization and efficiency benchmarks. ➤ Accessible, responsive, coordinated and comprehensive Mental Health and Addiction Services ➤ Standardized delivery of mental health and addiction services across the Mississauga Oakville LHIN ➤ Standardized admission and discharge criteria and protocols, assessment tools and evaluation framework
Lead contact person		
Name: Ehsan Sharif Title: Mental Health Program Manager Telephone: 905 275-7646/227		Organization: Peel Integrated Crisis Response Program e-mail address: esharif@saintelizabeth.com
Name: Darlene Holowachuk Title: General Manager Telephone: 905 276-9322/212		Organization: YMCA Peel Employment & Community Services e-mail address: Darlene.holowachuk@ymca.net

High Level Action Plan

#	Description of the Tasks / Actions
1.	Establish Steering Committee in the framework of LHINs representing mental health and addiction services
2.	Establish an inclusive Network of Mental Health and Addiction Services to ensure seamless autonomy of each service provider
3.	Provide a complete inventory of existing mental health and addiction resources and services
4.	Draw a table of priority needed services in Mississauga Oakville
5.	Conduct a needs assessment of different population e.g child and family psychiatry, Psycho-geriatric dual diagnosis and ethno-racial in Mississauga Oakville
6.	Engage all stake holders e.g family, primary care giver and self help groups
7.	Integration of Mental Health and Addiction with Primary Health Care System
8.	Ensure equitable funding across service provider sectors for mental health and addiction services
9.	Recognize, coordinate and integrate volunteer services in the structure of community mental health services
10.	Develop Human Resource plan to include accreditation, training, standardized qualification and standards across mental health and addiction services
11.	Influence education system curriculum to increase the professional capacity of mental health and addiction
12.	Include Information technology and management in administrative processes
13.	Recognize/utilize the work already done in the Mental Health and Addictions system, ie. Implementation task forces, making it happen, setting the course etc

Title of initiative:		Type of integration (more than one box can be checked)	
#21 Bridging health care delivery from hospitals to community care and support services		<input type="checkbox"/> Horizontal	<input checked="" type="checkbox"/> Vertical
		<input 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 <small>* Note initiated / existing activities do not need to be confined within LHIN boundaries</small>		Jannine Bolton (RNAO), Brent Chambers (Central Care Corp), Cathy Hecimovich (CCAC Halton), Chris Power (Trillium Health Care), Courtland Thomson (COTA Health), David Rowe (Credit Valley Hospital), Dwight Winfield (Care Partners), Gerry Park (VON Halton), Marianna Kreppi (Peel Halton ABI Services), Nancy Berner (MDS Labs), Tariq Asmi (GTA/905 Healthcare Alliance), Yvonne Hodge (Nucleus Independent Living), Cindy McDonnell (Halton Healthcare), Dr. Shelley Fine (Credit Valley Hospital), Angela Brewer (VON Halton)	
Brief description of the initiative			
<p>Description:</p> <p>This initiative will provide a seamless transition for the consumer across the continuum of care; utilizing a single point of access with a single funding source. This will:</p> <ul style="list-style-type: none"> • Ensure client-focused, holistic care the promotes quality outcomes • Ensure resources are tied to client needs • Enhance communication of consumer information across the continuum of care • Foster collaboration of the healthcare team with respect to research, evidence-based best practices and models of care • Ensure that the appropriate service is delivered in the appropriate setting • Ensure ease of accessibility to the healthcare system <p>This is a long-term initiative and should be easy to replicate across the province.</p> <p>Rationale:</p> <ul style="list-style-type: none"> • Current system fragmentation increases the risk of compromising consumer outcomes. Consumers have no 'guide' through the healthcare system. • Current system is resource and provider-focused, not client-focused • Eliminating redundancies inherent in the current system increases efficiencies in resource management • Streamlined transition enhances client-focused care • A new approach is needed to increase the ability to inventory current resources and plan future resource management <p>Key Enablers</p> <ul style="list-style-type: none"> • Within the current system there exists collective knowledge and expertise that can be utilized to move forward • There exists a realization that the current system is insufficient in providing positive consumer outcomes • The MOHLTC is committed to the development of a client-focused system • Consumers are more knowledgeable <p>Key Barriers:</p> <ul style="list-style-type: none"> • The current funding structure leads to the existence of 'silos' within the healthcare system which fosters insufficient communication regarding the consumer and with the consumer • The competitive model for community care breeds competition, not collaboration and prohibits continuity as the providers change frequently • The current system has not been able to develop universal evidence-based practice • There exists a lack of public knowledge re: accessing the healthcare system. There is no easy 			

<p>access to the system.</p> <ul style="list-style-type: none"> • The eligibility criteria for consumers in inconsistent • Redundancies and gaps exist in the system currently • There is no easy access to the system • The perceived accountability currently is between the funder and consumer; not the provider and the consumer • An integrated system for IT does not exist (electronic health record) 	
Current Status (If this is an initiated/existing activity)	Outcomes / lessons learned (if any)
0% complete	Not applicable
Lead contact person	
<p>Name Angela Brewer Title Executive Director, Telephone (905) 827-8800 ext. 2010</p>	<p>Organization: VON Halton e-mail address: abrewer@vonhalton.ca</p>
<p>Name Janine Bolton Title RN, Telephone (905) 821-4474 x 2123</p>	<p>Organization: RNAO Email address: jhb23@look.ca</p>
<p>Name Cindy McDonnell Title Chief Operating Officer, HHS, Milton Site Telephone (905) 876-7021</p>	<p>Organization: Halton Health Services, Milton Site Email address: cmcdonnell@haltonhealthcare.on.ca</p>

High Level Action Plan

#	Description of the Tasks / Actions
1.	Under the auspices of the LHIN, form a Steering Committee consisting of representatives from acute care, community care (CCAC and providers) and LTC.
2.	Determine the population-based needs of the Oakville-Mississauga LHIN
3.	Identify redundancies and gaps that exist in the current system
4.	Define sector responsibilities (who does what)
5.	Develop LHIN-wide consistent specific eligibility criteria for services
6.	Develop client-based funding model
7.	Develop comprehensive consumer information system to enhance communication, collaboration
8.	Implement a system with 'care managers' that would provide a 'single point of contact' for consumers
9.	Train the 'care managers' to be client-focused and resource knowledgeable. They know where the consumer 'fits' into the system. This would also be a single point of initial assessment.
10.	Develop quality indicators/outcomes measurement that will assess success and indicate areas for improvement
11.	Establish a simple method of access to the system (i.e 1-800 number)
12.	Develop a marketing plan to ensure public awareness

Title of initiative: #22 Innovation In Service/Care Delivery Models to Maximize Human Resources Across the Continuum		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: Opportunity for integration through all areas. Programs on line to service clients directly (E-education) a true solution																						
Existing or new initiative? <input type="checkbox"/> Initiated / existing integration activity* <input checked="" type="checkbox"/> New integration opportunity <small>* Note initiated / existing activities do not need to be confined within LHIN boundaries</small>	List of Partners involved Hospitals, Public Health, Community, LTC Facilities and RHPA Members Planning Contact Selection																							
	<table border="0"> <thead> <tr> <th style="text-align: center;">NAME</th> <th style="text-align: center;">ORGANIZATION</th> </tr> </thead> <tbody> <tr> <td>Carmen DiMauro</td> <td>Extendicare</td> </tr> <tr> <td>Natalia Lishchyna</td> <td>Miss. Physical Rehab Centre</td> </tr> <tr> <td>Ron Noble</td> <td>Credit Valley Hosp.</td> </tr> <tr> <td>Russ Ford</td> <td>Lamp Community Health Centre</td> </tr> <tr> <td>Steve Haas</td> <td>Paramed Home Health Care</td> </tr> <tr> <td>Susan Graham Walker</td> <td>ALS Society of Ont.</td> </tr> <tr> <td>Valerie Cook</td> <td>Canadian Red cross</td> </tr> <tr> <td>Janet Doering</td> <td>Halton CCAC</td> </tr> <tr> <td>Marg Di Cesare</td> <td>Saint Elizabeth Health Care</td> </tr> <tr> <td>Sharon Mills</td> <td>Halton CCAC</td> </tr> </tbody> </table>	NAME	ORGANIZATION	Carmen DiMauro	Extendicare	Natalia Lishchyna	Miss. Physical Rehab Centre	Ron Noble	Credit Valley Hosp.	Russ Ford	Lamp Community Health Centre	Steve Haas	Paramed Home Health Care	Susan Graham Walker	ALS Society of Ont.	Valerie Cook	Canadian Red cross	Janet Doering	Halton CCAC	Marg Di Cesare	Saint Elizabeth Health Care	Sharon Mills	Halton CCAC	
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Brief description of the initiative As a result of brain storming at the LHINs workshop the following bundled integration opportunities were identified as having the ability to utilize human resources more effective and efficiently. Increased numbers of clients may receive care in a location of their choice accomplishing Health Outcomes with fewer dollars.																								
<p>Scope of Practice:</p> <ul style="list-style-type: none"> Examining the scope of practice of all RHPA members as well as the unregulated worker Examine current scope of existing providers to determine range of skill sets Expanding the scopes of practice of the individual provider Promote care in the home, self care through E-education- Expanding/utilizing the role of the Nurse Practitioner as an alternative to MD contact Review best models of care: need to improve supportive care skill development <p>Models of Care:</p> <ul style="list-style-type: none"> Reviewing best models of care; recognize skill/talent to improve capacity Explore alternatives to physician driven models Employ alternate professionals for assessment and entry in to health care system; decrease costs Ensure right care is provided by the right person in the right environment at the right time Providers needs to use evidence based decision making Use outcomes to evaluate effectiveness of services Define a public interest focused service delivery model...more consumer involvement at all levels <p>Technology:</p> <ul style="list-style-type: none"> Using technology to maximize access to services. Ie. Telehealth, telehomecare remote access to radiology, etc. Promote care in the home, self/client care through E-education-(diabetes, wound care, obstetrics) <p>LHINs Accountability:</p> <ul style="list-style-type: none"> LHINs define the rules of innovation through examination of unnecessary barriers (reason?) LHIN the purchaser of services that sets common outcomes/ performance indicators Promote collaboration within a competitive environment : Incentive and rewards Need to share/transfer innovation without losing competitive edge <p>Short term: Run identified pilots simultaneously</p> <p>Long Term: Analyse results identifying best practices and role out across Province</p>																								

Current Status (If this is an initiated/existing activity)	Outcomes / lessons learned (if any)
<ul style="list-style-type: none"> ➤ Shortage of professionals ➤ Limited access to expert knowledge; technology allows remote access to expert knowledge ➤ Professionals not equally distributed across all sectors of Health Care ➤ Mismanaged Resources-duplication of Services; need to stop professional from self defining what they want to do ➤ Physician care increases cost and not always needed; can be provided by others ie Nurse Practitioner ➤ Need to build better linkages to eradicate appropriate access and result in diminished waitlists ➤ Current system currently refers to Emergency too much as risk management solution ➤ Clinics need to be funded as an ongoing model ➤ Hospice needs to be include capturing the volunteer capacity ➤ Some Good Networks currently in existence; need to replicate across Province 	<p>Need to clearly identify who will take leadership? Will that be LHINS? Clarification of roles & responsibilities.</p> <ul style="list-style-type: none"> ➤ Build technology inventory, links ➤ Conduct a review of present Knowledge Management Systems available ➤ Develop an integrated Knowledge Management System ➤ Educate adequate resources to deliver coordinated services (need centralized planning for Policy & Procedure, Standards, Performance Indicators Outcome Analysis) ➤ Fund adequately to ensure consistent compensation across all sectors for each discipline ➤ Develop & fund an integrated client focused Service Delivery Model that crosses all sectors <p>Incentives for use of Best Practice in the model that results in system change All members need to but into process</p>
Lead contact person	
Name Marg DiCesare Title Project Manager Telephone 905 9409655 ext; 2106	Organization: Saint Elizabeth Health Care e-mail address: mdicesare@saintelizabeth.com

Outline any key assumptions you have made regarding the project or work plan and or any potential risks affecting the project

- Improved client Health Outcomes
- Members of Networks will be of equal status related to decision making
- Respect and dignity to all members of all teams
- Competitive edge may be maintained
- Increased client satisfaction in a fiscally responsible Health Care system
- Past successes will be integrated into new system (i.e. Hospital in the Home Project-Nov 18, 1991 to March 31, 1997).

High Level Action Plan

	Description of the Tasks / Actions
1.	LHINNs develop purpose, goal & their objectives
2.	Recruit LINNs team
3.	Establish a steering Committee with representation from across Province
4.	Review & Prioritize integration priorities for 1-5 yrs implementation

5.	Hire leads into positions Fund adequately to ensure consistent compensation across all sectors for each discipline Educate adequate resources to deliver coordinated services (need centralized planning for Policy & Proceedure, Standards, Performance Indicators Analysis
6.	Leads develop goals & objectives
7.	RFP for innovative ideas related to this topic; select and pilot a few
8.	Conduct a review of current Knowledge Systems
9.	Develop an integrated Knowledge System
10.	Develop and fund an integrated client focused Service Delivery system that promotes collaboration within the competitive model
11.	RFP to current providers in System
12.	Identify what the incentives for use of best practice in the model that results in system change Clarification of roles and responsibilities that will facilitate a smooth transition from entry to exit of Health Care system (i.e. care manager versus case management)

7.0 Important Role of Networks

Numerous health networks have been established nationally and provincially in Canada to better manage services that address specific diseases/illnesses, to coordinate system level planning and/or to coordinate specialized service delivery. While there is little formal evaluation of health networks in Ontario, a summary of key points from the following sources provide some observations about networks and insights into what makes networks successful and effective.

Paquette, David. *Source Document To Support the Development of End-of-Life Networks in Ontario*. Submitted to District Health Councils of Ontario, December 2004.

Provan, Keith G. and Sebastian, Juliann G. Networks within Networks: Service Link Overlap, Organizational Cliques and Network Effectiveness. *Academy of Management Journal*, 1998, Vol. 41, No. 4, 453-463.

The Change Foundation. *Accountability, Continuity and Effectiveness: Health Networks in Ontario*. November 2004.

7.1 Definition of Networks

- “In general, networks can be defined as: a set of autonomous organizations that come together to reach goals that none of them can reach separately” (Chisholm & Longman, 1998)
- Networks promote affiliation and collaboration amongst participating members to jointly utilize their resources and expertise in achieving a shared mission or mandate (Paquette, 2004)

Network Structures (adapted from Paquette, 2004)

Informal Networks

- Consist of a casual group of interested participants who come together to discuss issues of mutual concern and potentially take action to address a problem
- Participation is ad hoc and decisions do not bind individual members
- No written agreements to define membership, roles and responsibilities or anticipated benefits
- Typically engage in information sharing, joint planning and to a limited degree, resource sharing
- Allow participants to test various combinations of members, build trust and identify common interests outside a legal structure and without a large financial investment
- May serve as a foundation for the establishment of a formal network

Formal Networks

- May be governed by a written agreement, or they are incorporated entities
- Networks established by a written agreement usually have a memorandum of understanding which outlines the network's purpose and its membership
- May elect officers, adopt operating procedures form subcommittees and implement programs
- Are the preferred form when the network has a modes agenda, performs most of its responsibilities using in-kind resources, does not require employees, and cannot act on behalf of its members without explicit approval from all member organizations
- Usually address a short term problem and disband after the problem is solved or function for a limited number of years

Incorporated Networks

- May be profit or not-for-profit entities and have articles of incorporation which describe their purpose, directions and office locations as well as by-laws which define their mandate, membership composition and operating procedures
- Tend to be more focused and committed to achieving their prescribed mandates
- Considered more permanent than networks based only on written agreements

7.2 Common Features of Networks (adapted from Paquette, 2004)

Although networks vary in their structures and mandates, they share common features:

- Oriented to a higher purpose and sharing a common vision
- Their activity affects the whole system through decisions that have internal and external impacts
- Horizontal integration (network structure is not hierarchical; each member is equal within the network)
- Voluntary participation
- Decentralized power
- Member controlled
- Self regulating
- Collaborative
- Cognitive (a learning organization with self knowledge and awareness of operating environment)
- Involves a division of labour where members have specialized tasks and skills sets

- Autonomous members (member organizations retain independent decision making powers)
- Deliberative (deciding/addressing/exploring constructively)

7.3 Purpose of Health Networks (adapted from Paquette, 2004)

- *To improve the health of individuals and communities through better care.* To do this effectively, all the systems that affect health including health, socio-economic, justice and education need to work together. Networks are vehicles to bring different systems together (The Change Foundation, 2004).
- *To address integration and continuity in care problems and facilitate systems planning through shared accountability* (The Change Foundation, 2004). Shared accountability is defined as “a relationship based on obligations, to demonstrate, review, and take responsibility for performance, both the results achieved in the light of agreed expectations and the means used (The Auditor General of Canada (2002) in The Change Foundation, 2004). Shared accountability means organizations are accountable not only within their organizations, but to other organizations and the public for the care received by individual consumers and therefore they share accountability (The Change Foundation, 2004). In these partnering arrangements there are three kinds of accountability relationships: accountable among the partners; accountability between each partner and its own governing body; and accountability to the public (Lenihan, Godfrey, Valeri, & Williams 2003, in The Change Foundation, 2004).
- *To build capacity* on health care issues through partnerships, collaboration, information dissemination, and sharing of expertise, knowledge, resources and thereby address common challenges.

7.4 Characteristics of Successful Health Networks

Successful health networks are (adapted from Paquette, 2004 & the Change Foundation, 2004):

- responsive to community needs
- client focused
- supported by innovative and enterprising leadership
- supported by, and inclusive of, local stakeholders
- based on a willingness to collaborate on an ongoing basis
- focused on, and supportive of, service and system change
- based on representation across a continuum of care
- based on representation across professional groups
- supportive of integration
- able to create and enhance best practices

- able to promote efficiency and effectiveness
- progressive and dynamic
- close to the locus of decision making
- transparent in revealing the successes, challenges and failures
- influential
- based on equality among participants
- clear with respect to expectations, funding allocation and rationale, roles and responsibilities of individuals and organizations
- able to develop an accountability framework and promote shared accountability

7.5 Factors Facilitating the Development of Successful and Effective Networks (adapted from The Change Foundation, 2004 and Paquette, 2004)

Practices and characteristics that build effective networks and strengthen shared accountability relationships include:

- Clear, well understood and agreed upon roles and responsibilities for all clinicians and organizations in the Network
- Clear performance expectations in terms of explicit, understood and agreed upon objective and outcomes
- Balanced expectations and capacities so that performance expectations are clearly linked to and aligned within the Network with each individual and organization having the capacity to deliver
- Credible reporting that includes timely and credible information to demonstrate what has been achieved, whether the means used were appropriate and what was learned
- Reasonable review and adjustment by all participants in terms of feedback on performance, achievements recognized, corrections made and consequences carried out
- Time allocated to build credibility and earn mutual respect among participating groups
- Group members buy into the roles, responsibilities, expectations and objectives of the Network
- Group members have a systems perspective
- The people involved have a desire to collaborate, understand how to collaborate (e.g. listen actively, understand barriers health care providers face, gain broad stakeholder input to develop solutions), and build common values, vision and objectives
- There is representation of each level of health care delivery, including champions from senior management, strategic policy, program design and clinical care and “ambassadors” within organizations who are responsible for getting Network information back to colleagues
- Health care services are integrated from the planning stage
- All sectors are represented, including consumers, and the needs of all participants are considered and balanced

- Dedicated resources including financial, human (e.g. in recognition of time commitment) and technological, to support networks in achieving their mandates
- Leaders with facilitation skills

7.6 Networks within Networks

Network effectiveness may be more likely explained by the intensive integration of network cliques of provider agencies or sub-groups within a network, than by integration across a full core network (Provan & Sebastian, 1998; Paquette, 2004). In other words, it is the multiple and overlapping links within and across organizations (e.g. through reciprocated referral and case coordination where there is integration among providers that serve clients) that compose the core network that contributes to intensive integration, rather than the core network in and of itself. “[Through multiple and overlapping links, multiplex integration occurs because clique members learn a great deal about each other, and ideas developed in one cluster can be built on by others. This minimizes their transaction costs while establishing working relationships built on norms of cooperation and trust”] (Larson, 1992; Uzzi, 1997 in Provan & Sebastian, 1998). Other organizations that are more loosely linked to these cliques can also benefit, as learning is disseminated, contributing to the effectiveness of the entire network” (Larson, 1992; Uzzi, 1997 in Provan & Sebastian, 1998).

This points to the need to understand networks in a more microanalytic way (e.g. at the level of the client or customers and professional staff members that serve clients) than has been done previously, in order to understand network effectiveness (Provan & Sebastian, 1998). Multiplex, reciprocal ties among small network subgroups can be very effective and this has implications for network development and governance (e.g. focus on building and maintaining intensive integration among cliques of key member organizations, who will then have ties to other members rather than on attempting to loosely integrate entire networks) (Provan & Sebastian, 1998).

7.7 Role and Value of Voluntary Networks in LHINs

If successful, voluntary networks will play a key role in building capacity within and across organizations in the health sector and other sectors, that will lead to improved integration, coordination and the health and well being of individuals and communities. The previous sections illustrate the complexity of networks and their development. While this summary is not based on an exhaustive study of networks, the insights and observations suggest that LHINs on their own will not achieve integration or improve health. Integration and health improvement involves participants from diverse organizations, geographic areas and systems coming together.

LHINs working together with voluntary networks, including the sub-groups within networks, are vehicles for achieving different levels of integration (governance, administrative, clinical). Voluntary networks and their sub-groups will serve as the foundation for integration as LHINs develop. They serve as important resources to providers in terms of ensuring that community needs are met, providing an opportunity for continuous learning and facilitating change quickly because participants are connected to community. To this end, government should be aware of the power of integration that is already occurring locally and build on this. No one structure will achieve integration.

Recognizing the critical role that voluntary networks play in facilitating integration the LHIN should:

- Conduct an inventory of existing networks including local, regional and provincial (see Appendix C for a preliminary list of Networks that Mississauga-Oakville providers are involved in)
- Conduct an environmental scan identifying the role, function, deliverables and effectiveness of existing networks
- Recognize that there are many success stories within, across and beyond the Mississauga-Oakville LHIN. Identify these successes and seek opportunities to learn from them
- Engage local communities
- Develop network principles consistent with LHIN mandate
- Recognize that networks require support; determine the resources required to support networks and allocate those resources
- Recognize that most networks are based on long histories of collaboration

8.0 Next Steps

The members of the Mississauga-Oakville LHIN Steering Committee are strong supporters and advocates of the development of Local Health Integration Networks to the extent that they will enable and facilitate the long-term goals of integration. Collectively, the members have spent literally hundreds of hours developing their individual integration opportunities and the other components of this report. As such, they are very committed to ensuring that their work is of value to the LHIN Board and CEO and ultimately leads to improvements in the health care system.

While completion of this report marks the conclusion of the Steering Committee's mandate, the members expressed a strong desire and willingness to meet with the Board and CEO once these positions have been finalized. The purpose of this meeting would be to ensure that there is a good understanding of the integration opportunities presented in this report and to share the excitement and renewed commitment all share regarding the development of a health system that is more person-centred and responsive to the needs of the residents.

The members of the Steering Committee appreciate the opportunity to be involved in the process of helping to shape the future health system and look forward to opportunities for continued involvement.

Appendix A – Central West LHIN Steering Committee Agendas / Minutes / Materials



Mississauga-Oakville LHIN
Priority Integration Opportunities
Steering Committee

Meeting Agenda

Thursday December 16, 2004
9:00 a.m. – 11:00 a.m.

Halton-Peel District Health Council
Suite 600, 6711 Mississauga Road
(see attached instructions)
Board Room

#	Agenda Category / Item	Lead	To be Accomplished	Time
1.	Welcome and Agenda Review	Scott McLeod	To welcome, introduce members, and review and approve the agenda.	2 min
2.	Overview of the Resource Guide and the Deliverable	Scott McLeod/ ALL	To briefly review the content of the Resource Guide To review and discuss the specific deliverable due to the Ministry February 14, 2005	15 min
3.	Role of the Steering Committee	Scott McLeod / ALL	To discuss and reach consensus on the role of the Steering Committee in completing the deliverable To discuss and reach consensus on the general approach to completing the work; the principles, assumptions, process, level of consultation, template etc	20 min
4.	Report from Planning Leads	All	To briefly hear from the Planning Leads for each of the 10 prioritized integration opportunities, their thoughts on completing the task	50 min
5.	Work plan for the steering Committee	Scott McLeod/ ALL	To reach consensus on key milestones and meeting schedule for completing the deliverable on schedule	20 min
6.	Wrap-up and Adjournment	Scott McLeod	Summarize action items, identify agenda items for future meetings, and meeting schedule.	2 min



**Mississauga-Oakville LHIN
Priority Integration Opportunities
Steering Committee**

Meeting Agenda

Thursday January 20, 2005
9:00 a.m. – 12:00 noon

Halton-Peel District Health Council
Suite 600, 6711 Mississauga Road
(see attached instructions)
Board Room

#	Agenda Category / Item	Lead	To be Accomplished	Time
1.	Welcome and Agenda Review	Scott McLeod	To welcome, introduce members, and review and approve the agenda.	5 min
2.	Minutes of the December 16, 2005 Meeting (Attached)	Scott McLeod	To review and approve the minutes of the last regular meeting and provide updates on action items not covered elsewhere in the agenda.	10 min
3.	LHIN Community Planning Forum	Scott McLeod / ALL	To provide a de brief on the Community Planning Forum held by the LHIN planning team with all of the planning contacts	10 min
4.	Presentation of Priority Integration Opportunities	Appropriate Planning Contacts	To present 5 or more of the draft priority integration opportunities and the high level work plan. Each planning team will be provided with approximately 10 minutes to share their draft document To provide an opportunity for members to offer possible enhancements / clarification.	75 min
5.	Update on Priority Integration Opportunities in progress	Appropriate Planning Contacts	To receive an update from the planning contacts for opportunities that are in the process of being finalized. To discuss and clarify any questions that planning contacts may have,	15 min
6.	Demographic Profile	Chris Altmayer	To provide an update on the status of the demographic profile. To brainstorm some of the unique characteristics of the LHIN that are	20 min

#	Agenda Category / Item	Lead	To be Accomplished	Time
			known and need to be addressed in the submission.	
7.	Voluntary Networks	Jane Richardson / Elaine Kachala	To provide a brief overview of the draft that has been prepared to address the important role of voluntary networks in the LHIN.	20 min
8.	Work plan for the Steering Committee	Scott McLeod/ ALL	To review the work plan for completing the deliverable and make any adjustments as required.	10 min
9.	Wrap-up and Adjournment	Scott McLeod	Summarize action items and next steps	5 min

The Next Meeting is scheduled for February 3, 2005 from 9:00 am – 12:00 noon



Mississauga-Oakville LHIN
Priority Integration Opportunities
Steering Committee

Meeting Agenda

Thursday February 3, 2005
9:00 a.m. – 12:30 p.m.*
(note – changed adjournment time)

Halton-Peel District Health Council
Suite 600, 6711 Mississauga Road
Board Room

#	Agenda Category / Item	Lead	To be Accomplished	Time
1.	Welcome and Agenda Review	Scott McLeod	To welcome members, and review and approve the agenda.	5 min
2.	Minutes of the January 20, 2005 Meeting (Attached)	Scott McLeod	To review and approve the minutes of the last regular meeting and provide updates on action items not covered elsewhere in the agenda.	10 min
3.	Presentation of Priority Integration Opportunities	Darlene Holowachuk / Ehsan Sharif Lawna Paulos / Lynn Harrett	To present the 2 remaining priority integration opportunities and the high level work plan. To provide an opportunity for members to offer possible enhancements / clarification. To reach consensus on final date for submission of completed templates for consolidation.	60 min
4.	Voluntary Networks	Jane Richardson / Elaine Kachala	To review and reach consensus on the draft that has been circulated to address the important role of voluntary networks in the LHIN.	20 min
5.	Demographic Profile	Chris Altmayer	To review and reach consensus on the draft content for the Demographic Profile	15 min
6.	Unique characteristics	Jane Richardson / Elaine Kachala	To review and reach consensus on the draft content for the overview of unique characteristics of the LHIN.	15 min
7.	Transformational Thinking	Scott McLeod	To brainstorm the transformational thinking and process that has guided our approach including:	40 min

#	Agenda Category / Item	Lead	To be Accomplished	Time
			<ul style="list-style-type: none"> ➤ approach to the task ➤ key learning's from the process ➤ organizations that have been involved 	
8.	Structure of the Final Report	Scott McLeod	To reach consensus on the proposed structure of the final report.	20 min
9.	Work plan for the Steering Committee	Scott McLeod/ ALL	To review the work plan for completing the deliverable and make any adjustments as required.	10 min
10.	Wrap-up and Adjournment	Scott McLeod	Summarize action items and next steps	5 min

Mississauga-Oakville LHIN Priority Integration Opportunities Steering Committee Minutes

Thursday December 16, 2004 9:00 a.m. – 11:00 a.m.	Halton-Peel District Health Council Boardroom
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PRESENT:	REGRETS:
Raymond Applebaum, Peel Senior Link Jannine Bolton, RNAO Angela Brewer, VON Halton Marg DiCesare, Saint Elizabeth Health Care Carmen DiMauro, Extendicare Mississauga Jasmin Earle, Saint Elizabeth Health Care Lynn Harrett, Etobicoke & York CCAC Darlene Holowachuk, YMCA Greater Toronto Natalia Lishchyna, Mississauga Physical Rehab Centre Cindy McDonell, Halton Healthcare Services Scott McLeod, Halton-Peel District Health Council Ron Noble, The Credit Valley Hospital Lawna Paulos, Nucleus Independent Living Jane Richardson, Halton-Peel District Health Council Laurie Ridler, Supportive Housing in Peel Maria Sewell, Independent Living Halton Jacqie Shartier, Hope Place Women’s Treatment Centre	Janet Doering, CCAC of Halton Allan Halls, Halton Healthcare Services Cathy Hecimovich, CCAC of Halton Chris Power, Trillium Health Centre David Rowe, The Credit Valley Hospital Eshan Sharif, Integrated Mobile Crisis Programme of Peel

1. Welcome and agenda review

Scott McLeod welcomed the Steering Committee to its inaugural meeting. Round table introductions were facilitated and members introduced themselves. To assist in facilitating the steering committee work and related processes, Scott McLeod introduced Jane Richardson, a senior health planner, at the DHC.

Planning contact information was circulated and updated as necessary by members.

The agenda was approved as circulated.

2. Overview of the resource guide and the deliverable

3. Role of the Steering Committee

Given the natural relationship between these two agenda items, they were combined.

Scott provided an overview of the resource guide and deliverable (presentation slides circulated at meeting). Based on discussion at the meeting, the possible work plan for the Steering Committee (slides 19 & 20 of the PowerPoint presentation) was amended as follows:

Local Opportunities for Health System Integration

Ideas / Template	Task Recommended	Lead	Timeline
For the 19 ideas that were not prioritized as the top 10 at the workshop (excluding 10 priorities)	These templates are required to be completed for all ideas generated at the workshop. There are differences between Templates A & B and those used at the workshop to capture ideas		
Template A & B: Description of patient care / services and administrative support services integration opportunity	Cut and paste content developed at the workshop into the applicable template (A or B)	DHC	Nov – Jan 10
	Circulate to originator to add/confirm	DHC	Jan 10
	Originator to review and sign off	Originator	Jan 10 – Jan 18
For the 10 integration priorities	There was agreement that Template A / B should be combined with Template C (natural relationship)		
Template A & B Template C	Circulate combined Template A/B & C to planning leads (Word-based)	DHC	Dec 22
	Planning leads complete combined template through, at a minimum, consultation with: <ul style="list-style-type: none"> - Those who were participated in the initial idea generation - Those who were in the group when planning leads were identified (at the end of the workshop) <p>It was suggested that leads may wish to complete a draft of the template and seek consultation input (as it may be easier to provide something for people to react, comment on rather than starting from scratch)</p> <p>Other avenues for consultation, at the discretion of the planning leads, include</p> <ul style="list-style-type: none"> - Relevant provincial associations, local groups, committees, networks 	Planning leads	Dec 22 – Feb 2
	Completed templates are due	Planning leads	Feb 3

Ideas / Template	Task Recommended	Lead	Timeline
Description of unique characteristics of the LHIN and existing Networks Template D	Templates are presented to Steering Committee	Planning leads	Jan 13, Feb 3
	Obtain additional demographic data and develop profile	DHC	Dec 1 – Jan 21
	Steering Committee to provide feedback regarding demographic profile	DHC	Jan 22 – Feb 3
	Confirm demographic profile	Steering	Feb 3
	Solicit input from Steering Committee regarding unique characteristics.	DHC	Dec 22
	Confirm unique characteristics	Steering	Jan 13
	Draft information on role of Networks	DHC	Jan 6
Description of the transformational thinking and process that guided the group Template E	Confirm role of Networks	Steering	Jan 13
	Summarize and discuss at the last Steering Committee meeting	Steering	Feb 3
	Pull all report components together	DHC	Feb 3 – 11
	Circulate to steering committee for review	DHC	Feb 11
All templates	Steering committee review	Steering	Feb 11 – 14
	Submit final report	Steering	Feb 16

In addition to those suggestions and input that were incorporated into the revised template, the following were key points raised during the discussion:

- Means for consultation regarding the 10 priority integration opportunities should not be limited to face-to-face meetings – email and reviewing relevant reports are additional means of receiving input when completing Template C
- Rather than focus on identifying and listing all relevant networks, Template D should define the different types of Networks (voluntary versus mandatory, key examples) along with highlighting the inherent value and role these groups can bring to integration activities. Suggestions could be made as to how the LHIN could use these Networks, along with recognition of the potential impact that the LHIN geography has on cross-LHIN Networks. It was also suggested that planning leads consider noting the possible role of local Networks / groups as a step within their action plan.
- It was recommended that the final report (perhaps in Template E) that the Halton-Peel DHC, in its role as host / facilitator / secretariat to the Steering Committee, be acknowledged as important to facilitating task completion.
- Planning leads may wish to review priority opportunities in other LHIN areas and connect with leads of similar ideas

4. Report from planning leads

5.

Integration Priority	Planning Leads	Status	Key discussion points
Fair funding: Population-based funding	Ron Noble Allan Halls	Planning leads have met	The Steering Committee confirmed that this priority should be interpreted as fair funding for the Mississauga Oakville LHIN, rather than how the funding is distributed between agencies within the Mississauga Oakville LHIN (which will be the responsibility of the LHIN).
Continuum of care	Lawna Paulos Lynn Harnett	Planning leads have met	Process maps will help shape this priority. Rather than tackle the full topic scope, 3 –4 specific projects will be identified that are “ready to go”, but aren’t currently funded. Also 3 – 4 systems projects (over time) will also be identified.
Mental health and addictions service delivery	Darlene Holowachuk Ehsan Sharif	Email sent out to participants in small group discussion at LHIN workshop	Hosting a meeting in January with interested providers / individuals
Integration of links to primary health care services	Chris Power Natalia Lishchyna	Planning leads have met	Draft action plan has been completed. Has been circulated to those who were in the small group when planning leads were identified.
Bridging health care delivery: Hospitals to community support services	Angela Brewer Cindy McDonnell Jannine Bolton	Planning leads have connected	
Electronic health records	Jasmin Earle Scott McLeod	Planning leads have connected	Planning leads have reviewed personal notes relative to discussion notes
Creating a culture of common knowledge	Maria Sewell Raymond Applebaum	Planning leads have met	Preliminary action plan steps have been scoped out.
Innovation in health service delivery models to maximize human resources	Janet Doering Marg DiCesare	Planning leads have met	Email sent with key questions to those who participated initial idea generation + those who were in the group when planning leads were identified. Meeting scheduled for first week in January. Model for discussion has been developed.

Local Opportunities for Health System Integration

Additions and mental health integrated through client centred care models	Jacqie Shartier Laurie Ridler	Planning leads have met	Dates have been set to meet with specific stakeholders / individuals
Enhanced partnerships between LTC, hospitals, CCACs and clients	Cathy Hecimovich David Rowe Carmen DiMauro	Planning leads have connected	

6. Work plan for the Steering Committee

The next two Steering Committee meetings were confirmed as follows:

- January 13, 2005
- February 3, 2005

Both meetings will be from 9:00 a.m. to 12:00 noon at the Halton-Peel District Health Council.

7. Wrap-up and adjournment

The meeting was adjourned at 11:00 a.m.

Mississauga-Oakville LHIN Priority Integration Opportunities Steering Committee Minutes

Thursday January 20, 2005 9:00 a.m. – 12:00 noon	Halton-Peel District Health Council Boardroom
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PRESENT:	REGRETS:
Jannine Bolton, RNAO Angela Brewer, VON Halton Marg DiCesare, Saint Elizabeth Health Care Carmen DiMauro, Extendicare Mississauga Allan Halls, Halton Healthcare Services Darlene Holowachuk, YMCA Greater Toronto Natalia Lishchyna, Mississauga Physical Rehab Centre Cindy McDonell, Halton Healthcare Services Scott McLeod, Halton-Peel District Health Council Ron Noble, The Credit Valley Hospital Jane Richardson, Halton-Peel District Health Council Laurie Ridler, Supportive Housing in Peel Eshan Sharif, Integrated Mobile Crisis Programme of Peel Jacqie Shartier, Hope Place Women’s Treatment Centre	Raymond Applebaum, Peel Senior Link Janet Doering, CCAC of Halton Jasmin Earle, Saint Elizabeth Health Care Lynn Harrett, Etobicoke & York CCAC Cathy Hecimovich, CCAC of Halton Chris Power, Trillium Health Centre David Rowe, The Credit Valley Hospital Lawna Paulos, Nucleus Independent Living Maria Sewell, Independent Living Halton

1. Welcome and agenda review

Scott McLeod welcomed the Steering Committee to its second meeting.

A press release regarding the closure of District Health Councils as of March 31st was circulated. Despite this announcement, it was noted that the DHC is committed to working with the Steering Committee to complete the final report for submission on February 16th.

The agenda was approved as circulated.

2. Minutes of the December 16, 2004 meeting

The minutes were approved as circulated.

3. LHIN Community Planning Forum

A number of members attended the Provincial LHIN Planning Forum held in Toronto on January 12th and 13th. Materials from this meeting are available on-line at www.prioritysetting.ca (password: LHIN)

Comments regarding the forum included:

- Appreciated the chance to explore intra-LHIN opportunities, but felt that the discussion was positioned such that people could introduce new priority areas
- E-room is a good resource to facilitate sharing of materials www.prioritysetting.ca/eroom
- Forum was an opportunity for continued community involvement
- Concern regarding LHIN boards and possible limited understanding of health and the local community (i.e. providers are not eligible for appointment, nor are individuals that sit on boards of provider organizations)
- While board directors will be “voluntary”, a stipend of \$7,000 - \$10,000 may be available

4. Presentation of Draft Priority Integration Opportunities

Eight priority opportunities were presented (draft materials circulated at the meeting; faxed to those not in attendance):

Fair funding: A population, needs-based funding formula to ensure equitable funding for LHINs

Ron Noble / Allan Halls: Draft template circulated to list of partners involved for comment. A question raised to the Steering Committee was whether the action plan should focus on tasks/actions for the first year or multi-years. It was suggested that the initial focus should be on how the LHIN gets “fair” funding, with the longer-term focus on equity between sectors within the LHIN. It was noted that equitable and fair are not synonymous.

Enhanced partnerships between LTC, hospitals, CCAC and clients / families

Carmen DiMauro: Draft template circulated to list of partners involved; feedback received from 5 individuals.

Bridging health care delivery from hospitals to community care and support services

Angela Brewer, Cindy McDonnell, Jannine Bolton: Will add to the high level action plan: creation of a group / committee to ensure community input and involvement; opportunity to measure outcomes.

Addictions and mental health integrated through innovative client centred care models

Laurie Ridler, Jacqie Shartier: To ensure consistency between priority opportunities related to mental health and addictions, a meeting with the other co-leads is scheduled. Partners listed not limited to those involved at the workshop meeting. Co-leads did not receive the template; Jane to forward onto Laurie so text can be inserted into template.

Integration of and links to primary health care services

Natalia Lishchyna: Draft template circulated to list of partners involved. It may be more appropriate to list this integration as horizontal rather than intersectoral. Will add to the high level action plan the creation of a group / committee to ensure community input and involvement.

Electronic health record to promote effective service delivery and optimize client self care

Scott McLeod: Draft template to be circulated to partners involved.

Innovation in service / care delivery models to maximize human resources across the continuum

Marg DiCesare: Draft template to be circulated to list of partners involved. It was suggested that opportunities for pilot projects to showcase / explore innovation in human resources should be added to the high level action plan.

Creating a culture of common knowledge and appreciation for the critical role of community support services amongst all

Draft template has been circulated to the list of partners involved. Steering Committee members were asked to forward on any comments to Ray Applebaum by January 28th.

It was recommended that all high level action plans include a committee / group to ensure community involvement in the integration priority.

There are many common themes / key messages beyond the specific integration priorities (i.e. community involvement is critical, equity across sectors). It was suggested that these be included in the report, perhaps as an introduction.

5. Update on priority integration opportunities in progress

The following two priorities will be presented at the next Steering Committee meeting:

Mental health and addiction service delivery – Darlene Holowachuk, Ehsan Sharif
Continuum of care: Lawna Paulos, Lynn Harrett

6. Demographic profile & unique characteristics

The DHC continues to work with the Ministry to obtain the data parameters needed to create a demographic profile for the Mississauga-Oakville LHIN.

Further to the unique characteristics circulated previously, the following were additional suggestions for the Mississauga-Oakville LHIN:

- No academic teaching centre, including affiliated programs such as Regional Geriatric Programs
- Low localization index
- Mississauga is designated under the French Language Services Act
- Significant deaf population in Milton (E.C. Drury High School)
- Significant correctional population in Milton (Vanier Centre for Women and Maplehurst Correctional Complex)
- Alignment with regional and municipal boundaries

7. Voluntary Networks

Based on discussion at the last Steering Committee meeting, Elaine Kachala at the Halton-Peel DHC developed a brief overview of Networks, their role and importance to the LHIN. This draft was circulated and it was suggested that the document also be sent electronically to all members, with any suggestions or changes to be forwarded to Jane by January 27th.

8. Work plan for the Steering Committee

The work plan as outlined in the December 16th meeting minutes was briefly reviewed.

9. Wrap-up and adjournment

The next Steering Committee meeting is scheduled on Thursday February 3rd from 9:00 a.m. to 12:30 p.m. at the Halton-Peel DHC.

The meeting was adjourned at 12:00 noon

Mississauga-Oakville LHIN Priority Integration Opportunities Steering Committee Minutes

Thursday February 3, 2005 9:00 a.m. – 12:30 p.m.	Halton-Peel District Health Council Boardroom
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PRESENT:	REGRETS:
Chris Altmayer, Halton-Peel DHC	Carmen DiMauro, Extendicare Mississauga
Raymond Applebaum, Peel Senior Link	Janet Doering, CCAC of Halton
Jannine Bolton, RNAO	Lynn Harrett, Etobicoke & York CCAC
Angela Brewer, VON Halton	Cathy Hecimovich, CCAC of Halton
Marg DiCesare, Saint Elizabeth Health Care	Chris Power, Trillium Health Centre
Jasmin Earle, Saint Elizabeth Health Care	
Allan Halls, Halton Healthcare Services	
Darlene Holowachuk, YMCA Greater Toronto	
Natalia Lishchyna, Mississauga Physical Rehab Centre	
Cindy McDonell, Halton Healthcare Services	
Scott McLeod, Halton-Peel District Health Council	
Ron Noble, The Credit Valley Hospital	
Lawna Paulos, Nucleus Independent Living	
Jane Richardson, Halton-Peel District Health Council	
Laurie Ridler, Supportive Housing in Peel	
David Rowe, The Credit Valley Hospital	
Eshan Sharif, Integrated Mobile Crisis Programme of Peel	
Jacqie Shartier, Hope Place Women's Treatment Centre	
Maria Sewell, Independent Living Halton	

1. Welcome and agenda review

Scott McLeod welcomed the Steering Committee to its third and final meeting.

The agenda was approved as circulated.

2. Minutes of the January 20, 2005 meeting

The minutes were approved as circulated.

3. Presentation of Priority Integration Opportunities

The two final priority opportunities were presented (circulated at the meeting):

Mental health and addiction service delivery enhanced through an integrated seamless cross-sectorial approach

Darlene Holowachuk / Ehsan Sharif: A joint meeting with the other priority integration opportunity pertaining to mental health and addictions was held on January 25th, hosted by the 4 co-leads and attended by interested parties. It was suggested that consideration of job opportunities for mental health and addictions survivors be added to the action plan. It was agreed that this would be more appropriate for inclusion in integration priority # 14 (Addictions and Mental Health Integrated Through Client Centred Care Models).

Building a continuum of care that ensures the right care, at the right time, in the right place

Lawna Paulos: Within the action plan, it was suggested that engagement of the community should be tied to influence on change. Under current status, it was suggested that additional examples be included as there has already been a lot of work undertaken in this area.

10. Voluntary Networks

Jane Richardson provided an overview of the Network document circulated at the January 20th meeting (PowerPoint slide overview circulated at the meeting). It was suggested that an inventory of existing networks, groups, committees be attached to the final report to provide context to Template D. Scott McLeod agreed to circulate a listing used by the DHC, with members to provide additions to the document by Tuesday February 8th. It was stressed that this list is not meant to be comprehensive but rather a sample.

Other suggestions include noting in the document the different types of networks (local, regional, provincial) and the important roles each type plays in the health system.

11. Demographic Profile

Chris Altmayer, Epidemiologist at the Halton-Peel DHC, provided an overview of data relevant to the Mississauga-Oakville LHIN (presentation slides circulated at the meeting). Getting data has and will continue to be a challenge as the LHIN geography is not in alignment with existing data sources. For example, some of the data presented by Chris are LHIN-specific, other are municipal or regionally-based. It was suggested that one of the common themes to be noted in the final report is the importance of having accurate and accessible data.

12. Unique Characteristics

Jane Richardson circulated a “straw dog” outlining unique characteristics of the Mississauga-Oakville LHIN. Members provided several good suggestions regarding those characteristics already outlined – these will be incorporated into the final report and are noted below:

- Related to population growth and demographic change is the lack of appropriate per capita funding
- The health human resource challenges is not limited to physicians, but also includes nurses and personal support workers
- Transportation is an important example of infrastructure
- Emergency services should also include issues related to EMS
- Include reference to all of the work that has already been completed on the Local Opportunities for LTC Facility Capacity
- Create a combined section titled unique facilities and outline those provincial resources that are located in Mississauga-Oakville

7. Transformational Thinking

Scott facilitated a brainstorming of key learnings as well as outlining our approach to the task (see the final report – section 2.2. for an overview of key discussion points)

8. Structure of the Final Report

It was agreed that the final report would be structured as follows:

- Introduction / context
- Process and transformational thinking
- Demographic profile
- Unique characteristics
- Priority integration opportunities
- Common themes
- Important role of Networks
- Next steps
- Appendix – including those integration opportunities that were not prioritized

9. Work Plan for the Steering Committee

The work plan as outlined in the December 16th meeting minutes was briefly reviewed. It was noted that despite the tight timeframe, timelines were generally adhered to.

10. Wrap-up and adjournment

Co-leads agreed to submit finalized idea templates and action plans to Scott and / or Jane by February 7th. The DHC will endeavour to forward the draft report to the Steering Committee on Friday February 11th, with any comments and feedback to be submitted by Monday February 14th.

The meeting was adjourned at 12:40 p.m.

Appendix B – Non-priority Integration Opportunities

Consistent with the commitment at the Central West LHIN Workshop, all of the ideas that were not prioritized were reformatted into the new template and forwarded to the originator to review and add any additional information or details missing. While the originator was encouraged to add any new information, they were requested to remain true to the original discussion at the Workshop.

This appendix includes all of those documents that were not prioritized at the November 30th Workshop

#	Non-Priority Integration Opportunity	Page #
1	We must remember that the individual is key to any integration model. Be “people” centred.	75
2	Safety and security and health	76
3	Vertically integrated multidisciplinary hospice palliative care teams/ Continuum of Hospice Palliative Care	77
6	In order to achieve effective and efficient integration, the LHIN boundaries for Halton Region must be changed and Halton Region must be contained within ONE LHIN.	78
7	Incorporating population health into the transformation agenda	79
9	Standardization of expected outcomes	80
12	System’s Navigation/Access to Information	81
16	LHIN Community Advisory Committee	82
17	Identification of available health care resources	84
18	Imputabilite Envers Les Services De Sante En Francais	85
19	Access to transportation for both Community Services and Clients	86
20	Shared Administrative Services	87
24	Integration of Children’s Health Services Across the Full Continuum (from prenatal, health promotion, and early identification to protection, justice and tertiary care)	88
25	Co-ordinated Emergency Preparedness Plans across LHIN and Regional boundaries	89
26	Functional Ability Data System	90
27	Access to services – cultural sensitivity and equity	91
28	Health Human Resources: Who do we need, how many do we need, how do we recruit/retain them?	93
29	Long-Term Community Support for Adults with Cognitive Behavioural Needs	95

Title of initiative:		Type of integration (more than one box can be checked)									
# 1 We must remember that the individual is key to any integration model. Be “people” centred.		<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 type="checkbox"/> Initiated / existing integration activity* <input checked="" type="checkbox"/> New integration opportunity <small>* Note initiated / existing activities do not need to be confined within LHIN boundaries</small>		Participants at the Workshop <table border="0"> <thead> <tr> <th style="text-align: left;">NAME</th> <th style="text-align: left;">ORGANIZATION</th> </tr> </thead> <tbody> <tr> <td>Carolyn Clubine</td> <td>Tall Pines Long-Term Care Centre</td> </tr> <tr> <td>Melanie Stone</td> <td>MS Society</td> </tr> <tr> <td>Nancy Milne</td> <td>MS Society</td> </tr> </tbody> </table>		NAME	ORGANIZATION	Carolyn Clubine	Tall Pines Long-Term Care Centre	Melanie Stone	MS Society	Nancy Milne	MS Society
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Melanie Stone	MS Society										
Nancy Milne	MS Society										
Brief description of the initiative											
<p>All decisions run through the filter of “how does this work for, focus on, and impact the client”.</p> <p>The system must be simple enough that people can advocate for themselves and find resources/care they need without requiring outside advocacy and huge navigational help.</p> <p>It is a priority because health care is about the individual.</p>											
Current Status (If this is an initiated/existing activity)		Outcomes / lessons learned (if any)									
Lead contact person											
Name Nancy Milne Title Executive Director Telephone 905-278-6186		Organization: MS Society, Mississauga Chapter e-mail address: info.mississauga@mssociety.ca									

Title of initiative:		Type of integration (more than one box can be checked)					
#2 Safety and security and health		<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					
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NAME	ORGANIZATION						
Not Identified	ATK Care Inc.						
Brief description of the initiative							
<p>Since we have only ten million people in the province and have more than 400 communities and have more than 300 police force, the idea of a LHIN could be used for the safety and security of all the citizens of this province in a very cost effective way for many years to come.</p> <p>It is a priority because since September 11th safety and security has become top priority in people's minds and it will be very difficult to tackle this issue by a small police force.</p>							
Current Status (If this is an initiated/existing activity)		Outcomes / lessons learned (if any)					
Lead contact person							
Name Not Identified		Organization:					
Title		e-mail address:					
Telephone							

Title of initiative:		Type of integration (more than one box can be checked)																			
# 3 Vertically integrated multidisciplinary hospice palliative care teams/continuum of Hospice Palliative Care		<input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:																			
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Brief description of the initiative																					
<p>Based on the Canadian Hospice Palliative Care Model to Guide Care (CHPCA) and the MOHLTC End of Life Strategy, the idea is to develop local multidisciplinary palliative care teams. Recognizing that teamwork is the cornerstone of hospice palliative care; it is essential in ensuring excellence in the provision of care. Currently, this important component of hospice palliative care is not available to all patients and their families. Team composition will vary depending on the disciplines available in any given geographical area or setting of care, but the patient and family/caregiver(s) are a vital part of the team and should be involved in all decisions about care.</p> <p>These Teams;</p> <ul style="list-style-type: none"> ➤ Would be part of the local service delivery model and require support from an end-of-life network that builds both service delivery and system capacity ➤ Assess whether the patient's and family's needs are being met and alter the plan of care when necessary ➤ Develop comprehensive care plans that determine what services and supports are required based on patient/family need ➤ Provide specialized support and expertise to primary care providers including family physicians ➤ Hold team meetings regularly to monitor ongoing patient/family needs ➤ Maintain a central database of patients within a defined geographic area ➤ Vertically integrated across care settings; own home-hospital-LTC-residential hospice, etc. ➤ Multidisciplinary including; physicians, hospice, community and hospital nurses, psycho/social/spiritual care, occupational therapy, physiotherapy, pharmacy, bereavement support, personal support worker, community health organizations, patient/family ➤ Include care for any illness/disease ➤ Provide care from diagnosis to bereavement ➤ Allow for equal access to services outside patient's home eg. day hospice, outpatient palliative care clinics ➤ Improve linkages between disease management (oncology, cardiology, neurology, respirology) and palliative care ➤ Provide support 24/7 <p>Why is it a priority?</p> <ol style="list-style-type: none"> 1. Addresses priorities, increases coordination and timely access to palliative care services for patients and families 2. Provides opportunities for collaboration and consultation that benefit the patient/family thereby: <ul style="list-style-type: none"> • Reducing admissions and length of stay in acute care hospitals • Reducing visits to emergency rooms 3. Provides a forum for problem solving 4. Flexibility of team allows quicker response to patient/family needs 																					
Current Status (If this is an initiated/existing activity)		Outcomes / lessons learned (if any)																			
Lead contact person																					
Name Diane Reid Title Co-ordinator Telephone 905-827-8111		Organization: Halton Peel Palliative Care Initiative e-mail address: dreid@vonhalton.ca																			

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Valerie Cook	Red Cross																											
Brief description of the initiative																												
<p>In order to continue to improve and expand Halton's integration efforts, the proposed boundaries must be re-aligned to reflect the boundaries of Halton's community based agencies and government delivered services. The proposed 3 LHIN boundaries for Halton have great potential to dismantle current integration initiatives and hinder future possibilities.</p> <p>Other provincial ministries are promoting integration of services with health services, such as MMAH, MOH and MCYS and MCSS. Many of these initiatives, such as the Community Rental Housing Program and the Best Start Program will be hampered in their integration efforts if the LHIN boundaries remain as proposed – fractured and cumbersome. Other examples include emergency planning, pandemic planning, a seamless co-ordination between acute care and long-term care.</p> <p>This is a major priority because administrative costs and efforts would be increased and require significant duplication of efforts in order to move anything forward. Already Halton agencies have had to participate in 3 different LHIN consultations.</p>																												
Current Status (If this is an initiated/existing activity)		Outcomes / lessons learned (if any)																										
Lead contact person																												
Name Dr. Bob Nosal Title Medical Officer of Health Telephone 905-825-6060, ext. 7806 Name Adelina Urbanski Title Commissioner of Social & Community Services Telephone 905-815-6000, ext. 7094		Organization: Region of Halton e-mail address: nosalb@region.halton.on.ca Organization: Region of Halton e-mail address: urbanskia@region.halton.on.ca																										

Title of initiative:		Type of integration (more than one box can be checked)																							
# 7 Incorporating population health into the transformation agenda		<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 type="checkbox"/> Initiated / existing integration activity* <input checked="" type="checkbox"/> New integration opportunity <small>* Note initiated / existing activities do not need to be confined within LHIN boundaries</small>		Participants at the Workshop <table border="1"> <thead> <tr> <th>NAME</th> <th>ORGANIZATION</th> </tr> </thead> <tbody> <tr><td>Anne Fenwick</td><td>Peel Public</td></tr> <tr><td>Chris Altmayer</td><td>Halton-Peel DHC</td></tr> <tr><td>Christiane Fontaine</td><td>Table de concertation franco en sante</td></tr> <tr><td>David Milovac</td><td>Extendicare</td></tr> <tr><td>Gayle Bursey</td><td>Peel Public Health</td></tr> <tr><td>Jann Houston</td><td>Toronto Public Health</td></tr> <tr><td>Jean McKellar</td><td>The Arthritis Society</td></tr> <tr><td>Karen Shue</td><td>ABI Possibilities/Psychologist</td></tr> <tr><td>Lauraine Woods</td><td>Oakville Kiwanis Meals on Wheels</td></tr> <tr><td>Sharon Mills</td><td>Halton Health Care Services</td></tr> </tbody> </table>		NAME	ORGANIZATION	Anne Fenwick	Peel Public	Chris Altmayer	Halton-Peel DHC	Christiane Fontaine	Table de concertation franco en sante	David Milovac	Extendicare	Gayle Bursey	Peel Public Health	Jann Houston	Toronto Public Health	Jean McKellar	The Arthritis Society	Karen Shue	ABI Possibilities/Psychologist	Lauraine Woods	Oakville Kiwanis Meals on Wheels	Sharon Mills	Halton Health Care Services
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Sharon Mills	Halton Health Care Services																								
Brief description of the initiative																									
<ul style="list-style-type: none"> ➤ To collaborate with other health care and other agency providers in the community to advocate for a stronger health promotion and population health system. ➤ Core components that need to change including: ➤ Adequate funding ➤ Utilizing health promotion and population health expertise ➤ Inspired leadership to move beyond rhetoric and create action ➤ Requires public health expertise in the health results team ➤ Formal liaison with municipalities is required since municipalities have responsibility for determinants of health such as house ie., collaboration on official plan development to ensure healthy communities. ➤ To better address the determinants by integrating a range of agencies and community group/members who play a role in housing, food, employment, etc. to make a more population-based health system. ➤ In order to slow the health care costs we need to focus on prevention to reduce illness and this will therefore decrease health care costs. This is a fundamental premise of population health. ➤ To be "person centred" you need to collaborate broadly, beyond the health care sector, to systems such as schools, recreation programs, etc. A population health approach enables a person to navigate the health care system easily and prevent illness by making it easier to make healthy choices. ➤ At a LHIN level you can more effectively influence policy changes such as tobacco at the LHIN and provincial level. ➤ If you use a population health approach you will incorporate issues of cultural diversity which is a key to this LHIN (and others). 																									
Current Status (If this is an initiated/existing activity)		Outcomes / lessons learned (if any)																							
Lead contact person																									
Name Jan Houston		Organization: Toronto Public Health																							
Title		e-mail address:																							
Telephone																									

Title of initiative:		Type of integration (more than one box can be checked)	
# 9 Standardization of expected outcomes.		<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 type="checkbox"/> Initiated / existing integration activity* <input checked="" type="checkbox"/> New integration opportunity <small>* Note initiated / existing activities do not need to be confined within LHIN boundaries</small>		Not available	
Brief description of the initiative			
<p>LHIN would have defined performance specifications attached to their service contracts with providers (public health, LTC, community care, hospitals) that are based on standards that consistently apply across the province. The performance specs describe who provides the service, how it is provided, where it is provided, when it is provided, and at what cost. Development of standards is a provincial responsibility, relying on local input from all LHINs. The standards are evidence-based, client focused, outcome oriented, and are continually refined through an iterative CQI evaluation process. Expectations of access, quality, and cost effectiveness are known to both provider and consumer communities.</p> <p>Measurable standards enable quality assurance, and recognition and reward for superior outcomes.</p> <p>As we change from a centralized system, with existing provincial standards in many areas, it is necessary to retain standards of consistency and minimum expectations. LHINs have an excellent opportunity to apply CQI to the entire system, because their role as funder of the local system allows them to define performance expectations and continually promote better practice by all providers in the system.</p>			
Current Status (If this is an initiated/existing activity)		Outcomes / lessons learned (if any)	
Lead contact person			
Name Brent Chambers Title Director in H.C. Partnerships Telephone 905-257-9882		Organization: North Ridge LTC Facility e-mail address: brentchambers@cplodges.com	

Title of initiative: #16 LHIN Community Advisory Committee		Type of integration (more than one box can be checked) <input checked="" type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input checked="" 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 <small>* Note initiated / existing activities do not need to be confined within LHIN boundaries</small>	List of Partners involved	
	NAME Benoit Long Carole Jones Carole Ward Gerald Park Janet Doering Lyette Lacroix Tony McEvenue	ORGANIZATION Trillium Health Centre Canadian Red Cross Peel CCAC of Halton VON Halton CCAC of Halton Southern Health Network Canadian Mental Health Assoc.
Brief description of the initiative		
<p>The LHIN Board will be an OIC appointed skills based Board. Having a LHIN community advisory committee (CAC) will ensure that LHIN decisions have the benefit of community input and advice. Credibility of the LHIN Board will also be enhanced. Provides a venue for ongoing community input and advice to the LHIN Board</p> <p>Proposed LHIN CAC Membership</p> <p><u>Provider Sector</u></p> <ul style="list-style-type: none"> ➤ Health Promotion/Prevention/Primary Care ➤ Acute – hospitals ➤ LTC – LTC homes ➤ Community agencies ➤ Caregivers <p><u>Public</u></p> <ul style="list-style-type: none"> ➤ Clients/patients ➤ Caregivers ➤ Volunteers ➤ General Public <p><u>LHIN Board representation</u> – to ensure continuity between CAC and Board</p> <p>Proposed Principles/Criteria for Establishing the LHIN CAC</p> <ul style="list-style-type: none"> ➤ Equal representation/equal voice ➤ All health sectors represented ➤ Volunteer membership on the CAC (not paid) ➤ Balance of representation prescribed e.g. 40% providers 40%public 20% LHIN Board ➤ Representatives from other sectors e.g. education <p>Specific criteria to be represented:</p> <ul style="list-style-type: none"> ➤ Geographic ➤ Linguistic/ethnic ➤ People with disabilities ➤ Population groups e.g. children, seniors etc ➤ Urban/Rural ➤ CAC could have sub committees to address some these specific criteria. Establishment of sub committees would be based on identified needs. <p>Deliverables of LHIN CAC</p> <p>The LHIN Board will be an OIC appointed skills based Board. Having a LHIN community advisory committee (CAC) will ensure that LHIN decisions have the benefit of community input and advice. Credibility of the LHIN Board will also be enhanced.</p>		

<ul style="list-style-type: none"> ➤ Annual Community Needs Assessment, linked to LHIN Board strategic plan ➤ Ongoing input and advice to the LHIN from a community perspective 	
Current Status (If this is an initiated/existing activity)	Outcomes / lessons learned (if any)
Lead contact person	
Name Carole L. Ward/Janet Doering Title CCAC of Halton Board Vice Chair/ Director Quality and Organizational Development CCAC of Halton Telephone 905-639-5228 X 8920	Organization: Community Care Access Centre of Halton e-mail address: janet.doering@halton.ccac-ont.ca

Title of initiative: # 17 Identification of available health care resources		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 <small>* Note initiated / existing activities do not need to be confined within LHIN boundaries</small>		List of Partners involved	
		NAME Chris Altmayer Cindy McDonell Elizabeth Gill Geraldine Adams Jean McKellar Marion Bascom Wendy McBride	ORGANIZATION Halton Peel DHC Halton Healthcare Cheshier House Streetsville Cheshire House Streetsville The Arthritis Society Oakville Senior Citizens Res. SENECA Seniors Day Program
Brief description of the initiative			
<p>Identification of available healthcare resources across the system.</p> <p>Provide resource availability to healthcare providers across the continuum, through a comprehensive registry of who does what, where and how to contact them. Existing hospital resource tracking system could be expanded to include additional resource data for LTC, community care and community and tertiary hospitals.</p> <p>Providing resource data for all healthcare stakeholders supports vertical integration Provides better information about services available to all Supports patient transfer or repatriation to next level of care</p> <p>Challenges: Access to services is not consistent across the system. As the LHIN's develop, it will be important to clearly establish roles for all healthcare stakeholders and clearly define criteria for services.</p> <p>Key principles:</p> <ul style="list-style-type: none"> ➤ Same level of service available to all citizens ➤ Enhances communication across healthcare sectors ➤ Can potentially avoid gaps and identify duplication ➤ Greater ability to shift resources based on need ➤ Identifies alternative providers and services ➤ Helps to manage service distribution by leveraging economies of scale and critical mass ➤ Can help support a shared services model by defining regional and community roles and create accountabilities for each <p>While outside the scope of this topic, the group also indicated their substantial support for a provincial ambulance system to provide patient transportation between healthcare institutions. The existing municipally funded ambulance model has challenges in supporting services across many borders. A provincially funded, provincially managed ambulance service would be better equipped to manage the unique service needs between healthcare providers for urgent and emergent patients.</p>			
Current Status (If this is an initiated/existing activity)		Outcomes / lessons learned (if any)	
Lead contact person			
Name Shelley Moneta		Organization: Ontario CritiCall Program	
Title Director		e-mail address: moneta@hhsc.ca	
Telephone (905) 575-6260 x388			

Title of initiative: #18 Imputabilite Envers Les Services De Sante En Francais		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 <small>* Note initiated / existing activities do not need to be confined within LHIN boundaries</small>		List of Partners involved	
		NAME Carmen Gauthier Christiane Fontaine Claire P. McCullough Lyette Lacroix	ORGANISATION Comité de gestion, service en français Table de concertation en santé Conseil d'aministration CSC de Peel Réseau franco-santé du Sud de l'Ontario
Brief description of the initiative			
<p>Étant donné que <u>l'individu</u> est au centre de la transformation des soins de santé en Ontario, il est alors primordial d'accorder une importance significative à la langue dans laquelle il reçoit ses soins et services de santé surtout lorsque cette langue est le français, l'une des deux langues officielles au Canada.</p> <p>Les services et soins de santé offerts aux Francophones doivent tenir compte des principes sur lesquels est basée <i>Loi sur les services en français en Ontario</i>. Il faut donc que ces principes soient reflétés au niveau de l'accès, de la qualité et de la permanence des soins et services de santé, de la représentation francophone au niveau des instances décisionnelles et administratives. Pour ce faire il faut développer des indicateurs de performance pour assurer l'imputabilité, la qualité et l'équité.</p> <p>Avec la création des RLISS, c'est le moment opportun de fixer des critères qui permettront entre autres de recueillir des données/statistiques pour guider la planification, le développement, la prestation de soins et services en santé pour les Francophones.</p> <p>Nous constatons présentement plusieurs lacunes au niveau des soins et services de santé offerts aux Francophones de notre région malgré que Mississauga est désignée sous la <i>Loi sur les services en français en Ontario</i>:</p> <ul style="list-style-type: none"> ➤ Il existe très peu de soins et services en français actuellement et ceux qui sont offerts ne sont pas assurés d'une permanence; ➤ Le manque de consultation et de collaboration lors de la planification, du développement et de la mise en place des soins et services en santé pour la communauté francophone ; ➤ Le manque de données/statistiques sur les types de soins et services de santé offerts aux Francophones empêche la planification et le développement de soins et services de santé adéquats. Présentement il n'existe aucun mécanisme permettant de recueillir des données sur la langue des patients qui fréquentent le système de santé, autre que l'anglais. <p>C'est connu que la langue utilisée pour le diagnostic, le traitement et la réhabilitation a un impact sur l'amélioration de la santé du patient (à tous les niveaux). La création des LHIN est donc le moment opportun pour développer des critères qui permettront, entre autres, d'avoir des données/statistiques, des indicateurs de performance pour assurer l'imputabilité, la qualité et l'équité des services offerts à la communauté francophone.</p>			
Current Status (If this is an initiated/existing activity)		Outcomes / lessons learned (if any)	
Lead contact person			
Name Claire P. McCullough Title présidente Telephone 905.820-5361		Organization: Comité gestion, centre de santé communautaire de Peel e-mail address: cpmccullough@rogers.com	

Title of initiative: #19 Access to transportation for both Community Services and Clients		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 <small>* Note initiated / existing activities do not need to be confined within LHIN boundaries</small>		List of Partners involved	
		NAME Barb Abrams Carole Jones Diane Austin Heidi Canivet Sushil Sharma Peel	ORGANIZATION Hospice of Peel Canadian Red Cross Peel Seniors Life Enhancement Centres Seniors Life Enhancement Centres India Rainbow Community Svcs. Of Peel
Brief description of the initiative			
Briefly Describe the Integration Opportunity -Centralized access and delivery of transportation so Community Services can access specialized transportation for clients. -Referral to appropriate Transportation -Partnerships so that funding would be available for those that needed it to be able to purchase transportation from a provider. Provider could be existing i.e. Red Cross -Not all agencies want to be transportation providers, but do need this service for their clients. - Transportation funding must cover all costs associated with provision of service, inclusive of administration costs, insurance, operational and capital costs and uncollectible client fees. - Access to specialized transportation must include those clients who do not qualify for TransHelp – those who require escorts due to memory impairment, behavioral challenges, vision impaired, hearing impaired, mentally challenged.			
Why is it a priority -Public transportation and volunteer transportation programs do not meet the needs of special populations due to the extent of illness, challenging behaviours or physical disability. -There are more outpatient and Day Surgeries -Decentralization of services -Funding does not meet the demand for service. -We can no longer rely on this as a volunteer service. Due to the reduced number of available volunteers and the high cost of liability insurance. -More people are living at home longer with no family support. -If clients cannot access services they can not stay in their homes, therefore will end up institutionalized at greater cost.			
Current Status (If this is an initiated/existing activity)		Outcomes / lessons learned (if any)	
Lead contact person			
Name Carole Jones Title Branch Manager Telephone (905) 890-0704 x239		Organization: Canadian Red Cross Society - Region of Peel Branch e-mail address: carole.jones@redcross.ca	

Title of initiative: #20 Shared Administrative 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 <small>* Note initiated / existing activities do not need to be confined within LHIN boundaries</small>		List of Partners involved	
		NAME Bernard Souche Gayle Bursey John Oliver Lorraine Ladha Lynn Tintse Nicole Steward Scott McLeod Stephen Foreman Tom Valentich	ORGANIZATION Baxter Corp. Region of Peel Health Dept. Halton Healthcare Ont. Hospital Assoc. The Arthritis Society MOHLTC – Lab branch Halton-Peel DHC William Olsen Health Centre MOHLTC Human Services Cluster
Brief description of the initiative			
Create a shared services organization to maximize opportunities for joint activities in the following areas: <ul style="list-style-type: none"> ➤ Supply chain management, e.g. Purchasing/warehousing/distribution/contract management ➤ LHIN-wide e-commerce ➤ LHIN-wide centralized warehousing ➤ Consolidated legal services, e.g. privacy ➤ Business office, e.g. payroll, A/P,A/R ➤ Facilities management and redevelopment ➤ Information Technology ➤ Food services <p>Why is it a priority - Builds collaborative, mutual gain relationships</p> <ul style="list-style-type: none"> ➤ Cost saving opportunities ➤ Builds public trust in business nature of LHIN participants ➤ Can transcend LHIN boundaries and prevent LHIN silos ➤ Focuses management time on clients and patients, not “back office” operations ➤ Can respect organization’s desired level of participation: <ul style="list-style-type: none"> ○ Opt in/opt out provisions ○ Streams of shared activity ○ Menu-driven choices ➤ Standardizes processes and procedures across LHIN ➤ Aggregates volumes for buying transactions and processes ➤ Leverages existing resources ➤ Provides for specialized and enhanced admin resources ➤ Increased opportunity for innovative practices and sourcing capital to standardize LHIN-wide processes 			
Current Status (If this is an initiated/existing activity)		Outcomes / lessons learned (if any)	
Lead contact person			
Name John Oliver Title President & CEO Telephone (905) 338-4615		Organization: Halton Healthcare Services Corporation e-mail address: joliver@haltonhealthcare.on.ca	

Title of initiative: # 24 Integration of Children's Health Services Across the Full Continuum (from prenatal, health promotion, and early identification to protection, justice and tertiary 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 <small>* Note initiated / existing activities do not need to be confined within LHIN boundaries</small>	List of Partners involved	
	NAME Adelina Urbanski Anne Fenwick Bob Morton Chris McLean Linda Rothney Rob Low Sandra Henderson Sheldon Wolfson	ORGANIZATION Region of Halton Region of Peel CCAC Peel CNIB Erinoak CNIB CCAC Halton Region of Halton
Brief description of the initiative		
<p>Children's "health" spans the whole education, health, social services, and recreation systems. At the present time the new Ministry of Children and Youth Services does not include the community, acute, and tertiary health care. The integration opportunity for the LHIN is to provide the leadership and give priority to preparing a comprehensive plan for children's services that goes beyond the services currently identified as within the LHIN. There is a rich source of data (Healthy Babies, Healthy Children), a high functioning system for early identification, and a strong history of commitment to children by senior leaders in Oakville and Mississauga. The LHIN has an exciting opportunity and community responsibility to provide the leadership to ensure the emerging integrated system of services continues in a manner that meets the needs of children and their families.</p> <p>Why is it a priority</p> <p>Children can not advocate for themselves therefore the LHIN must provide the leadership and advocacy on their behalf to ensure they have the services and supports they deserve. Without this mandated priority/focus paediatric care will always take a "back seat" to pressures such as cancer care, cardiovascular care etc.</p> <p>Attention now to fostering "healthy" (in the broadest sense) children will lead to a healthier population in the long term that consumes less health care resources.</p> <p>A lot of good work has already begun in Oakville and Mississauga in this regard. It behoves the LHIN to build on the emerging system of integrated services and ensure strong linkages between MCYS, MOHLTC, and MOET services from the outset.</p>		
Current Status (If this is an initiated/existing activity)		Outcomes / lessons learned (if any)
Lead contact person		
Name	Linda M. Rothney	Organization: Erinoak Children's Centre
Title	CEO	e-mail address: lrothney@erinoak.org
Telephone	(905) 828-3200	

Title of initiative: #25 Co-ordinated Emergency Preparedness Plans across LHIN and Regional boundaries		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 <small>* Note initiated / existing activities do not need to be confined within LHIN boundaries</small>	List of Partners involved	
	NAME Allan Halls Carole Jones Carole Ward Donna Laevens-Van West Julie Wong Lorraine Ladha Marion Bascom Sharon Mills Sue Fedun	ORGANIZATION Halton Healthcare Svcs. Canadian Red Cross – Peel CCAC of Halton Halton Peel Emergency Network Northridge LTC OHA Oakville Senior Citizens Res. Halton Healthcare Svcs. Northridge LTC
Brief description of the initiative		
Briefly Describe the Integration Opportunity To create effective, co-ordinated, comprehensive emergency preparedness plans involving institutional and community service providers. <ul style="list-style-type: none"> Identify planning and resource gaps and opportunities. Raise the profile of the issue and advocate for resources (financial, human, technical, supplies etc.) Share best practice municipally, regionally, provincially. Standardization of emergency preparedness processes, systems and terminology. Why is it a priority <ul style="list-style-type: none"> The current state of emergency preparedness is fragmented, and only partially co-ordinated by the regions and municipalities. Not all community agencies are involved. The system is extremely under-resourced. Plans are developed in isolation with little standardization. Little or no capacity to deal with emerging risks (CBRN, pandemic, mass casualty). Goals: <ul style="list-style-type: none"> To develop a safer emergency response capability that is better able to respond effectively to a major incident. To avoid potentially huge consequences arising from lack of preparation: unnecessary death/injury, disruption of ongoing service, economic loss, property destruction and loss of confidence and credibility of our communities in the health care system. To ensure that the legislated roles of municipalities, regions and health providers are co-ordinated. 		
Current Status (If this is an initiated/existing activity)		Outcomes / lessons learned (if any)
Lead contact person		
Name Allan Halls Title Senior Vice President Telephone (905) 815-5098	Organization: Halton Healthcare Services Corporation e-mail address: ahalls@haltonhealthcare.on.ca	

Title of initiative: # 26 Functional Ability Data 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 <small>* Note initiated / existing activities do not need to be confined within LHIN boundaries</small>		List of Partners involved													
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NAME	ORGANIZATION														
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Maria Sewell	Independent Living Halton														
Shirley Ha	Ont. Assoc. of Optometrists														
Wendy McBride	SENECA Seniors Day Program														
Brief description of the initiative															
<p>Database of available information and resources using reported experiential data, not just numerical data.</p> <p>Why is it a priority</p> <ul style="list-style-type: none"> ➤ Creates proper data and assessment of functional abilities ➤ Sharing of data to improve referral and resource development ➤ Creates the opportunity to see the person holistically ➤ Opportunity to develop improved comprehensive database ➤ Plan the resources/services based on functional assessment data ➤ Creates a reliable quality of data ➤ Immediately reduce the anxiety/distress at the point of access ➤ Puts the consumer of control of information and choice ➤ Gives real time information ➤ Information/data emerges defining priorities for resource development ➤ Helps curb the cost as the consumer can go to the Consumer Service Agency instead of Hospital to access service ➤ Changes the way we look at data ➤ Creates opportunity for paradigm shifts in planning integration opportunities ➤ All encompassing information collection ➤ Feedback loop of data is added to the empirical and experiential information- see the Obermann's sphere 															
Current Status (If this is an initiated/existing activity)		Outcomes / lessons learned (if any)													
Lead contact person															
Name Hugh Stewart Title Executive Director Telephone (905) 878-6722		Organization: Independent Living Halton e-mail address: pmoilh@cogeco.net													

Title of initiative:		Type of integration (more than one box can be checked)																																			
# 27 Access to services – cultural sensitivity and equity		<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																																				
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<p>Briefly Describe the Integration Opportunity</p> <ul style="list-style-type: none"> ➤ Language for ethno-racial groups ➤ Cultural needs and practices not addressed ➤ Religious and spiritual beliefs not addressed ➤ Location of services creating barriers ➤ Lack of transportation ➤ Program design/format not catered to the above special needs ➤ Shortage of services, e.g. lack of family physicians, waitlist for specialty services ➤ Marginal group or people with special needs, different sexual orientations, substance abuse, mental health, new immigrants, age barriers, homeless people, etc. not fully accepted ➤ Lack of knowledge about the system – no timely referrals made ➤ Lack of knowledge or inability to recruit volunteers from cultural communities ➤ Lack of funding <p><u>Integration Opportunities</u></p> <ul style="list-style-type: none"> ➤ LHIN to have policy statement to acknowledge the barriers and the need to overcome those barriers ➤ In Accountability Agreement with agencies, standard should be for agencies to demonstrate effort to address those barriers ➤ An evaluation tool to assess whether actions have been taken appropriately to address barriers ➤ Recognize costs involved to implement programs/services that can address diversity ➤ More coordinated effort in community and system education among providers ➤ Diversity of community being represented in LHINs to ensure access/services. Participation can take the form of consultations, work groups, etc. ➤ These consultation should be truly accessible in terms of language appropriateness and be able to reach out to a wide spectrum of stakeholders ➤ A comprehensive assessment tool to enable people to navigate the system without having to repeat answering the same questions over and over again ➤ Making GPs more aware of different services available to link diagnoses with community services ➤ Resources (funding) to keep system up-to-date 																																					

- More coordinated effort and sharing re use of volunteer resources
- We need a stronger linkage and integratin among different services, departments and ministries
 - E.g. existing gaps in mental health, adult vs child mental health clients, different ministries dealing with different group, some people end up falling through the crack
- Equity of services and service standards across regions – need consistency of services and funding criteria which would affect accessibility
- Need multi-cultural resources across regions
- Partnerships with cultural and religious groups

We need data on to understand how diverse our community is. Social Planning Council and local health departments may have those info. But need to prioritize and engage different cultural and religious groups in interpreting the data

Why is it a priority

- We live in a diverse community, with lost of different cultural and special needs
- We need to meet their needs in order to build a healthy community where people feel welcome, can identify their needs at an early stage, get quicker access, which will lower cost for the system overall
- Existing health care system very fragmented and medically orientated. There is a need to address holistic health care so that all areas of health are addressed, including those beyond physical health

Current Status (If this is an initiated/existing activity)		Outcomes / lessons learned (if any)	
Lead contact person			
Name	Maureen Lynn	Organization:	Yee Hong Centre for Geriatric Care-Mississauga
Title	Executive Director	e-mail address:	maureen.lynn@yeehong.com
Telephone	(905) 568-0333		

Title of initiative: # 28 Health Human Resources: Who do we need, how many do we need, how do we recruit/retain them?		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:																								
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<ul style="list-style-type: none"> ➤ Creating opportunities for appropriate utilization of health human resources – multiple access points; right professional for right person for health needs ➤ Better education and professional development – current competencies and experience as community needs change over time, access to timely education when needed ➤ Improve manpower planning – reduce workload through introduction of technologies, etc.; 10 year planning framework will support the number and variety of professionals ➤ Establish positive and healthy work environments – equitable compensation package with comparators across the health care system (hospitals, LTC, community); adequate resources for everyone to do their job and flexibility that promotes professional development; reduce casualization ➤ Value care providers – creating collegial relationships; partners in care ➤ Work-life balance – address workload issues esp in 24/7 context, safety ➤ Team-building – need strategies to break the silos; use of interdisciplinary teams will more effectively meet patient needs ➤ Reduce staff attrition and turn-over to reduce recruitment and education requirements and associated costs and improve the quality of patient care ➤ Opportunities with students will provide enriched work experiences and ready resource for new and replacement staff hiring ➤ Develop better relationships between the Ministry of Health & LTC and the Ministry of Training, Colleges and Universities-so know to educate health care workers in advance of needing them ➤ Break down the funding silos for professionals ➤ Address legislative barriers to work to full scope <p>Create a work environment culture that is patient centred with common health human resource standards for satisfaction</p> <p>Why is it a priority</p> <ul style="list-style-type: none"> ➤ Without adequate manpower, the system is not sustainable – need to attract young people and to retain the people and their expertise in the current system ➤ By using the right people, we maximize the use of professionals ➤ Cost effective to have the right person providing care ➤ Supports innovation ➤ More seamless system with improved patient outcomes and continuity of care ➤ LHIN will know educational needs and be able to respond quickly to emerging needs ➤ Won't meet the needs of patients without a stable and satisfied work force 																										

Local Opportunities for Health System Integration

Current Status (If this is an initiated/existing activity)		Outcomes / lessons learned (if any)
Lead contact person		
Name	Jane Sanders	Organization: Registered Nurses Association of Ontario e-mail address: jsanders@rnao.org
Title	Policy Analyst	
Telephone	(416) 599-1925 x227	

Title of initiative:		Type of integration (more than one box can be checked)																	
# 29 Long-Term Community Support for Adults with Cognitive Behavioural Needs		<input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:																	
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Brief description of the initiative																			
<p>Adults with Cognitive/Behavioural needs are currently served in a variety of settings in Peel and Halton. Making up a large portion of this population are people who have sustained acquired brain injuries and require supportive living environments with trained personnel and clinical resources that enable safe and secure living opportunities.</p> <p>Due to a shortage of supportive housing for these individuals many people are currently being referred to Long-Term-care facilities. Some clients referred are presenting LTC facilities with management challenges that they currently do not have the resources and expertise to deal with successfully.</p> <p>Integration opportunities were discussed as follows:</p> <ol style="list-style-type: none"> Vertical integration opportunities: <ul style="list-style-type: none"> ➤ Placement of these individuals in the Peel and Halton regions requires an integration of services and expertise during the placement decision/making process. It was suggested that these individuals when identified for placement should be presented at a placement committee made of up representatives from community who provide services and expertise e.g. Housing, ABI specific providers, mental health, addictions, shelters, chronic care hospitals, etc. ➤ Integration of information – Identification of the extent of the need. How many people under the age of 55 with cognitive/behavioural sequelae are being placed in LTC facilities or are soon to be placed in these environments for lack of more appropriate options? Information from hospitals, CCAC, LTC, community agencies needs to be integrated and accessible to all stakeholders. Horizontal integration opportunities: <ul style="list-style-type: none"> ➤ Accessibility to community services should be based on client need and not limited by legislation. Eg. Age limits, a young adult living in a long-term care facility cannot access a day program outside of the facility that better meets his/her peer relational needs/interests. ➤ Organizations in the community with particular expertise should be able to provide long-term consultation and/or direct staffing support to facilities requiring that support for the management of people with behavioural issues. This support should be modeled after the PACE consultative model that allows for an increase of staffing resources and consultation based on individual client need. This support should be provided for as long as the client/service requires it given that cognitive/behavioural needs tend to be long-term in nature. <p>Why is it a priority</p> <p>There are insufficient long-term supportive housing alternatives for Ontarians acquiring brain injuries each year. Long-Term Care facilities have become a convenient placement alternative for many of these individuals but are not appropriately resourced to support them. The model of care in the LTC system is</p>																			

acceptable for people with physical care needs but does not effectively work for people with moderate cognitive and behavioural needs.

This is already approaching crisis proportions and is expected to become more problematic in the future as more moderately complex people access the LTC system. Desperate families and discharge planners will continue to be forced to refer to LTC because of a lack of other, more appropriate supported living options. Young adults with cognitive behavioural needs require alternate living arrangements. Older adults with cognitive/behavioural issues need a LTC system better resourced to manage them proactively.

Current Status (If this is an initiated/existing activity)	Outcomes / lessons learned (if any)

Lead contact person

Name	Scott Farraway	Organization: Peel Halton Acquired Brain Injury Services e-mail address: scottf@phabis.com
Title	Program Director	
Telephone	(905) 949-4411 x235	

Appendix C - Linkages and Networks

Communication & Planning Linkages

In addition to the many projects and related committees, Halton-Peel District Health Council staff participate in numerous committees / networks. We refer to these as “linkage activities”. Ongoing participation in existing and forging new linkages are a vital component of staff work and are important to achieving our deliverables. Linkages are important for: information sharing, relationship building, keeping informed on sectoral issues, increasing Council’s visibility, getting input and feedback, and influencing direction of the linkage group. Linkages may be provider-based, sector-based, program-based, consumer-based or geography-based.

The following list summarizes the Linkage activities that are currently active and serves as an example of the numerous Network groups and committees that involve stakeholders in Mississauga-Oakville LHIN area.

Planning Area	Linkage Activities	Linkage Category (planning / communication)
Multi Sectoral	Halton-Peel Regional Information Technology Group	Communication Linkage
Addictions	Addictions Services Group	Planning Linkage
Children's Services	Evaluation and Monitoring Action Group (Peel Action Group for Integrated Early Years Services)	Communication Linkage
Children's Services	Halton-Peel Preschool Speech and Language Program	Communication Linkage
Children's Services	Halton Healthy Babies Healthy Children	Communication linkage
Children's Services	Peel Healthy Babies Healthy Children – Success by 6	Communication linkage
Children's Services	Children's Leadership Council	Communication Linkage
Children's Services	Our Kids	Communication linkage
Community	Halton-Peel Diabetes Network	Communication Linkage
Community / Long-Term Care	Peel Older Adults' Housing Advisory Working Group	Communication Linkage
Community Health	Brampton/Malton CHC	Communication Linkage
Emergency Services	Regional Emergency Services Coordinators	Communication Linkage
Emergency Services	Halton Land Ambulance Advisory Committee	Communication Linkage
Emergency Services	Peel Base Hospital Paramedic Program Utilization Committee	Communication Linkage
Emergency Services	Halton Region Healthcare Emergency Management Planning Group	Communication Linkage

Planning Area	Linkage Activities	Linkage Category (planning / communication)
Emergency Services	Peel Region Health Care Emergency Planning Working Group	Communication Linkage
Emergency Services	Halton-Peel/West Toronto Communicators Group	Communication Linkage
Emergency Services	West GTA Stroke Network: Acute Stroke Advisory Working Group	Communication Linkage
Emergency Services	Halton – Peel Emergency Health Services Network	Planning Linkage
Emergency Services	Long-term Care Placement Steering Group (Previously called ALC Steering Committee)	Planning Linkage
Emergency Services	Administrative Medical Directors Group	Planning Linkage
Emergency Services	Halton- Peel Emergency Department Charge Nurses Group	Planning Linkage
French Language Services	Halton-Peel French Language Health Services Forum	Communication Linkage
Health Human Resources	Halton Region Physician Recruitment Committee	Communication Linkage
Hospitals	The West Cluster (Halton-Peel) Maternal Child Program Steering Committee	Communication Linkage
Hospitals	Peel Regional Cancer Centre – Network	Communication Linkage
Hospitals	Halton-Peel Cardiac Services Network	Planning Linkage
Hospitals	Halton-Peel Kidney Care Network	Planning Linkage

Planning Area	Linkage Activities	Linkage Category (planning / communication)
Hospitals	Halton-Peel Rehabilitation Advisory Group	Planning Linkage
Hospitals / Long-Term Care	New Supportive Care Program Steering Committee	Communication Linkage
Long-Term Care	Addressing Seniors' Needs in Peel	Communication Linkage
Long-Term Care	Focused Action for Seniors in Halton	Communication Linkage
Long-Term Care	CCAC / LTC Administrators/ Discharge Planners – Halton	Communication Linkage
Long-Term Care	Halton Health & Community Support Services Network	Communication Linkage
Long-Term Care	Community Support Services Group of Peel	Communication Linkage
Long-Term Care	Halton CCAC Community Advisory Committee	Communication Linkage
Long-Term Care	Peel CCAC Community Advisory Committee	Communication Linkage
Long-Term Care	Accompanied Transportation Committee	Communication Linkage
Long-Term Care	Halton-Peel Palliative Care Initiatives (HPPCI) Advisory Committee	Communication Linkage
Long-Term Care	Elderly Services Advisory Committee	Communications Linkage
Long-Term Care	Halton Dementia Network	Planning Linkage
Long-Term Care	Peel Dementia Network	Planning Linkage
LTC / Hospitals	Peel and Halton Coalition for Acquired Brain Injury	Communication Linkage

Planning Area	Linkage Activities	Linkage Category (planning / communication)
Mental Health	Halton Geriatric Mental Health Outreach Program – Program Advisory Committee	Communication Linkage
Mental Health	CAMH-PEEL Access Advisory Committee	Communication Linkage
Mental Health	CAMH Psychogeriatric/ Neuropsychiatry Advisory Committee	Communication Linkage
Mental Health	CAMH Peel Programs Advisory Committee	Communication Linkage
Mental Health	Halton-Peel Mental Health Leaders Forum	Communication Linkage
Primary health care	Halton-Peel Family Practice Liaison Group	Communication Linkage
Primary health care	East Mississauga CHC	Communication Linkage
Primary health care	The Brampton/Malton-East Mississauga Community Family Health Team Proposal	Planning Linkage
Primary health care	The Halton Region Community Family Health Team Proposal	Planning Linkage
Primary health care	Nurse Practitioner Advisory Committee	Planning Linkage
Primary health care	Trillium Primary Health Care Initiative	Communication Linkage
Primary health care	Trillium/Peel Region Family Physician working group	Communication Linkage
Regional / Provincial Planning	Regional Cancer Advisory Committee Jurvanski Cancer Centre - Hamilton)	Communication Linkage
Regional / Provincial Planning	Mississauga / Oakville Local Health Integration Network –	Planning Linkage

Planning Area	Linkage Activities	Linkage Category (planning / communication)
	Steering Committee	
Regional / Provincial Planning	Central West Local Health Integration Network – Steering Committee	Planning Linkage
Regional Planning	Halton- Peel Health Care Leaders Forum	Planning Linkage
Regional/ Provincial Planning	Association of Public Health Epidemiologists in Ontario	Communication Linkage
Regional/ Provincial Planning	Provincial Executive Directors	Communication Linkage
Regional/ Provincial Planning	South Central / Central West DHCs	Communication Linkage
Regional/ Provincial Planning	Central East Health Information Partnership	Communication Linkage
Regional/ Provincial Planning	GTA Rehab Network Coordinating Council	Communication Linkage
Regional/ Provincial Planning	Network 18 (WOHC & DCHC)	Communication Linkage
Regional/Provincial Planning	JPPC Volumes Committee	Communications linkage
Regional/Provincial Planning	Local Health System Monitoring Project	Planning Linkage
Regional/Provincial Planning	End-of-Life Provincial Advisory Committee	Communications linkage

