

**South West
Local Health Integration Network
(LHIN #2)**

Integration Priority Assessment

Final Report

February 11, 2005

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Introduction

Introduction

Ontario is currently engaged in extensive health system transformation. Some of the key goals of the Ministry of Health and Long-Term Care (MOHLTC) are to make the system more integrated, more person-centred and more responsive to local needs. To accomplish these goals, the government is introducing a made-in-Ontario solution, Local Health Integration Networks (LHINs). LHINs will be 14 community-based organizations with a mandate to plan, coordinate, integrate, manage, and fund local health care within their defined geographic areas.

To initiate planning, the Ministry's Health Results Team conducted 14 regional stakeholder workshops. These consultations were aligned with the new geographic health region LHIN boundaries to stimulate discussion and planning with the intent of engaging communities in dialogue about local integration opportunities. On November 23, 2004, the Southwest LHIN workshop was held in London. It resulted in the identification of 47 local health integration opportunities and from that, 10 planning priorities. For these top-ranked priorities, planning leads were selected from among their peers. (Appendix 2).

This report incorporates and builds on the November 23rd discussions. It also includes population and health status indicators prepared by the Grey Bruce Huron Perth and Thames Valley DHCs, which will be helpful to the planning work of the new Southwest LHIN. The Southwest LHIN is a large geographic planning area comprised of a mix of small to large urban and rural areas. As a new planning region, the Southwest LHIN has unique characteristics that require coordinated health system planning, implementation and evaluation to ensure an integrated approach to the provision of health care, priority setting and decision-making. The report highlights the current network integration activities, a number of which have been underway for many years, and identifies some lessons learned so that the new Southwest LHIN can build on these existing strengths. For new integration opportunities, there are also some high-level action plans that will be of use to the new LHIN as it develops its strategic plan.

Description of LHIN #2: Population and Health Indicators

Description of LHIN #2: Population and Health Indicators

The following information has been prepared by the Grey Bruce Huron Perth and Thames Valley District Health Councils, and is intended to provide a brief overview of the following features for LHIN-2:

Demographics:

- population change
- population age distribution
- population density
- estimates of education levels, income and language indicators

Health Behaviours and Lifestyle Practices:

- estimates of population reporting having regular medical doctor
- estimates of population reporting daily smoking status
- estimates of population considered overweight and obese
- estimates of population reporting stress
- estimates of physical activity across populations

Health Services:

- profile of in-patient hospital use by patient geography and leading causes of hospitalizations
- profile of beds staffed/in operation as of March, 2004 (Note: these figures may have changed over the past fiscal year)
- profile of long term care facilities
- estimated number of Ministry of Health and Long-Term Care transfer payment agencies (Note: some areas may have a larger number of TP agencies however some of the agencies are very small – i.e., Meals-on-Wheels programs)
- estimated number of active, non-specialist physicians

Please note that parts of certain municipal areas are included in LHIN 2 (i.e., parts of Lambton and Norfolk) while parts of other municipal areas are excluded from LHIN 2 (i.e., parts of Grey County, Oxford County). Footnotes have been included to indicate where tables include “total” or “partial” estimates.

Demographics

Local Health Integration Network (LHIN 2) includes the following areas¹: the Thames Valley District (Elgin County, the city of London, Middlesex County and Oxford County—excluding a portion of Blandford-Blenheim); most of the Grey Bruce Huron Perth District (Grey County--excluding parts of Southgate Township and the Town of Blue Mountains, Bruce County, Huron County and Perth County) as well as a section of the census subdivision of Norfolk and 5 census subdivisions in Lambton County--the City of Lambton Shores, Warwick Township, Brooke-Alvinston Township, part of Dawn-Euphemia Township, and Kettle Point 44 Indian Reserve. According to published Ministry figures, LHIN 2 ranks 6 of 14 in terms of total population size.

There are also a number of First Nations' Reserves in LHIN 2 including two in Bruce County, three in Middlesex County and one in Lambton. It is often difficult to obtain reliable demographic data for those living on First Nations' Reserves.

- Table 1 shows the total population of the areas in LHIN 2 for 1991, 1996, 2001 and 2003. The area grew by more than 41,000 from 1996 to 2003, an increase of 4.3%. Elgin, London, Middlesex were the fastest growing areas in LHIN 2 over the time periods shown while Oxford, Grey and Perth Counties grew at slightly slower rates. Bruce, Huron, Norfolk and Lambton (selected areas) had the smallest population growth rates or population decreases over the years shown.

Table 1
Population and Population Changes, Selected Years
LHIN 2

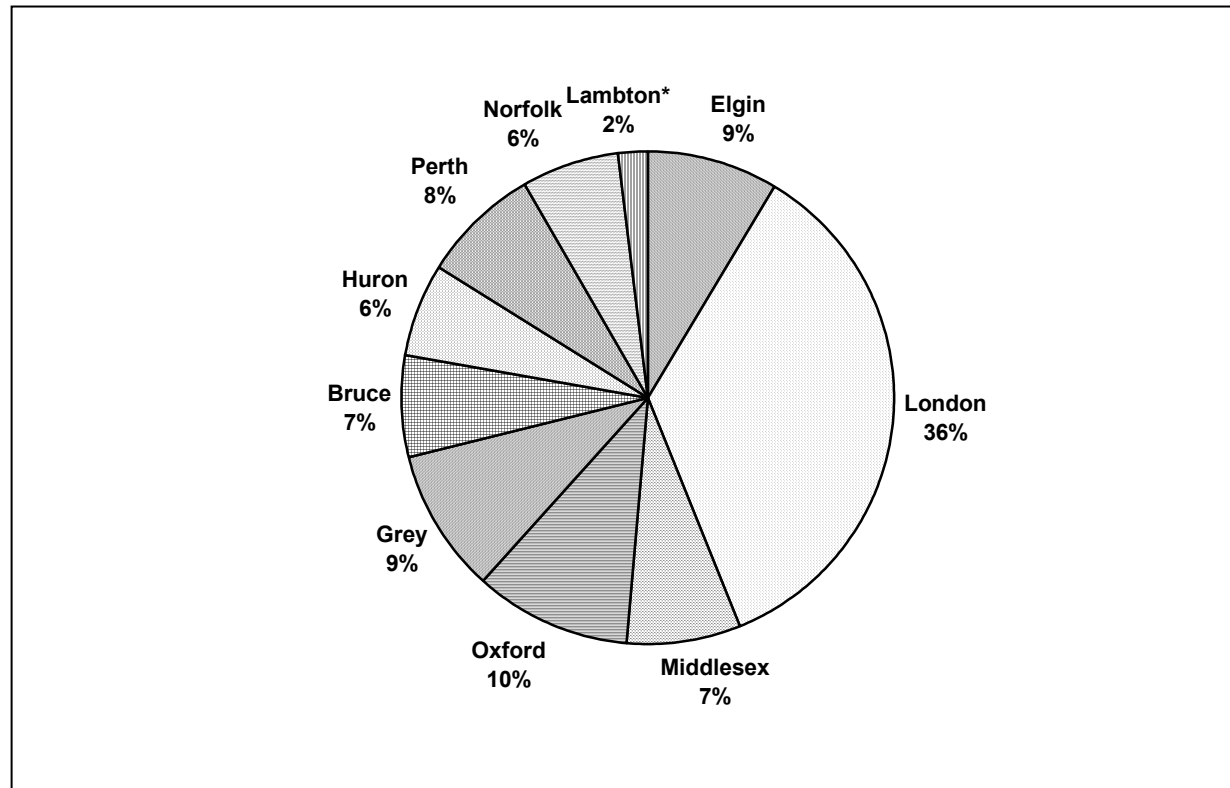
Area	1991	1996	2001	2003	% change	
					1991-2003	1996-2003
Elgin	77,804	81,356	84,737	86,096	10.7	5.8
London	322,264	334,853	349,979	355,169	10.2	6.1
Middlesex	64,327	68,004	71,990	73,459	14.2	8.0
Oxford	95,774	99,786	103,149	103,880	8.5	4.1
Grey	86,557	89,925	92,476	93,468	8.0	3.9
Bruce	67,224	68,043	66,342	67,156	-0.1	-1.3
Huron	60,764	61,821	61,999	61,896	1.9	0.1
Perth	72,098	74,091	76,543	77,265	7.2	4.3
Norfolk	67,915	62,171	63,216	63,496	-6.5	2.1
Lambton*	20,198	20,964	20,508	20,545	1.7	-2.0
Total	934,925	961,014	990,939	1,002,430	7.2	4.3

Source: Statistics Canada population estimates, obtained from the MOHLTC Provincial Health Planning Database. *Lambton consists of 4 census subdivisions (Dawn-Euphemia, Warwick, Lambton Shores and Brooke-Alvinston). All of Dawn-Euphemia and all of Norfolk are included in the figures although only portions of these census subdivisions are included in the LHIN. In addition, all of Grey and all of Oxford are included in the figures although portions of census subdivisions in these counties are excluded from the LHIN.

¹ Boundaries are based on the maps available at: http://www.health.gov.on.ca/transformation/lhin/lhinmap_mn.html

- Figure 1 shows the population distribution by area in LHIN 2. More than one third of the LHIN 2 population lives in London and when combined with Middlesex, 43% of LHIN 2's population is located in this area. Oxford, Elgin, Grey and Perth had the next largest percentages of LHIN 2's population at 10%, 9%, 9% and 8% respectively. The Lambton census subdivisions included in LHIN 2 represent roughly 2% of the total LHIN population.

Figure 1
Population Distribution by Area
LHIN 2 - 2003



Source: Statistics Canada population estimates, obtained from the MOHLTC Provincial Health Planning Database. *Lambton consists of 4 census subdivisions (Dawn-Euphemia, Warwick, Lambton Shores and Brooke-Alvinston). All of Dawn-Euphemia and all of Norfolk are included in the figures although only portions of these two census subdivisions are included in the LHIN. In addition, all of Grey and all of Oxford are included in the figures although portions of census subdivisions in these counties are excluded from the LHIN.

- LHIN 2 consists of a vast geographic area, as shown in Table 2; one of the largest LHIN planning areas in Southern Ontario. Grey, Bruce and Huron Counties comprise close to half of the land area in LHIN 2. London is the most densely populated area while Lambton, Bruce and Huron Counties have the lowest population densities.

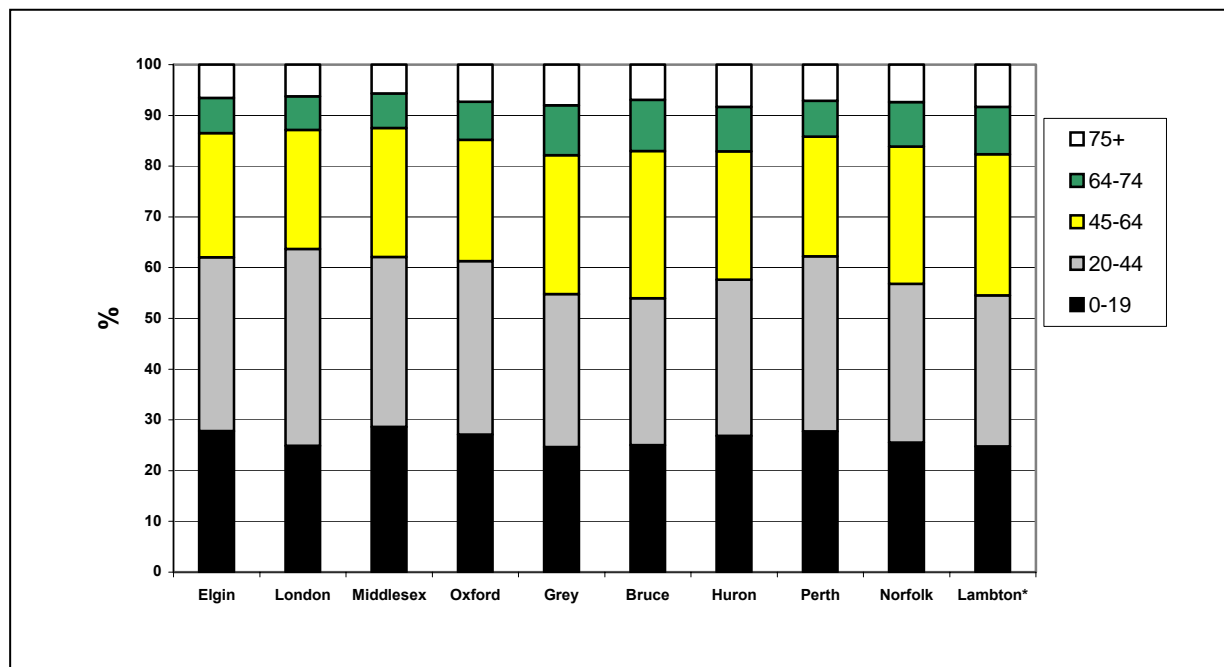
Table 2
Land Area and Population Density
LHIN 2

Area	Square km (2001)	2003 Popn.	Popn./km ²
Elgin	1,881	86,096	45.8
London	422	355,169	842.1
Middlesex	2,895	73,459	25.4
Oxford	2,039	103,880	50.9
Grey	4,508	93,468	20.7
Bruce	4,156	67,156	16.2
Huron	3,408	61,896	18.2
Perth	2,218	77,265	34.8
Norfolk	1,607	63,496	39.5
Lambton*	1,378	20,545	14.9
Total	24,513	1,002,430	40.9

Source: Statistics Canada population estimates, obtained from the MOHLTC Provincial Health Planning Database. *Lambton consists of 4 census subdivisions (Dawn-Euphemia, Warwick, Lambton Shores and Brooke-Alvinston). All of Dawn-Euphemia and all of Norfolk are included in the figures although only portions of these two census subdivisions are included in the LHIN. In addition, all of Grey and all of Oxford are included in the figures although portions of census subdivisions in these counties are excluded from the LHIN.

- Figure 2 shows the age distribution of the areas included in LHIN 2 and highlights the differences across the area. Middlesex had the largest proportion of children and youth (0-19 year olds) while Grey had the smallest percentage. London had the greatest percentage of 20-44 year olds and Bruce had the smallest. Bruce had the largest proportion of those aged 45-64 years of age as well as those 65-74 years old. Other areas with large proportions of those aged 65-74 years old include Grey, Huron, Norfolk and Lambton (selected areas). Grey, Huron and Lambton (selected areas) also had the largest proportion of those aged 75+ years.

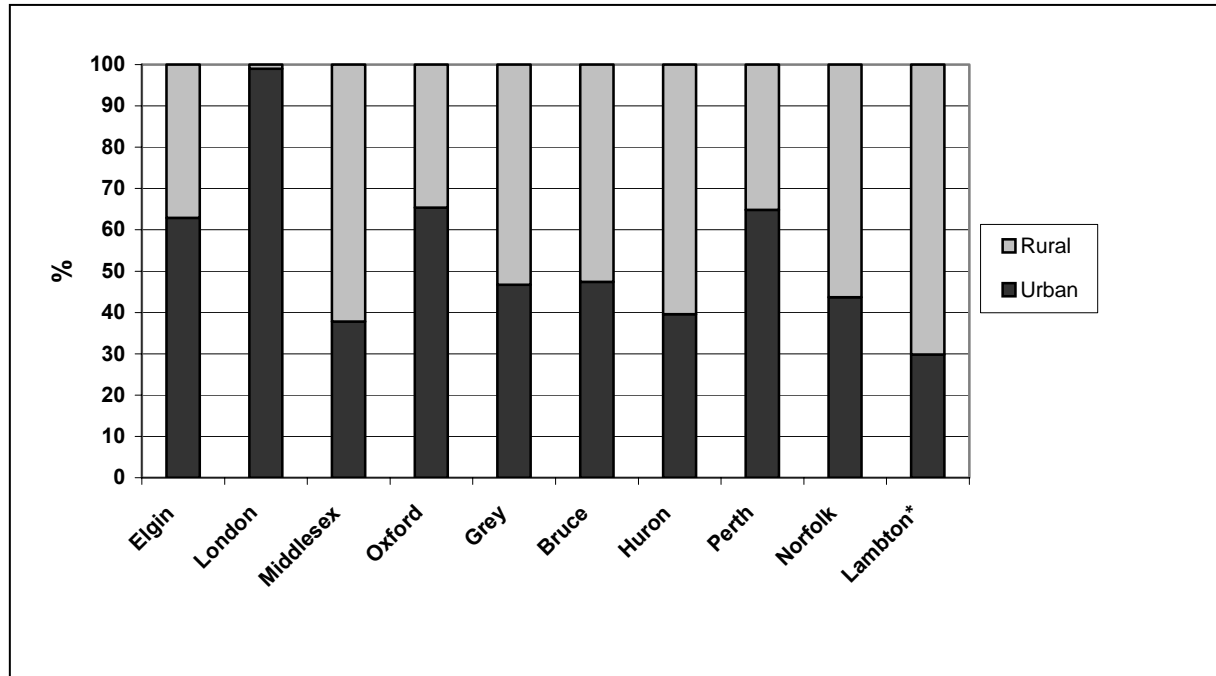
Figure 2
Age Distribution
LHIN 2- 2003



Source: Statistics Canada population estimates, obtained from the MOHLTC Provincial Health Planning Database. *Lambton consists of 4 census subdivisions (Dawn-Euphemia, Warwick, Lambton Shores and Brooke-Alvinston). All of Dawn-Euphemia and all of Norfolk are included in the figures although only portions of these two census subdivisions are included in the LHIN. In addition, all of Grey and all of Oxford are included in the figures although portions of census subdivisions in these counties are excluded from the LHIN.

- As shown in Figure 3, LHIN 2 comprises a mix of urban and rural populations.² All areas, with the exception of London, include both rural and urban populations. In particular, Norfolk, Middlesex, Grey, Bruce, Huron and Lambton (selected areas) are the more “rural” areas in LHIN 2.

Figure 3
Urban and Rural Population
LHIN 2 - 2001



Source: Statistics Canada, 2001 Census. *Lambton consists of 4 census subdivisions (Dawn-Euphemia, Warwick, Lambton Shores and Brooke-Alvinston). All of Dawn-Euphemia and all of Norfolk are included in the figures although only portions of these two census subdivisions are included in the LHIN. In addition, all of Grey and all of Oxford are included in the figures although portions of census subdivisions in these counties are excluded from the LHIN.

² An urban area has a minimum population concentration of 1,000 persons and a population density of at least 400 persons per square kilometre, based on the current census population count. All territory outside urban areas is classified as rural. Source: Statistics Canada, 2001 Census Dictionary.

- As shown in Table 3, English is the mother tongue³ of the majority of the residents in LHIN 2. London had the largest proportion of residents who had a mother tongue other than English with almost 20% having another language as a mother tongue. Some of the other mother tongue languages in London included Polish, Arabic, Portuguese, Spanish and French, a reflection of the mix of nationalities and ethnic origins of the London population. German and Dutch were common mother tongue languages for residents in much of the rest of LHIN 2. In particular, Elgin, Norfolk and Perth had large proportions of residents with German as a mother tongue, representing the low-German speaking and Amish and Mennonite populations in these areas. Middlesex also had a large percentage of residents with Portuguese as a mother tongue.

Table 3
Mother Tongue (Single Responses)
LHIN 2 – 2001

	Elgin		London		Middlesex		Oxford		Grey	
	#	%	#	%	#	%	#	%	#	%
Single responses	79,580	100.0	329,490	100.0	65,355	100.0	97,525	100.0	87,275	100.0
English	67,570	84.9	265,805	80.7	58,210	89.1	86,695	88.9	80,985	92.8
French	755	0.9	4,615	1.4	485	0.7	960	1.0	765	0.9
German	6,560	8.2	3,525	1.1	810	1.2	2,060	2.1	2,670	3.1
Dutch	1,360	1.7	2,905	0.9	2,490	3.8	3,150	3.2	1,025	1.2
Polish	375	0.5	6,485	2.0	235	0.4	770	0.8	130	0.1
Arabic	100	0.1	5,685	1.7	15	0.0	85	0.1	30	0.0
Portuguese	325	0.4	5,175	1.6	1,515	2.3	500	0.5	115	0.1
Spanish	60	0.1	4,590	1.4	115	0.2	120	0.1	50	0.1
Hungarian	350	0.4	1,430	0.4	255	0.4	840	0.9	130	0.1
Italian	240	0.3	3,675	1.1	220	0.3	345	0.4	200	0.2
Other languages	1,885	2.4	25,600	7.8	1,005	1.5	2,000	2.1	1,175	1.3

³ Mother tongue refers to the first language learned in childhood and still understood at the time of the Census. Source: Statistics Canada, 2001 Census Dictionary.

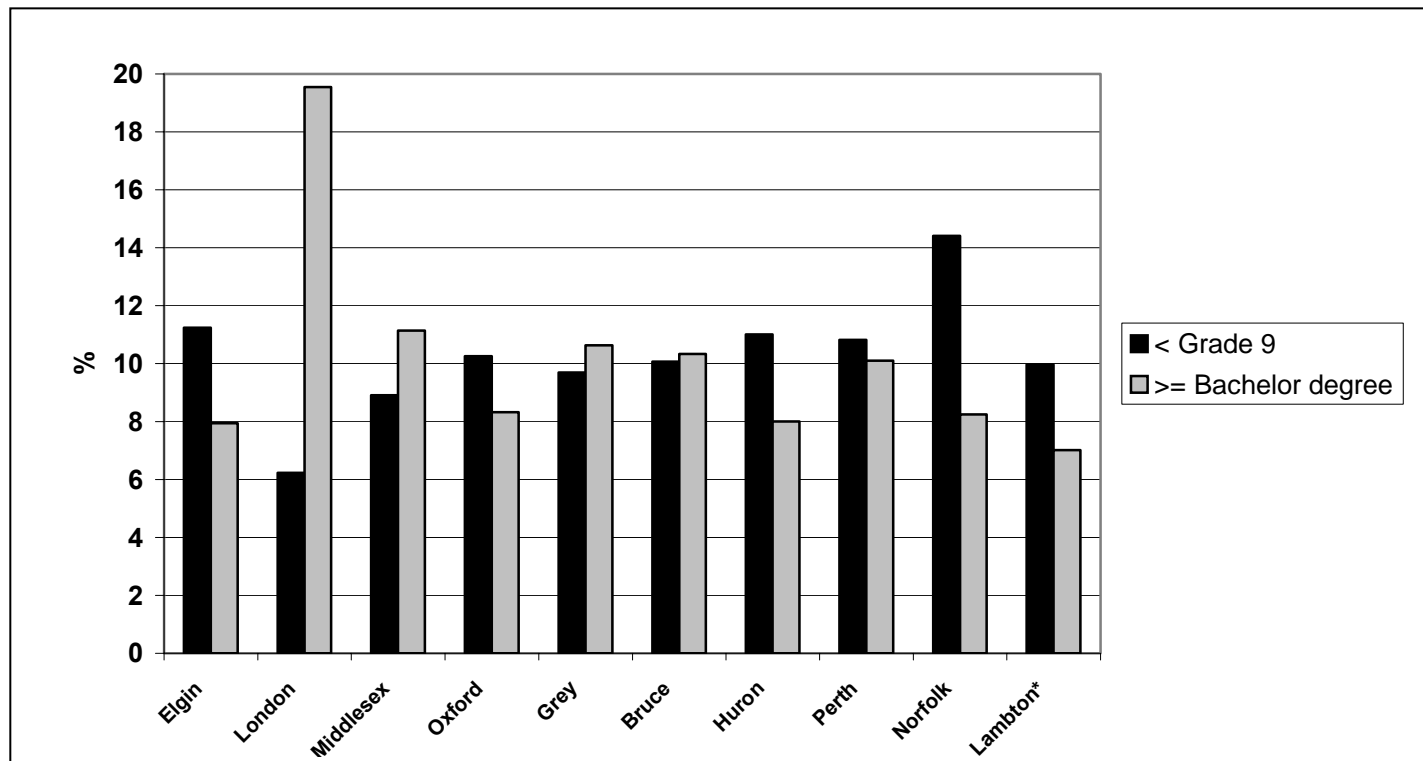
Setting Integration Priorities

	Bruce		Huron		Perth		Norfolk		Lambton*	
	#	%	#	%	#	%	#	%	#	%
Single responses	62,765	100.0	58,490	100.0	72,205	100.0	59,605	100.0	19,415	100.0
English	58,530	93.3	53,445	91.4	65,095	90.2	50,975	85.5	17,865	92.0
French	580	0.9	395	0.7	355	0.5	650	1.1	120	0.6
German	1,575	2.5	2,130	3.6	3,080	4.3	3,655	6.1	390	2.0
Dutch	830	1.3	1,660	2.8	1,485	2.1	585	1.0	615	3.2
Polish	145	0.2	80	0.1	130	0.2	360	0.6	35	0.2
Arabic	45	0.1	-	-	10		30	0.1	-	-
Portuguese	125	0.2	20	0.0	135	0.2	685	1.1	20	0.1
Spanish	20	0.0	60	0.1	180	0.2	140	0.2	10	0.1
Hungarian	105	0.2	50	0.1	75	0.1	760	1.3	-	-
Italian	95	0.2	30	0.1	225	0.3	100	0.2	65	0.3
Other languages	715	1.1	620	1.1	1,435	2.0	1,665	2.8	295	1.5

Source: Statistics Canada, 2001 Census. *Lambton consists of 4 census subdivisions (Dawn-Euphemia, Warwick, Lambton Shores and Brooke-Alvinston). All of Dawn-Euphemia and all of Norfolk are included in the figures although only portions of these two census subdivisions are included in the LHIN. In addition, all of Grey and all of Oxford are included in the figures although portions of census subdivisions in these counties are excluded from the LHIN.

- Education levels, along with other determinants of health such as income, influence health status and health care utilization. Education levels varied considerably across LHIN 2 and in particular, London's education levels were quite different than those in the rest of LHIN 2, as shown in Figure 4. The proportion of the population with less than a grade 9 education ranged from a low of 6.2% in London to a high of 14.4% in Norfolk. The proportions with a university degree varied from 7.0% in Lambton (selected areas) to more than double that, 19.5%, in London.

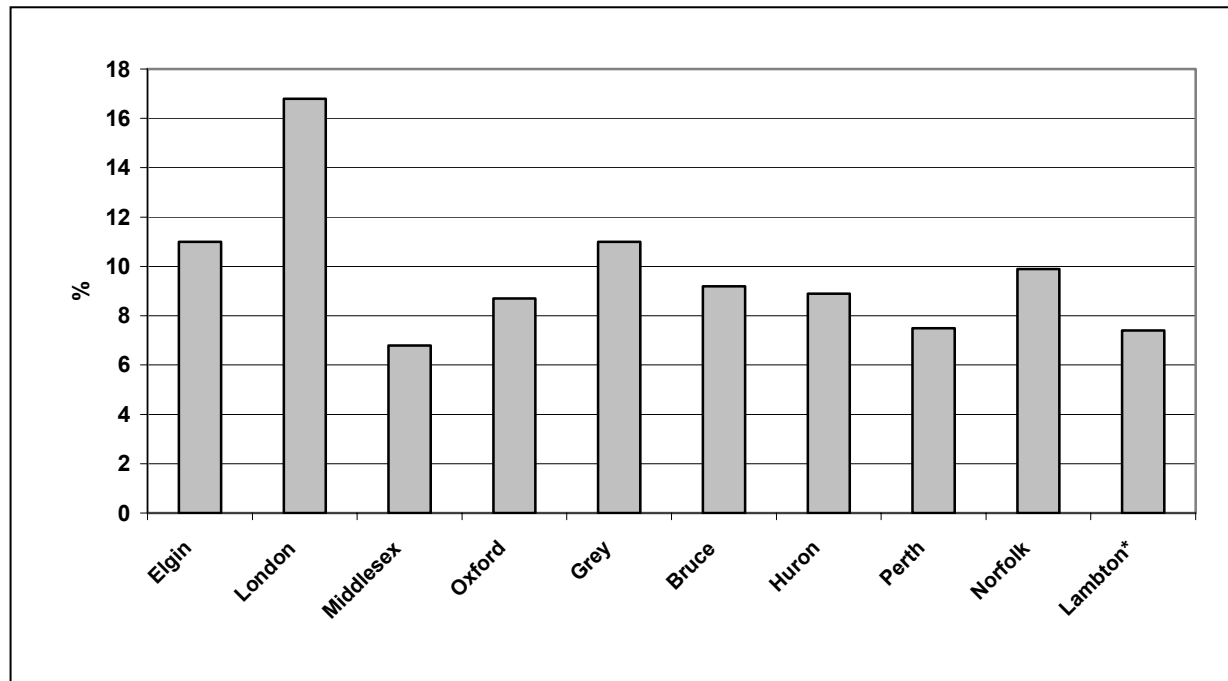
Figure 4
Education Levels, Ages 20+
LHIN 2 - 2001



Source: Statistics Canada, 2001 Census. *Lambton consists of 4 census subdivisions (Dawn-Euphemia, Warwick, Lambton Shores and Brooke-Alvinston). All of Dawn-Euphemia and all of Norfolk are included in the figures although only portions of these two census subdivisions are included in the LHIN. In addition, all of Grey and all of Oxford are included in the figures although portions of census subdivisions in these counties are excluded from the LHIN.

- Figure 5 show the proportion of the population living below Statistics Canada low income cutoffs according to 2000 income figures.⁴ Although London had the most highly educated population in LHIN 2, it also had the greatest proportion of residents living below Statistics Canada low income cutoffs, more than twice the proportion living in low income households compared to some of the other areas (Middlesex, Perth and Lambton) in the LHIN. Lambton (selected areas) had the lowest percentage of its population living in low income households.

Figure 5
Population Living in Low Income Households
LHIN 2 - 2001

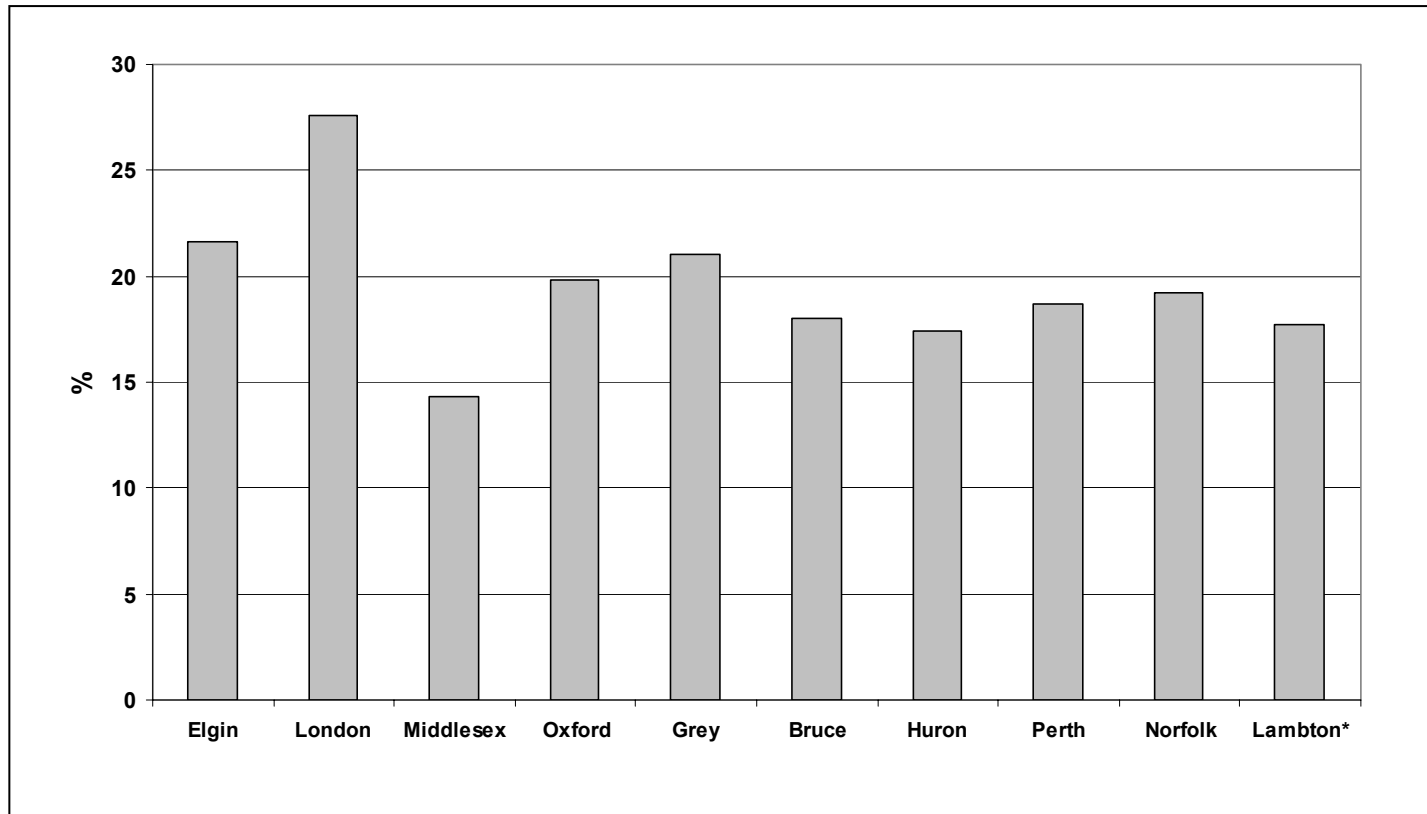


Source: Statistics Canada, 2001 Census. *Lambton consists of 4 census subdivisions (Dawn-Euphemia, Warwick, Lambton Shores and Brooke-Alvinston). All of Dawn-Euphemia and all of Norfolk are included in the figures although only portions of these two census subdivisions are included in the LHIN. In addition, all of Grey and all of Oxford are included in the figures although portions of census subdivisions in these counties are excluded from the LHIN.

⁴ The proportions of economic families or unattached individuals who are below Statistics Canada's low income cutoffs are calculated from unrounded estimates of economic and the size of area of residence. A family living below the low income cut-off is considered to be spending too much of its income on basic necessities (food, shelter, clothing).

- As shown in Figure 6, London also had the largest proportion of single parent families (of all families with children at home) in LHIN 2 while neighbouring Middlesex had the smallest. The proportion ranged from 17.4% to 21.6% in the remaining areas of LHIN 2.

Figure 6
Single Parent Families
LHIN 2 - 2001

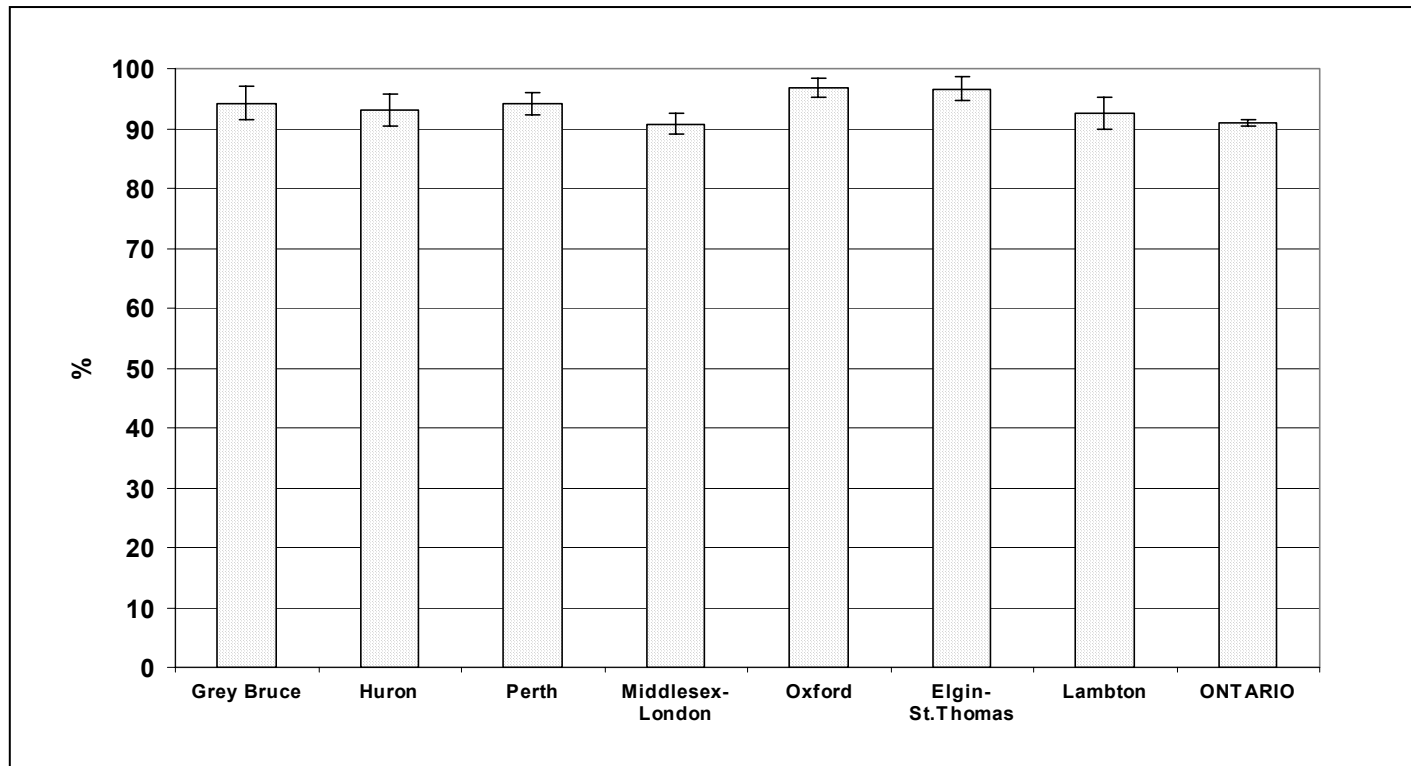


Source: Statistics Canada, 2001 Census. *Lambton consists of 4 census subdivisions (Dawn-Euphemia, Warwick, Lambton Shores and Brooke-Alvinston). All of Dawn-Euphemia and all of Norfolk are included in the figures although only portions of these two census subdivisions are included in the LHIN. In addition, all of Grey and all of Oxford are included in the figures although portions of census subdivisions in these counties are excluded from the LHIN.

Health Behaviours and Lifestyle Practices⁵

- Oxford [96.7% (± 1.6)], Elgin-St. Thomas [96.6% (± 2.0)], and Perth [94.2% (± 1.9)] had significantly higher proportions of residents reporting having a regular medical doctor compared to Ontario [90.9% (± 0.5)], as shown in Figure 7.

Figure 7
**Population with Regular Medical Doctor, 12+
 LHIN 2* and Ontario - 2000/01**

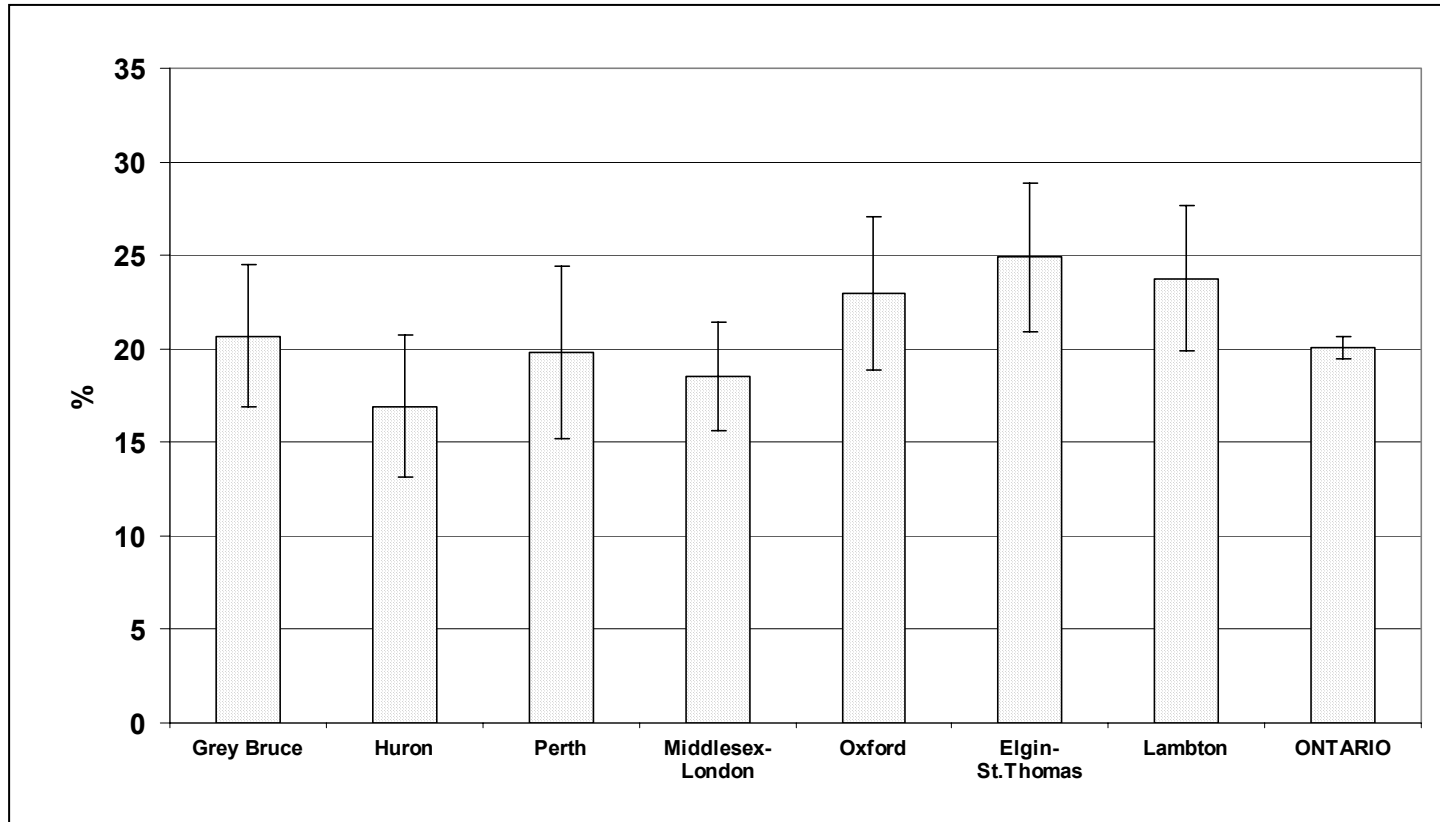


Source: Canadian Community Health Survey Cycle 1.1, 2000/01. *Lambton includes all of Lambton County, Norfolk is excluded.

⁵ This section is drawn from: Southwest Region Health Status Working Group (2004). Health Behaviours and Lifestyle Practices in Southwestern Ontario: Results from the Canadian Community Health Survey (2000/2001). London Ontario: Southwest Region Health Information Partnership.

- Elgin-St. Thomas [24.9% (± 4.0)] had a significantly higher proportion of daily smokers than Ontario [20.1% (± 1.3)], as seen in Figure 8.

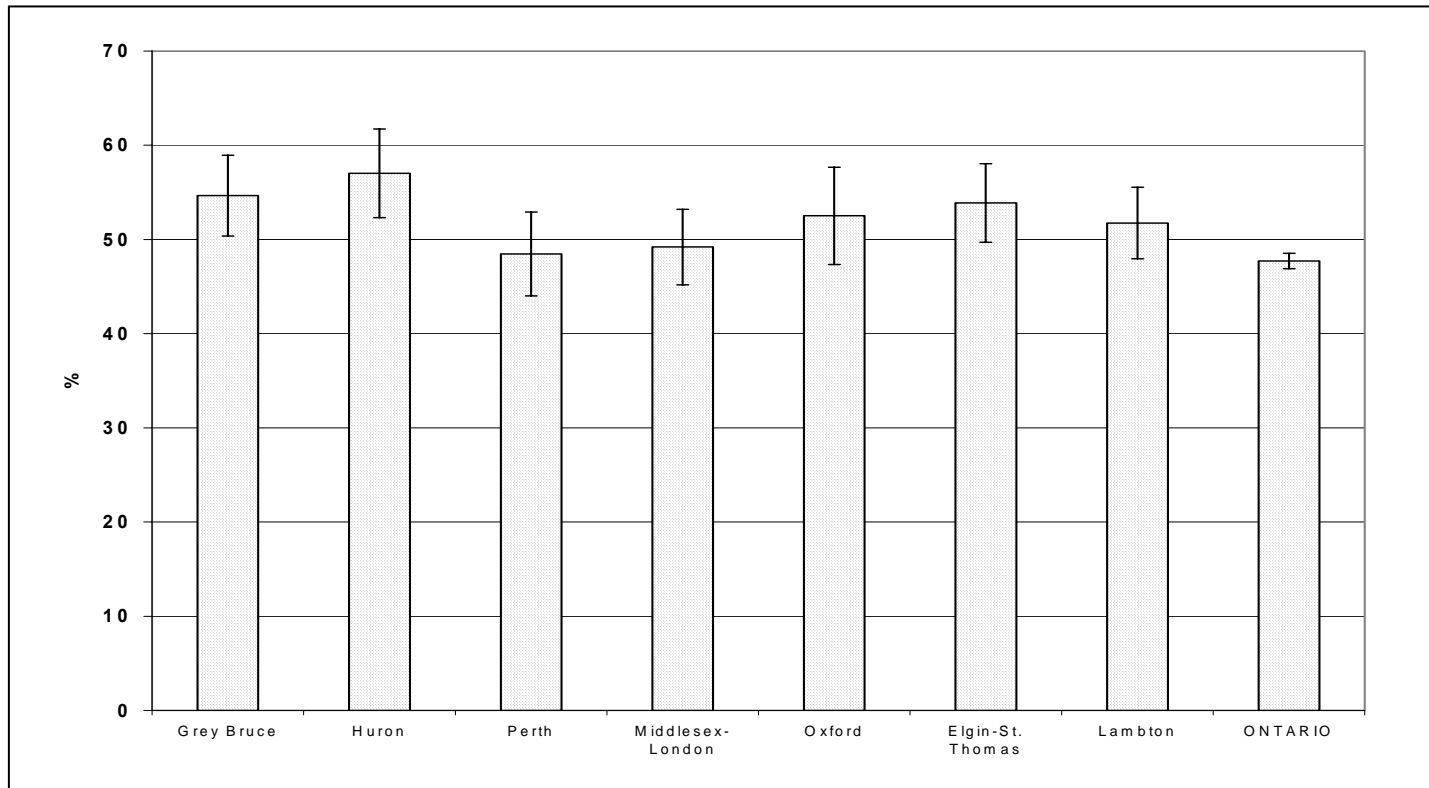
Figure 8
Daily Smoking Status, 12+
LHIN 2* and Ontario - 2000/01



Source: Canadian Community Health Survey Cycle 1.1, 2000/01. *Lambton includes all of Lambton County, Norfolk is excluded.

- Huron [57.0% (± 4.7)], Grey Bruce [54.7% (± 4.3)] and Elgin-St. Thomas [53.9% (± 4.2)] all had significantly higher proportions of respondents whose BMI was overweight/obese compared to Ontario [47.7% (± 0.8)], as shown in Figure 9.

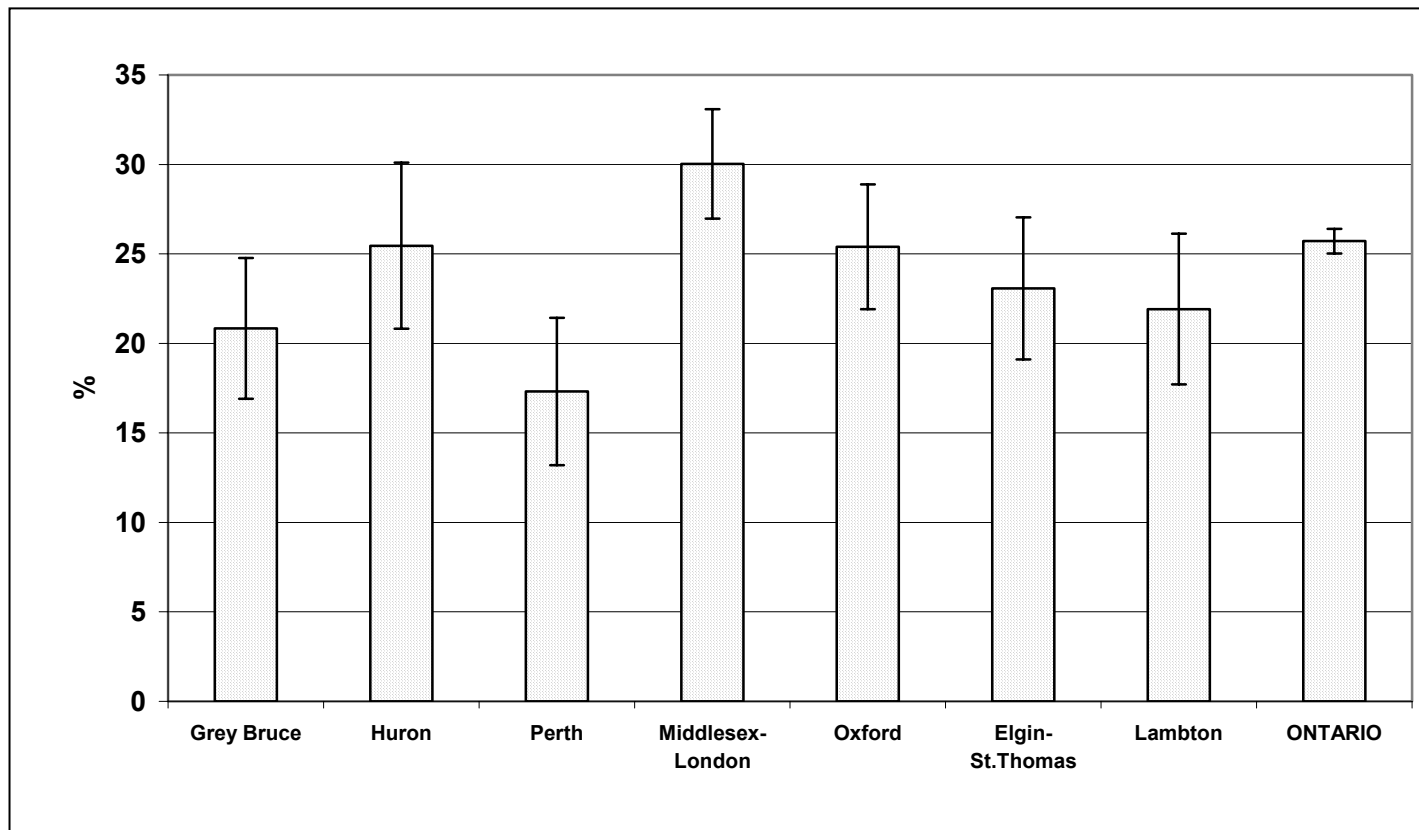
Figure 9
Overweight and Obese Population, 18+
LHIN 2* and Ontario - 2000/01



Source: Canadian Community Health Survey Cycle 1.1, 2000/01. *Lambton includes all of Lambton County, Norfolk is excluded.

- As shown in Figure 10, Grey Bruce [20.8% (±3.9)] and Perth [17.3% (±4.1)] all had significantly smaller proportions of residents who reported that most days were quite a bit/extremely stressful compared to Ontario [25.7% (±0.7)]. Middlesex-London [30.0% (±3.1)] had a greater percentage of residents who reported that most days were quite a bit/extremely stressful compared to Ontario residents.

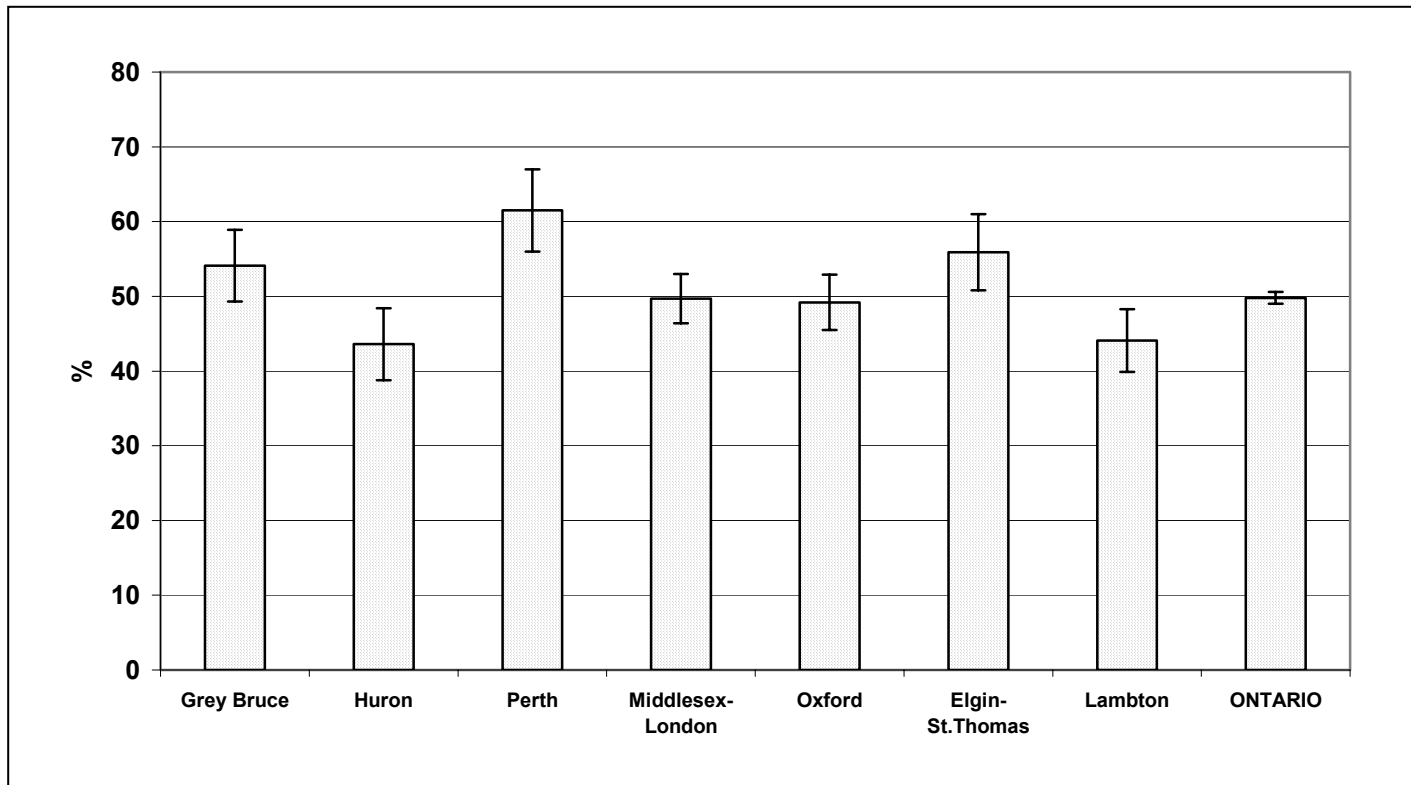
Figure 10
Most Days Quite a Bit/Extremely Stressful
LHIN 2* and Ontario - 2000/01



Source: Canadian Community Health Survey Cycle 1.1, 2000/01. *Lambton includes all of Lambton County, Norfolk is excluded.

- Both Huron [43.6% (± 4.8)] and Lambton [44.1% (± 4.2)] had significantly lower proportions of inactive persons compared to Ontario [49.8% (± 0.8)], while Perth [61.5% (± 5.5)] and Elgin-St. Thomas [55.9% (± 5.1)] had significantly higher proportions of inactive persons than Ontario, as shown in Figure 11.

Figure 11
Physical Activity Index-Inactive
LHIN 2* and Ontario - 2000/01



Source: Canadian Community Health Survey Cycle 1.1, 2000/01. *Lambton includes all of Lambton County, Norfolk is excluded.

Health Services

- Table 4 shows the number of acute hospital separations for leading causes (by ICD10CA Chapter) for areas in LHIN 2 in 2003/04. In total, there were more than 88,000 acute hospital separations for residents of LHIN 2 over that time period. With the exception of London, diseases of the circulatory system were the leading cause of acute hospitalization for all areas in the LHIN. This category represented between 11% (London) to 18% (Norfolk--selected areas) of all acute separations in each area.

**Table 4
Number of Acute Hospital Separations, Leading Causes
(ICD10CA Chapter Headings)
LHIN 2 - 2003/04**

Patient Residence	ICD 10CA Chapter	#	%
Elgin			
	Circulatory	1,132	14%
	Digestive	986	12%
	Pregnancy/Childbirth	924	11%
	Respiratory	858	10%
	Injuries and Poisoning	724	9%
	Other	<u>3,749</u>	<u>45%</u>
	Total Separations	8,373	100%
London			
	Pregnancy/Childbirth	4,326	16%
	Circulatory	3,059	11%
	Digestive	2,776	10%
	Mental and Behavioural	2,487	9%
	Injuries and Poisonings	2,427	9%
	Other	<u>11,718</u>	<u>44%</u>
	Total Separations	26,793	100%
Middlesex			
	Circulatory	791	14%
	Digestive	738	13%
	Pregnancy/Childbirth	716	12%
	Injuries and Poisonings	575	10%
	Respiratory	447	8%
	Other	<u>2,589</u>	<u>44%</u>
	Total Separations	5,856	100%

Setting Integration Priorities

Patient Residence	ICD 10CA Chapter	#	%
Oxford			
	Circulatory	1,555	14%
	Digestive	1,356	12%
	Pregnancy/Childbirth	1,238	11%
	Signs, Symp.-Abnormal Findings	950	8%
	Injuries and Poisonings	906	8%
	Other	5,174	46%
	Total Separations	11,179	100%
Grey (excluding Southgate)			
	Circulatory	1,483	15%
	Digestive	1,077	11%
	Injuries and Poisonings	966	10%
	Respiratory	851	9%
	Pregnancy/Childbirth	746	8%
	Other	4,754	48%
	Total Separations	9,877	100%
Bruce			
	Circulatory	1,206	15%
	Digestive	817	10%
	Injuries and Poisoning	774	10%
	FIHS	741	9%
	Pregnancy/Childbirth	613	8%
	Other	3,658	47%
	Total Separations	7,809	100%
Huron			
	Circulatory	894	13%
	Digestive	673	10%
	FIHS	624	9%
	Injuries and Poisonings	599	9%
	Mental and Behavioural	570	8%
	Other	3,447	51%
	Total Separations	6,807	100%

Setting Integration Priorities

Patient Residence	ICD 10CA Chapter	#	%
Perth			
	Circulatory	1,003	14%
	Injuries and Poisonings	685	9%
	FIHS	674	9%
	Digestive	664	9%
	Pregnancy/Childbirth	664	9%
	Other	3,622	50%
	Total Separations	7,312	100%
Norfolk**			
	Circulatory	132	18%
	Digestive	84	12%
	Pregnancy/Childbirth	77	11%
	Injuries and Poisoning	74	10%
	Respiratory	63	9%
	Other	300	41%
	Total Separations	730	100%
Lambton*			
	Circulatory	588	17%
	Digestive	379	11%
	Pregnancy/Childbirth	290	8%
	Neoplasms	286	8%
	Injuries and Poisonings	283	8%
	Other	1,612	47%
	Total Separations	3,438	100%

Source: CIHI data obtained from the MOHLTC Provincial Health Planning Database. Figures exclude newborns and stillbirths. **Norfolk includes the areas defined by the following postal codes N0E 1M0 (Port Rowan), N0E 1G0 (Langton) and N0J 1E0 (Courtland). *Lambton consists of 5 census subdivisions (Dawn-Euphemia, Warwick, Lambton Shores and Brooke-Alvinston and Kettle Point). All of Oxford is included in the figures.

➤ Table 5 summarizes the leading causes of hospital separations by area.

**Table 5
Leading Causes of Acute Hospital Separations
(ICD10CA Chapter Headings)
LHIN 2 - 2003/04**

	Elgin	London	Middlesex	Oxford	Grey (excl. Southgate)	Bruce	Huron	Perth	Norfolk**	Lambton*
1 st	Circulatory	Pregnancy, Childbirth	Circulatory	Circulatory	Circulatory	Circulatory	Circulatory	Circulatory	Circulatory	Circulatory
2 nd	Digestive	Circulatory	Digestive	Digestive	Digestive	Digestive	Digestive	Injuries & Poisonings	Digestive	Digestive
3 rd	Pregnancy, Childbirth	Digestive	Pregnancy, Childbirth	Pregnancy, Childbirth	Injuries & Poisonings	Injuries & Poisonings	FIHS	FIHS	Pregnancy, Childbirth	Pregnancy, Childbirth
4 th	Respiratory	Mental and Behavioural Disorders	Injuries & Poisonings	Signs, Symptoms, Abnormal Findings	Respiratory	Factors Influencing Health Status & Contacts with Health Services	Injuries & Poisonings	Digestive	Injuries & Poisonings	Neoplasms
5 th	Injuries & Poisonings	Injuries & Poisonings	Respiratory	Injuries & Poisonings	Pregnancy, Childbirth	Pregnancy, Childbirth	Mental and Behavioural Disorders	Pregnancy, Childbirth	Respiratory	Injuries & Poisonings

Source: CIHI data obtained from the MOHLTC Provincial Health Planning Database. Figures exclude newborns and stillbirths. **Norfolk includes the areas defined by the following postal codes N0E 1M0 (Port Rowan), N0E1G0 (Langton) and N0J1E0 (Courtland). *Lambton consists of 5 census subdivisions (Dawn-Euphemia, Warwick, Lambton Shores and Brooke-Alvinston and Kettle Point)

- Table 6 shows the number of hospital beds staffed and in operation at the end of the 2003/04 fiscal year in LHIN 2. There are 32 hospital sites in LHIN 2 with more than 3,100 hospital beds (including acute, psychiatric, complex continuing care and rehabilitation beds).

**Table 6
Beds Staffed and in Operation at March 31, 2004
LHIN 2**

Hospital	Med.	Surg.	Comb. MS	ICU	Obstetric	Paed.	Psych.	CCC(*)	Rehab.	TOTAL
Elgin County										
St. Thomas-Elgin Gen. Hosp.	56	28		11	6	6		49	10	166
St. Joseph's Health Care St. Thomas-MH							174			174
Total	56	28		11	6	6	174	49	10	340
City of London										
London Health Sciences Centre-University	72	111	41	37						261
London Health Sciences Centre-Victoria South St.	78	96		38			68			280
London Health Sciences Centre-Victoria Westminster	69	48			21	70	11			219
St. Joseph's Health Care London	51	95		12	49	2				209
St. Joseph's Health Care London-Parkwood								236	119	355
St. Joseph's Health Care London-MH							397			397
Total	270	350	41	87	70	72	79	236	119	1,721
Middlesex County										
Four Counties Health Services			12					8		20
Strathroy Middlesex Gen. Hosp.	30	15		4	4	2		32		87
Total	30	15	12	4	4	2		40		107
Oxford County										
Woodstock Gen. Hosp.			61	6	8	3	17	25		120
Tillsonburg District Memorial Hosp.			46	5		4		24		79
Alexandra Hosp.			16	3	2			14		35
Total			123	14	10	7	17	63		234
Grey County										
Hanover and District Hosp.			23	4	4	4		27		62

Setting Integration Priorities

Hospital	Med.	Surg.	Comb. MS	ICU	Obstetric	Paed.	Psych.	CCC(*)	Rehab.	TOTAL
South Bruce Grey Health Centre-Durham			8							8
Grey Bruce Hlth. Serv.-Grey Bruce	36	42		12	8	8	30	38	16	190
Grey Bruce Hlth Serv-Markdale			20		1					21
Grey Bruce Hlth Serv.-Meaford			26	3		1				30
Total	36	42	77	19	13	13	30	65	16	311
Bruce County										
South Bruce Grey Hlth Centre-Chesley			8							8
South Bruce Grey Hlth Centre-Walkerton			21		2			2		25
South Bruce Grey Hlth Centre-Kincardine			19					2		21
Grey Bruce Hlth Serv-Lion's Head			4							4
Grey Bruce Hlth Serv-Bruce Peninsula			22		1					23
Grey Bruce Hlth Serv-Saugeen Memorial			15			1				16
Total			89		3	1		4		97
Huron County										
Clinton Public Hosp.			14							14
South Huron Hosp.			11							11
Alexandra Marine and General Hosp.	18	8		4	2		20	14		66
Wingham and District Hosp.			17	7	2	1			5	32
Seathforth Comm. Hosp.	18				3	2		11		34
Total	36	8	42	11	7	3	20	25	5	157
Perth County										
Listowel Memorial Hosp.			20	1	4	1		25		51
St. Mary's Memorial Hosp.			13		2			6		21
Stratford General Hosp.	30	33		5	8	7	18	18	15	134
Total	30	33	33	6	14	8	18	49	15	206
GRAND TOTAL	458	476	413	152	127	112	338	531	165	3,173

Source: Daily Census Summary, MOHLTC, Finance and Information Management System. (*) CCC = Complex Continuing Care

- Table 7 shows the number of LTC homes and beds in each area in LHIN 2. There are close to 7,000 LTC beds in total in the LHIN.

Table 7
Number of LTC Beds at September, 2003
LHIN 2

Elgin	#
Bobier Villa	57
Caessant Care on Mary Bucke	60
Elgin Manor	90
Valleyview H F A	136
Extendicare Port Stanley	60
Terrace Lodge	100
Caessant Care on Bonnie Place	114
Chateau Gardens (Aylmer) Nursing Home	60
Total	677
London	#
Versa-Care Centre, Lambeth	139
Dearness Home for Seniors	372
Extendicare, London	170
Marian Villa	217
McCormick Home for the Aged	141
Chelsey Park Nursing Home	247
Meadow Park Nursing Home	122
Versa-Care Elmwood Place	78
Chateau Gardens Nursing Home	63
Kensington Village	108
Mount Hope Centre for Long Term Care	177
Longworth Long Term Care Facility	160
Total	1,994

Setting Integration Priorities

Middlesex	#
Craigholme	83
Middlesex Terrace	105
Country Terrace	120
Strathmere Lodge	175
Sprucedale Care Centre	62
Babcock Nursing Home	60
Chateau Gardens (Parkhill) Nursing Home	59
Total	664
Oxford	#
Oxford Regional Nursing Home	80
Norvilla Nursing Home	40
Bonnie Brae Health Care Centre	80
PeopleCare Tavistock	100
The Maples Home for Seniors	43
Maple Manor Nursing Home	102
Woodingford Lodge	228
Caressant Care Nursing Home	95
Total	768
Grey	#
Country Lane Long Term Care	34
Village Seniors' Community	70
Grey Gables Home for the Aged	66
Meaford Long Term Care Centre	77
Lee Manor	150
Versa-Care Summit Place	119
Errinrung Nursing Home	42
Versa-Care Georgian Heights	40
Versa-Care Maple View, Owen Sound	29
Rockwood Terrace	100
Hanover Care Centre	41
Total	768

Setting Integration Priorities

Bruce	#
Parkview Manor Health Care Centre	34
Pinecrest Manor	61
Southampton Care Centre	84
Brucelea Haven	144
Gateway Haven	100
Golden Dawn Nursing Home	45
Elgin Abbey Nursing Home	27
Trillium Court	40
Total	535
Huron	#
Huronview	120
Fordwich Village Nursing Home	33
Maitland Manor	91
Queensway Nursing Home	60
Seaforth Manor	63
Blue Water Rest Home	65
Exeter Villa	47
Braemar Retirement Centre	69
Huronlea Home for the Aged	64
Total	612
Perth	#
Knollcrest Lodge	77
Ritz Lutheran Villa	83
Mitchell Nursing Home	48
Hillside Manor	90
Spruce Lodge	128
People Care Centre	60
Caessant Care Listowel Nursing Home	52
Kingsway Lodge Nursing Home	62
Wildwood Care Centre Inc.	60
Greenwood Court	45
Total	705

Norfolk	#
Sacred Heart Villa	54
Lambton	#
North Lambton Rest Home	88
Watford Quality Care Centre	63
Total	151
GRAND TOTAL	6,928

Source: PDST, MOHLTC, Finance and Information Management System. Figures for Norfolk and Lambton only include those facilities located in LHIN 2.

- Table 8 lists the number of Transfer Payment Agencies by category in LHIN 2. There are more than 230 TPAs located in the LHIN.

Table 8
Ministry of Health and Long-Term Care
Transfer Payment Agencies (TPAs)
LHIN 2

Area	Addiction Treatment Services	Ambulance Services	Community Care Access Centres	Community Health Centres	Community Mental Health Services	Hospital Sites*	LTC Community Support Services	LTC Homes	Public Health Units
Elgin		1	1	1	3	2	2	8	1
London	4	1	1	1	8	6	25	12	1
Middlesex									
Oxford		1	1		5	3	9	8	1
Grey	2	1	1		3	5	8	11	1
Bruce		1				6		8	
Huron	1	1	1		4	5	22	9	1
Perth	1		1			3		10	1
Norfolk		1	1					1	
Lambton		1	1	1				2	

Hospital sites include Mental Health only sites (i.e. former Provincial Psychiatric Hospitals). Agencies are listed according to the areas in which their main offices are located. Many agencies serve residents in counties other than the ones in which they are located--for example, many London-based agencies serve residents in Middlesex and other counties. TPAs in Norfolk and Lambton are only those that are located in the areas included in LHIN 2. TPAs exclude practitioners and independent health facilities.

- Table 9 shows the number of active non-specialist physicians (family medicine/general practice, family practice/anaesthesia and family practice/emergency medicine)⁶ as well as physician to population ratios in LHIN 2 in 2003. The physician to population ratio, a crude measure of the supply and demand of family physicians⁷, was highest in London and lowest in Middlesex County and Lambton (selected areas). Many communities in LHIN 2 are also designated as underserved for family physicians.

Table 9
Number of Non-Specialist Physicians and Physician to Population Ratios, LHIN 2 - 2003

	# Phys.	Population	Phys. to Popn. Ratio
Elgin	54	86,096	62.7
London	346	355,169	97.4
Middlesex	36	73,459	49.0
Oxford	62	103,880	59.7
Grey	69	93,468	73.8
Bruce	51	67,156	75.9
Huron	47	61,896	75.9
Perth	61	77,265	78.9
Norfolk	35	63,496	55.1
Lambton*	10	20,545	48.7

Source: Number of physicians-Ontario Physician Human Resource Data Centre (OPHRDC), Population figures-Statistics Canada population estimates, obtained from the MOHLTC Provincial Health Planning Database. *Lambton consists of 4 census subdivisions (Dawn-Euphemia, Warwick, Lambton Shores and Brooke-Alvinston). All of Dawn-Euphemia and all of Norfolk are included in the figures although only portions of these two census subdivisions are included in the LHIN. All of Grey and Oxford are included in the figures.

⁶ Figures were not available at the census subdivision level for family medicine/general practice physicians alone. Family physicians with emergency and anaesthesia training are unlikely to work in family practice settings.

⁷ There are many limitations to the physician to population ratio. For example, it does not take into account different physician workloads and types of services provided or that physicians may provide care to non-county residents and that residents may obtain care from non-local physicians. Furthermore, it does not adjust for the age, sex and health status of a population, factors that may affect its use of family physicians.

Prioritized Integration Opportunities

Prioritized Integration Opportunities

South West LHIN Integration Opportunities (from Nov. 23/2004 workshop)

#	Opportunity	Initiator
1	Protecting academic and research mission	Diane Beattie
2	Access to standard sets of evidence-based information resources	Jan Figurski
3	LHIN to provide access to services using flexibly defined CHC model – as single point of access, health promotion focused and multidisciplinary services – and equal access across the LHIN	Shirley Biro
4	Delivery of health care services meeting the French Language Services Act requirements	Lorraine Desjardins
5	Healthy community development	Maureen Lapointe
6	Strong “local” autonomy within a regional network	Stephen Molnar
7	Needs-based funding	Brent Gingerich
8	Capitalizing on established resources by enhancing existing networks	Nancy Johnston
9	Integrating rehabilitation networks	Nancy Ambrogi
10	Regionally integrated cancer care	Michael Sherar
11	A framework for a common patient focused health care pathway – components, barriers and opportunities	Margret Comack
12	Individuals with developmental disabilities moving into or living in long-term care facilities	Barb Gauntlett
13	Develop a more responsive/nimble local health care system by building an integrated and coordinated primary care/community care system (including linking family physicians to community care)	Paul Huras/Sandra Coleman
14	The issue of Alternate Level of Care (ALC) and opportunity for integrated solutions to providing care in an appropriate setting	Tom Peirce
15	Rural networks supporting the Southwest LHIN	Jim Whaley
16	Develop a life long system of support for people with significant physical and/or sensory disabilities	Judith Fisher
17	Transformation of CCAC’s to better work with our LHIN	Jennifer Smit
18	Strategies for End-of-Life Care services	Wendy McEwen, Sharon Baker
19	Advocacy-Quality of care	Christine Williams
20	Improved rural transportation	Andrew Williams
21	E-health/IT in LTC and community: creating a common data system for LHINs	Mary Raithby
22	Delivery rural/remote health care services which are equal to urban services	Carolyn Yantzi
23	Networking –care of elderly	Catherine Glover

Setting Integration Priorities

24	Human resources	Georgia McIlwraith
25	Communication and information as enablers for integration	Michael Petrenko
26	To form rural mental health networks at rural/county level to provide system/regional level planning; 2) to provide LHINs with rural mental health voice; 3) LHINs would require specific MH advocate	Molly Murphy
27	Women's mental health and addiction	Susan Macphail
28	Integrating parallel health care services	Doug Norsworthy
29	Improve system navigation for people with chronic complex health issues eg. geriatrics, paediatrics, palliative, mental health, etc.	Maureen McVickers, Judy Chalmers
30	Community support services must be integral to a transformed health system	Jackie Wells
31	Maintaining and building mental health consumer/survivor initiatives as an integral component of the LHIN structure Ensuring that mental health consumers have a voice and continue to have input in the restructuring of the health system in Ontario	Barb Frampton
32	Geriatric and therapeutic (rehabilitation) programs for seniors	Denise Bedard "The Story of Bill"
33	Develop formal structure for rehab services in LTC for target populations (SCI/ABI/Stroke)	Mary Raithby
34	Chronic disease prevention and management integrated strategies and system to deal with primary and secondary prevention of chronic illnesses across life continuum, health sectors (eg. public health, primary health care, home care, acute care) and other sectors	Cathy Goetz-Perry
35	To develop a model to provide comprehensive integrated care to patients/families who do not have a primary health care provider	Laurie McKellar
36	Access to primary health care for the homeless	Gordon Milak
37	Mental health and addiction services as core components in an integrated health care system	Sandy Stockman
38	Management of chronic diseases	Doug Earle
39	Integrated collaborative solutions for people with disabilities that cross various government sectors	Deborah Delorme
40	E-health – 1 patient – 1 record	Diane Beattie
41	Effecting cultural change	Nitin Madhvani
42	Community mental health services	Diehl Elkin
43	Thehealthline.ca, I&R, and 211 and how that can support the LHIN	Sandra Coleman
44	Maintaining and enhancing continuity of care and quality of services, program standards both inter and intra-LHIN(s)	Christine Ozimek
45	Integrating community support services	Craig Nicks, Alan Johnston
46	Integrated quality to ensure person driven system	Kathy Scanlon
47	Infection Control	Dr. Sharon Baker

**Top Ten Integration Opportunities in Southwest LHIN
(based on Nov. 23/2004 ranking process)**

Rank	Integration Opportunity	Number of Votes
1	e-Health: 1-patient/1-record (Administrative)	129
2	Needs-based Funding (Administrative)	91
3	e-Health in LTC & Community Services (Administrative)	90
4	Rural Networks (Administrative)	86
5	Human Resources (Administrative)	78
6	Primary Care (Patient Care)	72
7	Mental Health & Addictions (Patient Care)	58
8	Community Support Services (Patient Care)	56
9	Rural Services Equal to Urban Services (Patient Care)	55
10	Improved Rural Transportation (Patient Care)	52

A. Patient Care/Services Integration

A. Description of Patient Care/Services Integration Initiative

Title of administrative support service initiative:		Type of Integration (more than one box can be checked)	
Primary Health 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 <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>			
Please briefly describe the initiative:			
<u>Current Primary Health Care Integration Initiatives in Areas of LHIN 2:</u> <ul style="list-style-type: none"> - Grey Bruce Huron Perth District Health Council (2003). 10 Point Action Plan for Rural Health Care - North East London Primary Health Care Model/Project (2004). Approved proposal for an interdisciplinary primary health care team to address the primary health care needs in a significantly underserved area of London. - CCACLM Hospital in the Home program (2004) in partnership with LHSC and LIHC providing more acute care in the home. - Sauble and Area Clinic Board of Directors (2003). Sauble Rural Community Health Centre Proposal. - Thames Valley District Health Council (2004). Improving Access to Primary Health Care in the Thames Valley District. - MOHLTC Transformation Agenda, specifically, Family Health Teams and Primary Health Care Reform. 			
<i>If this is an initiated/existing activity...</i>		What are the outcomes/lessons learned (if any)?	
What is the current status?			
Lead contact person:			
Name: Paul Huras Title: Executive Director Telephone: 519-858-5015		Organization: Thames Valley District Health Council Email Address: phuras@tvdhc.on.ca	

A. Description of Patient Care/Services Integration Initiative

Title of administrative support service initiative: Delivery of Rural Remote Care/Services		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 <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	List of partners involved:	
Please briefly describe the initiative:		
If this is an <i>initiated/existing</i> activity... What is the current status? Not applicable	What are the outcomes/lessons learned (if any)?	
Lead contact person: Name: John Saidak Title: Service Delivery Care Manager Telephone: 519-668-2997	Organization: Saint Elizabeth Health Care Email Address: jsaidak@saintelizabeth.com	

A. Description of Patient Care/Services Integration Initiative

Title of administrative support service initiative: Community Support Services		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 <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	List of partners involved:	
Please briefly describe the initiative:		
<i>If this is an initiated/existing activity...</i> What is the current status? Not applicable	What are the outcomes/lessons learned (if any)?	
Lead contact person: Name: Jackie Wells Title: Manager Telephone: 519-245-3170	Organization: VON Email Address: wellsj@von.ca	

A. Description of Patient Care/Services Integration Initiative

Title of administrative support service initiative: Mental Health and Addiction Services		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 type="checkbox"/> Initiated/existing integration activity* <input checked="" type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	List of partners involved: Anita Bacon, Patty Chapman, Martha Connoy, Lindsay Damen, Heather Debruyn, Deb Delorme, Bob Fehir, Barry Fellingner, Cheryl Forchuk, Barbara Frampton, Fred Hagglund, Catherine Hardman, Steven Holbert, Barry M, Alison Mahon, Beth Mitchell, Molly Murphy, Walter Osoka, Sue Ousely, Joe Penton, Beth Powell, Linda Sibley, Vicky Stevens, Caroline Tykoliz, Maureen Vichas, Sandy Whittall and Sandy Stockman	
Please briefly describe the initiative: <p>Mental health and addiction problems (including problem gambling) affect a significant proportion of the population of Ontario. They represent a tremendous burden for those who are directly affected by them, their families, the larger community and the health care system as a whole. Mental health and addiction problems do not exist in isolation from other health problems: they can and do impact on the incidence and treatment outcomes for many physical health problems. Their impact on well-being is so great that, without mental health, there is no health. Given this, service gaps and waiting lists for mental health and addiction services are no less important than other health care priorities. Therefore planning, funding and policy decisions of the LHIN must demonstrate that Mental Health and Addiction Services are integrated as core components of the health care system for the Southwest LHIN.</p> <p>Despite the prevalence and impact of mental health and addiction problems, and despite the numerous and persuasive planning documents that have illustrated the need to prioritize these issues, they have historically been marginalized within the health care system. It is time to reverse this trend and provide these issues and those affected by them with the attention and services they require. The LHIN is well-positioned to do this.</p> <p><u>Rationale for Integrating Mental Health and Addiction Services as Core Health Care System Components</u> The prevalence of mental health and addiction problems demands that they be prioritized within the health system</p> <ul style="list-style-type: none"> • Canadian Health Network states that 10% of adult Canadians report problems with their drinking and 50% report problems with someone else's drinking (Ontario Federation of Community Mental Health and Addiction Programs) • 20% of Canadians will experience a mental illness in their lifetime. (Health Canada Report, 2002) • Over 1.5 million Canadians now experience clinical depression, a disorder that affects 10-15% of Canadians at some point in their lives. ("Community Integration Planning: Key Issues in Mental Health and Addictions", Joint Paper of CAMH, Federation and Canadian Mental Health Assoc. Ontario, December, 2004) • One in eight Canadians will be hospitalized for mental illness at least once in their lives, more than are hospitalized for cancer or heart disease (Joint paper of CAMH, OFCMHAP and CMHA) • Ten per cent of Canadians surveyed by Stats Canada in 2002 reported symptoms consistent with alcohol or illicit drug dependence 		

and 5% reported problem gambling or at risk behaviour. (Canadian Community Health Survey, 2002)

- Research reflects a high rate of co-occurring addiction and mental health problems and shows that people who have such concurrent disorders experience poor treatment outcomes, high rates of relapse, suicide and homelessness.

The impact of mental illness and addiction on other health issues illustrates the need for the health care system as a whole to be able to recognize and intervene with those who have problems and those at risk:

- A review of 62 research studies conducted from 1980 to 2003 has found that depression increases the risk of mortality for people with coronary heart disease. (Psychosomatic Medicine)
- 43% of adults suffer adverse health effects from stress (CMHA Ontario)
- Over 30 % of lifetime users of illicit drugs other than cannabis report harm to their physical health arising from drug use (Canadian Addiction Survey, 2004)
- Depression is frequently a predictor of disease and research has found that people with serious mental illness have higher rates of grave medical illness and premature death than the general population (CMHA Ontario)

The economic and social cost of mental health and addiction problems is well documented:

- Alcohol and illicit drug abuse accounted for \$4.9 billion in lost productivity due to illness and premature death, \$1.7 billion in law enforcement and \$2.1 billion in direct health care costs. (Kirby Report, November, 2004)
- Mental illness costs \$6.3 billion in direct health care costs and \$8.1 billion in lost productivity due to illness and premature death. (Kirby Report, November, 2004)
- 90% of suicide victims have a diagnosable mental illness or substance use disorder (Kirby Report, November, 2004)
- 22% of homeless persons claimed that mental health or substance abuse was the reason for becoming homeless. (Kirby Report, November, 2004)

The benefits of early intervention and of timely, appropriate intervention are many:

- Research has shown that the longer psychotic symptoms are left untreated, the worse the prognosis and there is greater evidence of brain damage in persons who experience long, untreated psychotic episodes than in those who experienced shorter, more efficiently treated episodes. (Kirby Report, November, 2004)
- "Without early intervention and treatment, child and adolescent disorders frequently continue into adulthood...these childhood disorders are likely to persist and lead to a downward spiral of school failure, poor employment opportunities and poverty in adulthood. No other set of illnesses damages so many children so seriously." (Kirby Report, 2004)
- It has been found that by two years following treatment for substance use there are significant declines in the use of health services, resulting in considerable cost savings to the overall health care system. (Federation report, 2003)
- It is reported that each dollar spent on the treatment of alcohol use disorders saves between \$4 and \$12 in long-term societal, economic and medical costs. (Federation report, 2003)

Investment in mental health and addiction services is an investment in population health

- According to WHO, addictions and mental illness account for the greatest degree of disability, worldwide. (CAMH, Federation, CMHA Joint Paper)
- Over the next 20 years, Harvard University and the World Bank foresee depression becoming the leading source of workdays lost through disability and premature death. Heart disease will be number two. (Federation report, 2003)

There are other significant benefits to be derived from integrating mental health and addiction services as core health system components:

- It sends a clear signal to consumers, family members and the organizations that serve them that their need for an effective, responsive and adequately resourced mental health and addiction system is important and legitimate.
- Identifying mental health and addiction issues as health care priorities significantly reduces the stigma associated with these problems, thereby increasing the likelihood of early intervention.
- It enables the LHIN to build on the province's mental health and addiction system planning efforts and commitments.
- It provides an opportunity to develop a comprehensive mental health and addiction strategy within the health care system that :
 - ✓ secures dedicated funding for mental health and addictions
 - ✓ builds system capacity
 - ✓ ensures the availability of core supports and services throughout the Southwest LHIN
 - ✓ develops mental health and addiction service delivery partnerships with clear roles and accountabilities at the community agency, Schedule One and tertiary levels
 - ✓ promotes client-centred and family-focused service
- It fosters collaboration within the health care system in health promotion, identification and early intervention with at risk populations. The need for a collaborative approach is illustrated by the results of the 2002 Statistics Canada Community Health Survey: of those who reported feelings and symptoms of the surveyed mental disorders or substance dependencies, only 32% saw or talked to a health professional during the 12 months prior to the survey.
- It fosters integrated treatment of co-occurring mental health and addictions problems and of integrated approaches to other health problems which are impacted by mental health and/or addiction

Intended Outcomes of Integrating Mental Health & Addictions Services as Core Components of the Health System

- Better understanding of mental health and addiction issues throughout the health care system and improved capacity to identify those with problems and those at risk.
- Timely, effective and coordinated response to those with mental health and addiction problems and those at risk
- Those with mental health and/or addiction problems receive an effective and appropriate response from all components of the health care system, which work together to ensure timely and appropriate referrals, service coordination and continuity of care.
- Increased awareness, acceptance and use of mental health and addiction services
- More appropriate and cost-effective use of acute care services
 - ✓ Bed utilization and efficiency benchmarks met
 - ✓ Appropriate use of ER services
- Mental health and addiction services are accessible, responsive, coordinated and comprehensive
- Decreased stigma and discrimination
- Standardized delivery of mental health and addiction services across the Southwest LHIN catchment area (standardized admission and discharge criteria and protocols, assessment tools and evaluation framework)

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

What is the current status?

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

Lead contact person:

Name: Sandy Stockman
 Title: Executive Director
 Telephone: 519-371-4120

Organization: Grey Bruce Community Health Corporation
 Email Address: sstockman@gbchc.org

A. Description of Patient Care/Services Integration Initiative

Title of administrative support service initiative:		Type of Integration (more than one box can be checked)	
Rural Transportation		<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 <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>		Sylvia White, Ontario March of Dimes; Angie Woodcock, Canadian Red Cross, Woodstock/Oxford; Aafke VanRooyen, Canadian Red Cross, Woodstock/Oxford; Vicki Wolfe Hinz, Mitchell Community Outreach; Lynne Strugnell, Stratford General Hospital; Paul Williams, St. Mary's Community Living; Sharon Rudy, St. Mary's Mobility Bus; Wendy Orchard, Stratford Meals On Wheels and Neighbourly Services; Dale Kenney, Alzheimer Society of Perth County; Jennifer O'Grady, North Perth Community Support Services; Caroline Simons, Epilepsy Huron, Perth, Bruce; Ron Latham, Community Volunteer; Andy Underwood, Grey Bruce Community Support Services; Jean Young, Town and County Support Services, Huron County; Sallie Lawton, Midwestern Adult Day Services, Huron County; Diane Beattie, Chair, Regional Stroke Steering Committee; Muriel Boyd, Community Living Stratford and Area; Dale Howatt, Community Services Advisory Committee, Consultant, Perth County; Heinz Schweinbenz, Transportation Consultant; Nina Dupuis, Cheshire Homes of London Inc.; Kathy Scanlon, Executive Director CCAC Perth & Huron Counties; Dianne Lichti, Milverton Community Outreach; Shirley Hanlon, VON Perth-Huron Community Support Services.	
Please briefly describe the initiative:			
<p>Transportation is one of the key issues for integration. Further, Rural Transportation is vital for a significant percentage of the population across the South West LHIN service area and must be a "made in South West" solution. Transportation, particularly in a rural setting, is the foundation of independence and a lynch-pin of integration. All current providers and funders of transportation must work together to create a more client-focused, coordinated, cost-effective, integrated, centralized transportation service. The existing silos within transportation (i.e. if you have a specific health need, then I can provide transportation for you) must be dismantled. We need to focus on what type of vehicle is required to provide the transportation service to a specific individual and the level of support that is needed during the transportation process (i.e. ambulance with medically trained staff, stretcher, wheelchair bound, ambulatory). Across the South West LHIN numerous volunteers provide what is commonly called "Volunteer Drivers". It will be imperative that this level of service provision remains within the local communities if we are going to effectively recruit, educate, support, reimburse and recognize these invaluable individuals. Appropriate, cost-effective Rural Transportation is integral to client-focused care and in the absence of the SW LHIN making it a key priority, it will become a barrier to the client and within our system of health care.</p>			

<p><i>If this is an initiated/existing activity...</i> What is the current status?</p> <p>Currently across the SW LHIN:</p> <ul style="list-style-type: none"> - transportation is very fragmented and non-existent in some areas - there is inconsistency in funding (for the service providers, for the client) and in service delivery standards - current funding will not support the anticipated growth of transportation needs across the rural communities - missed appointments cost the health care system significant dollars AND the patient increased distress - current fare structures (i.e. out of service area medical trips) can become a barrier for clients - some communities have Transportation Working Groups in existence with success stories - there is a variance in funding received from individual municipalities, and individual municipalities' interpretation of their role/responsibility in transportation 	<p>What are the outcomes/lessons learned (if any)?</p> <p>We have learned:</p> <ul style="list-style-type: none"> - there needs to be recognition of the cost involved to coordinate transportation - municipal decision-makers need to be at the transportation discussion groups - all special needs individuals need to be considered (i.e. children, mentally challenged, etc.) - transportation of non-emergent patients (hospital to LTC facility; hospital repatriation; etc.) is costly and not client focused. - transportation Working Groups need to exist in each County. Representative from these working groups could then provide expertise to the SW LHIN community. - There needs to be an awareness that we do not put at risk, any of the current transportation funding sources/opportunities.
<p>Lead contact person:</p> <p>Name: Shirley Hanlon Title: Community Support Services Manager Telephone: 519-271-0728</p>	<p>Organization: VON Perth-Huron Email Address: vonads@orc.ca</p>

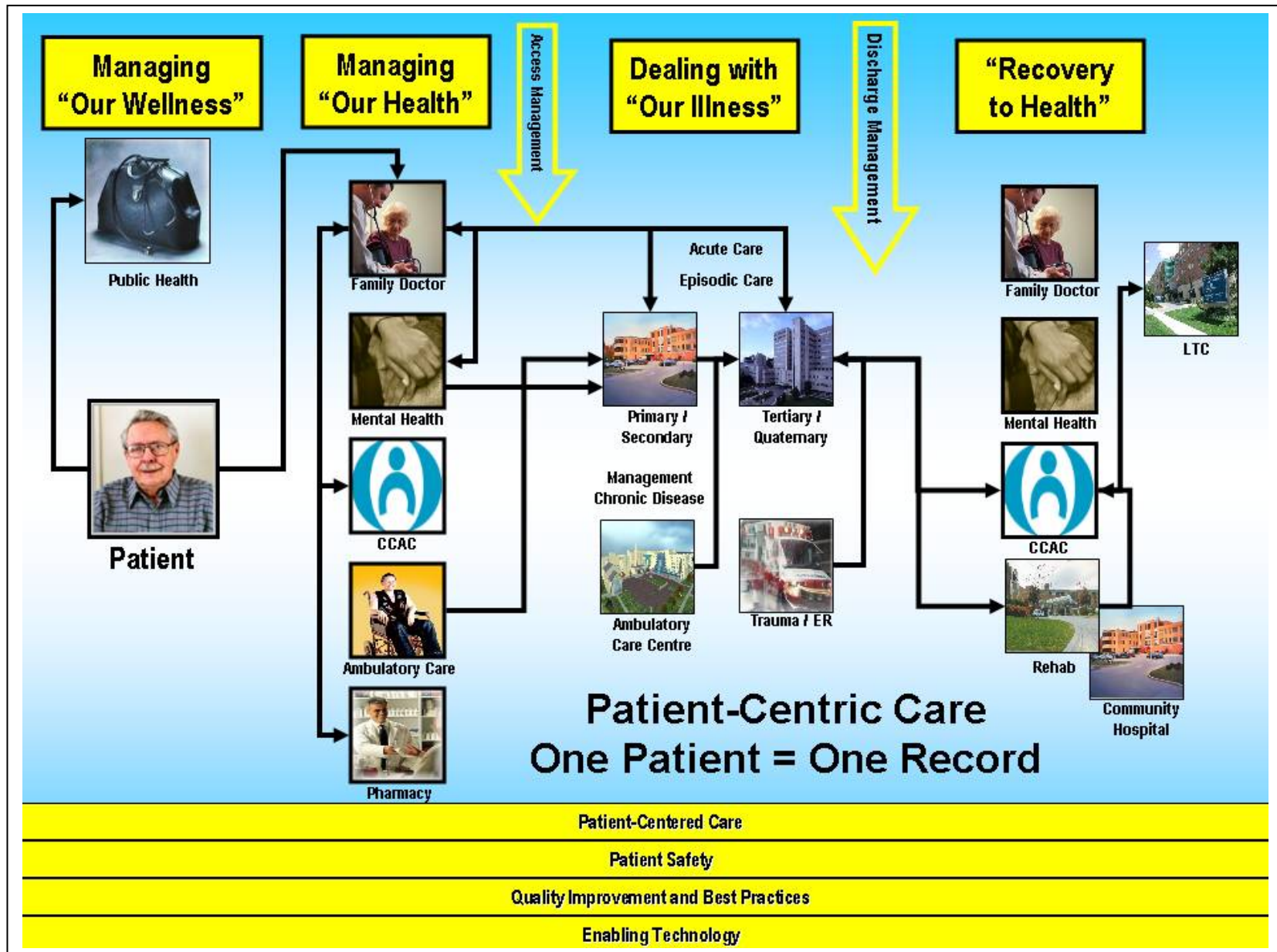
B. Administrative/Support Services Integration

B. Description of Administrative Support Services Integration Initiative

<p>Title of administrative support service initiative:</p> <p>1 Patient – 1 Record (E-Health)</p>		<p>Type of Integration (more than one box can be checked)</p> <p><input checked="" type="checkbox"/>Horizontal <input checked="" type="checkbox"/>Vertical</p> <p><input checked="" type="checkbox"/>Intersectoral</p> <p><input type="checkbox"/> Other, describe:</p>
<p>Existing or new initiative?</p> <p><input checked="" type="checkbox"/>Initiated/existing integration activity*</p> <p><input checked="" type="checkbox"/>New integration opportunity</p> <p><i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i></p>	<p>List of partners involved:</p>	
<p>Please briefly describe the initiative:</p> <p>e-Health is about achieving better health outcomes through the practical application of information and information technology. Connecting the Continuum of Care ensures that information about the right person/patient is available at the right time to the right provider any place. It is a cornerstone of our LHIN's ability to meet the government's Transformation Agenda and an essential step towards improving the quality of care for South Western Ontario. As LHIN 2 we realize that the real value of an e-Health strategy lies in its ability to improve the flow of patient information and ultimately patient care at the local/network and regional/LHIN levels.</p>		
<p><i>If this is an initiated/existing activity...</i></p> <p>What is the current status?</p> <p>LHIN 2 developed a model for information sharing and approaching how we might tackle prioritization and implementation of our initiatives. (See attachment #1)</p> <p>The model builds on the guiding principles of best practices, operational efficiencies and patient safety. Key to being patient centered is the capability of enabling technology.</p> <p>In our discussions, we identified a 2-prong strategy.</p> <ol style="list-style-type: none"> 1. Enhance each of the streams of care, i.e. <ul style="list-style-type: none"> • Managing our health • Dealing with Illness • Recovery to Health 2. Build the bridges between the streams, i.e. 	<p>What are the outcomes/lessons learned (if any)?</p> <p>The expected outcomes of Connecting the Continuum of Care or our e-Health Strategy is to have a seamless information system in the region/LHIN with the goals of:</p> <ul style="list-style-type: none"> • Increasing patient access to services • Mitigating the shortage of professionals • Enabling the achievement of a service environment in which information from any participating Provider can be viewed or interpreted at any other participating Provider • Improving the speed of treatment decisions • Improving access to specialists and second opinions • Improving the attractiveness of SWO to students and professionals • Providing leadership in establishing new standards of care • Making better use of physician resources 	

<ul style="list-style-type: none"> • Access Management • Discharge Management <p>These 2 approaches were further reviewed from 4 geographic perspectives, which form the basis for the high-level action plan (Template C):</p> <ol style="list-style-type: none"> 1. Thames Valley 2. Huron Perth 3. Grey Bruce 4. The LHIN – as a whole <p>Managing our Health</p> <ul style="list-style-type: none"> • Looks at what is happening in our Health system on a day-to-day basis. The linkages in and between the various components of primary care are limited. • Connectivity is dependant on SSHA. <p>Access Management</p> <ul style="list-style-type: none"> • Is the bridge or transition from “day to day” to acute or hospital care • SSHA has been working on a “core” data set (that we have been able to input to). Generally, it contains the information hospitals would need for the continuum of care. • Family physicians that are connected to the teaching hospitals (3 family medical centres) or who have privileges in a community hospital or who are members of a Family Health Team (or do we assume they will all have hospital privileges?) will naturally be connected. • Mental Health Association and CCACs have/need access to the hospitals network. • Community service providers and long-term care homes have/need to access to the CCAC network. <p>Dealing with Illness</p> <ul style="list-style-type: none"> • Is about acute/episodic care that requires a hospital visit. • The entry points to tertiary/quaternary care at the teaching centres (LHSC/SJHC) would also include: <ul style="list-style-type: none"> ○ Ambulatory centre ○ Centre for management of chronic disease • There is a natural integration in community hospitals and primary care (family doctors) in that the family docs have privileges to the community hospitals and access to hospital HIS. 	<p>Guiding Principles developed by the South West include:</p> <ul style="list-style-type: none"> • The systems will be developed with ongoing collaboration with the participating organizations, Canada Health Infoway, and the Ontario Ministry of Health and Long-Term Care. • The regional approach will maximize the investments made and lessons learned by others • The regional approach will work to respect the investments partners have already made in systems and will work to ensure interoperability in order to realize the vision • The first option for investing will be to leverage and expand on current investments and shared services model • The regional systems will include the shared investment in, and access to, the common technology architecture.
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<ul style="list-style-type: none"> • Connectivity in Thames Valley is through LargNet. • Connectivity in general is through SSHA • The data model we are using in Thames Valley and Grey Bruce is based on our joint implementation of the Cerner System. • Diagnostic Imaging is a common platform throughout the Thames Valley and is/will be available via the web. The rest of the LHIN is in planning Phase for DI and we are working to common platforms wherever possible. <p>Discharge/Follow-up Management</p> <ul style="list-style-type: none"> • Looks at moving from the hospital to “Recovery to Health” or generally primary care. • SSHA has been working on a core data set for hospitals; a core data set is needed for the community • In Thames Valley, we can connect through the family medical centres and the family physicians with privileges, having access while in the hospital. We are looking at software that could also connect them to the hospitals from their office. For the last few years we have a web tool (LENS) that informs doctors outside the hospital when their patients have been admitted or discharged from the London hospitals. <p>Recovery to Health</p> <ul style="list-style-type: none"> • The patients return to primary care and good health and would match data model needed for “Managing Our Health”. As with “Managing Our Health” the interaction between providers is limited. 	
<p>Lead contact person:</p> <p>Name: Diane Beattie/Judy Chalmers Title: Integrated VP and CIO/Executive Director Telephone: 519-646-6100/519-371-2112</p>	<p>Organization: London Health Sciences Centre and St. Joseph’s Health Care London/Grey-Bruce CCAC Email Address: diane.beattie@sjhc.london.on.ca/judy.chalmers@gb.ccac-ont.ca</p>



B. Description of Administrative Support Services Integration Initiative

Title of administrative support service initiative: Needs-Based Funding		Type of Integration (more than one box can be checked) <input 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 <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	List of partners involved: Stephanie Loomer (Thames Valley District Health Council), Shirley Hodgson (Jarlette Health Services), Denise Bedard (Meadow Park London), Jan Figorski (London Health Sciences Centre), Lynne Anne Galloway (Watford Quality Care), Brent Gingerich (PeopleCare), Ellen Coffey (Extendicare), Michele Harris (Terrace Lodge), Jena Winterburn (Chateau Gardens), Heather Weir (Ritz Lutheran Villa), Reta Sproule (Hanover Hospital), Corrie Franson, Dalton Ferris, Christine Ozimek, Melissa Lewis (County of Elgin), Mike Boucher (St Josephs Hospital), Ron McRae (London Health Sciences)	
Please briefly describe the initiative: The Needs-Based Funding integration initiative focuses on funding resource allocation within the new LHIN structure. This initiative is critical to determining the utilization of limited health care dollars and supporting sustainability of the system. Moving toward a needs-based funding system is a formative step in providing localized health care and promoting population health. Needs-based funding would link resource allocation with population health needs, measurable care standards and defined outcomes.		
<i>If this is an initiated/existing activity...</i> What is the current status? While this is a new initiative for the Province of Ontario, we need to draw on existing experiences both across Canada and internationally.	What are the outcomes/lessons learned (if any)? In Canada, groups such as the Canadian Centre for Analysis of Regionalization & Health and the Centre for Health Economics and Policy Analysis (CHEPA) have published articles and information regarding needs-based funding models and experiences.	
Lead contact person: Name: Brent Gingerich Title: CEO Telephone: 519-655-2031	Organization: PeopleCare Email Address: bgingerich@peoplecare.ca	

B. Description of Administrative Support Services Integration Initiative

Title of administrative support service initiative: E-Health and Community/LTC Organizations		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 <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	List of partners involved:	
Please briefly describe the initiative:		
<i>If this is an initiated/existing activity...</i> What is the current status? Not applicable	What are the outcomes/lessons learned (if any)?	
Lead contact person: Name: Mary Raithby Title: Executive Director Telephone: 519-657-2955	Organization: Country Terrace Email Address: mraithby@countryterrace.ca	

B. Description of Administrative Support Services Integration Initiative

Title of administrative support service initiative:		Type of Integration (more than one box can be checked)	
Human Resources		<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 <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>			
Please briefly describe the initiative:			
<p>To develop a Human Resources Plan for the Southwest LHIN that will take into account the current difficulties already challenging the health care system. This will involve not only initiatives for our LHIN but can also encompass all the LHIN's provincially. To look at funding for such a project to enable all stakeholders to benefit from the plan. The challenges facing the development of such a plan will take strategy focused on attraction and retention of all health care workers in the province. We need a secure base of highly skilled and dedicated workers to practice in the Southwest LHIN.</p> <p>Reasons for the Initiative:</p> <p>The majority of the geographical structure of the Southwest LHIN is made up of smaller community and rural settings. This structure needs to be addressed in any plan that is devised for our region. Attracting medical staff, nurses and health professionals against the opportunities that can be offered in large urban areas or the U.S. is a trying task but one that must be dealt with to continue providing quality care in many services.</p> <p>The plan should also address the current situation already facing frontline health care workers such as the aging workforce, lack of full time positions and inequity in wages that makes it difficult for stakeholders in some sectors to attract and retain professionals</p> <p>The plan should take into consideration the loss of workers from the closure of the District Health Council, the Ministry of Health Regional offices, CCAC's and other services that may be impacted by the LHIN.</p> <p>The plan needs to recognize the increased acuity of care levels in hospital and in the community and offer educational development opportunities to enable current workers to upgrade their education to be able to stay in their positions or to seek others opportunities in the health care field as the need indicates from the changes in where and how the care is to be provided.</p>			

The plan must look at employment stability and have consultation with stakeholders, bargaining agents, frontline workers and allow for pension exit opportunities.

The plan would need to address that hospitals are currently getting funding for hiring extra nurses but are having to cut back on other professionals.

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

What is the current status?

The HR team conducted an e-mail survey as part of their stakeholder consultation process, which produced the following highlights:

- The majority of Stakeholders in the Southwest state that there are difficulties in recruitment and retention of health care professionals. Community Care and Long-Term Care cite the reasons for this are wage differences with hospital providers and rural settings. Shortages in Physicians, RN's and RPN's and technologists are also cited. Communities have been involved with recruitment initiatives for Doctors.
- Through the survey it was found that no provider has as yet put any plans in place for the LHIN's due to the fact that no information has yet been put out as to what changes are expected.
- Many providers are utilizing placement opportunities with educational institutes. This has helped some of them to hire from the graduates but again stated difficulties in retaining staff as they leave to take positions of higher pay.
- Managed competition is utilized mostly by the community sector.
- Some layoffs have occurred (eg. DHC closure) due to current health system transformation agenda.
- The majority of responders agree that they would likely benefit from an HR plan that was funded from the Ministry. Smaller organizations do not have the funds available for large recruiting initiatives.
- Two thirds of the respondents want a Public Health Care system.

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

Lead contact person:

Name: Georgia McIlwraith
 Title: RPN, President GBHS Local 260 OPSEU
 Telephone: 519-986-4253

Organization: Grey Bruce Health Services
 Email Address: mcillwraith@aol.com

B. Description of Administrative Support Services Integration Initiative

Title of administrative support service initiative: Rural Health Networks		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 <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	List of partners involved:	
Please briefly describe the initiative: <p>There is an opportunity for the Southwest LHIN to build on the structures, processes and lessons learned of existing rural health networks. These networks include but are not limited to rural hospital networks, rural mental health networks, long term care networks, and others. A number of existing rural health networks are already achieving progress in horizontal, vertical and inter-sectoral integration. By engaging, building and supporting existing rural networks, there is an exciting new opportunity for the Southwest LHIN. The rural networks will provide immediate support to the Southwest LHIN offering existing relationships and expertise as a springboard for the growth and development of a patient focused system of health care in Ontario. The government's new "Rural Action Plan to Build Strong Rural Communities" may be an enabling mechanism for this rural network building and integration.</p>		
If this is an <i>initiated/existing</i> activity... What is the current status? <p>The challenges of planning, coordinating, funding, and delivering rural health services is a long-standing problem. The rural networks help to keep "rural" on the radar screen by providing a common voice for local patient issues and system needs. The rural networks also help create a sense of equalization or equality in prioritization between urban-based and rural health care needs.</p> <p>The Ministry of Health and Long Term Care currently relies on the expertise, established resources and relationships of the rural networks. By using the rural networks to facilitate planning, implementation and evaluation initiatives, the Ministry has been able to produce quick "wins" with stakeholders in terms of streamlining, integrating and capacity building of the local health</p>	What are the outcomes/lessons learned (if any)? <p>The Southwest LHIN can seize this opportunity by enabling and empowering rural health networks through a variety of mechanisms. These include recognizing and formalizing existing networks; devolving some decision-making authority using accountability agreements; defining a clear and integrated working relationship between the LHIN and the networks; defining a clear dispute resolution mechanism; allowing the networks to identify local gaps in rural services; creating a rural consumer "voice" to LHIN decision-making; preserving rural identity by using rural expertise; assisting rural networks with health human resources planning, professional recruitment/retention and building rural primary care models; and assisting the rural networks with focus, composition, span of control, scope of responsibility/decision-making, and appropriate geographic coverage.</p>	

<p>care systems. The lessons learned from the existing rural networks are crucial for the successful implementation of the Southwest LHIN.</p> <p>The existing rural networks have created the building blocks for inter-sectoral collaboration between Ministry of Health funded services and other Ministry funded services such as Housing, Transportation, Social Services, Justice, etc. The existing rural networks have started to break down inter-ministerial barriers and will continue to achieve continued successes shifting away from "silo" thinking through the support of the Southwest LHIN. The existing rural networks provide an excellent forum for the establishment of future Healthy Rural Community models.</p>	<p>The Southwest LHIN needs to pay special attention to rural funding issues. This includes how "rurality" is defined in funding formulae; the need to protect dollars allocated to rural population needs; and the equalization of rural versus urban funding. The LHIN needs to balance provincial standards with the local reality of delivering rural health services and empower rural networks with prioritization of local funding allocations.</p> <p>The Southwest LHIN has an important role to play in ensuring that determinants of health are factored into rural health services planning. There are urban-rural differences in health status and socio-economic indicators, and LHINs (through the rural networks) can serve to create the interface between the health system and other players who have responsibility for the broader determinants of health (i.e. housing, social services, etc). The LHIN, by working in cooperation with the rural networks, can play a role in educating and informing the public about what services are available through rural networks and the most appropriate use of those services.</p>
<p>Lead contact person:</p> <p>Name: Jim Whaley Title: Executive Director Telephone: 519-348-4498</p>	<p>Organization: Grey Bruce Huron Perth District Health Council Email Address: jwhaley@gbhpdhc.on.ca</p>

C. High-Level Action Plans for New Integration Opportunities

C. High-Level Action Plans for New Integration Opportunities

I. Patient Care/Services Integration Opportunities		
	Priority Opportunity	High-Level Action Plan
1	Primary Health Care	<p><u>Integration Opportunity</u> Improved access to Primary Health Care for rural and urban communities using flexible and innovative service and funding models</p> <p><u>Action Plans:</u></p> <ol style="list-style-type: none"> 1) Using Environmental Scan and Unique Features of the SW LHIN, identify trends and unique challenges for specific communities/districts within the SW LHIN related to access to primary health care. <p>As noted in the SW LHIN Environmental Scan and outline of Unique Features, there are a number of trends and challenges which impact primary health care in the SW region, including: continuing shortages of primary health care providers and health professionals, particularly in rural areas; escalating secondary and tertiary health care costs; aging population with increased demands on the system, poor population health indicators requiring increased emphasis on health promotion and primary prevention strategies; and small rural communities are not eligible for funding under most current primary health care model initiatives (Grey Bruce Huron Perth District Health Council, 2003 and Thames Valley District Health Council, 2004).</p> <ol style="list-style-type: none"> 2) Establish/endorse essential elements (principles) for PHC models that support innovative, flexible PHC services in SW LHIN. <p>Although design for primary health care services vary by country, the following elements have emerged across models (MOHLTC Family Health Team Initiative, 2004; Halton-Peel District Health Council, 2004 quoting Marriot & Mable, 2000; Thames Valley District Health Council, 2004): Service and population health approach; multi-disciplinary team approach to care; physicians and other primary health care providers (e.g. nurse practitioners) are working in collaborative groups; change in the basis for physician payment and primary health care funding; citizen choice and participation in PHC planning, governance and management; locally designed PHC models; vertical and/or horizontal integration with intermediary health organizations and community care agencies; patient enrollment/rostering with PHC organization or provider group; information technology to support expanded capacity and quality; focus on quality (Halton-Peel District Health Council, 2004).</p> <ol style="list-style-type: none"> 3) Identify and build on current PHC model integration initiatives. 4) Identify communities/districts needing to design/build local PHC models based on PHC

	<p>utilization and referral patterns.</p> <ol style="list-style-type: none"> 5) Identify existing community networks, providers and systems that support PHC services. 6) Bring together key stakeholders to design community/district-based options for PHC services. 7) Educate stakeholders in essential elements for LHIN-approved PHC models; PHC models in existence; model design based on essential elements and local integration priorities. 8) Design local education strategies for citizens in communities to expand public understanding of trends and challenges impacting PHC services. 9) Present PHC model options to focus groups within communities to evaluate PHC options and validate recommended PHC model. 10) Provide policy flexibility and financial support for community-designed PHC models from within the MOHLTC Transformation Agenda. 11) Encourage policy and model flexibility and financial support for Family Health Teams as part of promotion of innovative, flexible PHC models. <p>The criteria set out for funding under the Family Health Team initiative prevents rural communities from qualifying for the initiative. Many medically underserved communities do not have the required number of physicians. The initiative needs to allow for flexible numbers of primary health providers, including Nurse Practitioners, on which to base the Team.</p> <ol style="list-style-type: none"> 12) Develop and fund electronic integration strategies for PHC services such as Telemedicine, E-Health, Community Health Information Network (CHINs), video conferencing, etc. <p>Various telemedicine and e-health strategies are being recommended to improve access to primary health care services, but there is little support and many barriers for physicians and PHC providers to use these solutions. There is need to provide policy and financial incentives that would allow physicians and other PHC professionals to incorporate telemedicine and e-health strategies as part of regular PHC clinical practice (Grey Bruce Huron Perth District Health Council, 2003).</p> <p><u>Other Initiatives Reviewed:</u> Halton-Peel District Health Council (2004). Building a Primary Health Care Infrastructure in Halton-Peel: Planning for the Future.</p>
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2	Delivery of Rural Remote Care/ Services	<p>As identified by the Southwest LHIN Rural Network, the Rural Health Service Delivery Plan endorses:</p> <ul style="list-style-type: none"> ➤ Supporting a variety of local health networks, alliances and partnerships to achieve greater operational and clinical efficiencies, and support appropriate access; ➤ Supporting the 10- Point Action Plan for Rural Health Care, developed in 2003 by the Grey Bruce Huron Perth District Health Council; ➤ The “best” health care is the health care provided as close to home as possible; and ➤ Equitable access to all levels of care regardless of location or geography. <p><u>Action Plan:</u></p> <ul style="list-style-type: none"> • Development of Rural Health Network – creation of communities of learning, sharing of best practices; • Undertake a “gap analysis” – what is needed, and how can linkages to urban areas be fostered; • Creation of mobile resources with teams supported by specialists; • Change funding model to allow dollars to follow the client; • Move to a higher level of In-Home Services (Home Care), and recognize what can be achieved using new and transformative technologies, i.e. specialized wound care services, telemonitoring, etc. • Remove barriers through the use of common health record; • Address inequities in wages (community vs. institution) • Support the use of telemedicine and E-Health by rural service providers by changing the funding from the current fee-for-service incentive; • Provide flexibility in service delivery – 24/7 access • Recognize various scopes of practice and ensure that the right person is providing the right care at the right place; • Examine funding formulas – population based funding versus rural based funding, meaning the “rurality” of the Region needs to be factored into funding formulas, recognizing distance, time and resources; • Link Web-based information; • Enable clients in self mastery through transformative technologies and web-based applications; • Focus on community capacity building; • Shift the “center of excellence” to the home and community setting.
3	Community Support Services	<p>Community Support Services must continue to be integral to a transformed health system</p> <p><u>Action Plan (Year 1):</u> Assign a LHIN staff person to work to ensure that Community Support Services continue to be integral to a transformed system. Ensure that this individual is experienced working in many cross sections of Community Support Services. These organizations are currently supported by MOHLTC staff and District Health Council staff. Building on that history and existing expertise</p>

	<p>would be invaluable.</p> <ol style="list-style-type: none"> 1. <u>Build a Quality Framework</u> to implement shared best practices, indicators and an evaluation system to facilitate benchmarking. 2. <u>Build a Foundation of Shared Information and Knowledge:</u> <ul style="list-style-type: none"> - Review past work and key themes - Require all LHIN staff and directors to read key documents - <i>Almost Home: Reforming Home and Community Care in Ontario</i>, by Patricia Baranek, Raisa Deber and Paul Williams, 2004 3. <u>Key Informant and Focus groups:</u> <ul style="list-style-type: none"> - Meet with existing groups working on integration initiatives which include community support services - identify current linkage strategies (e.g. Clinical Pathways that include Community Support Services, Stroke Strategy) - internal and external to the Southwest LHIN - Work collaboratively with various disease-based organizations. Community Support Services can identify high risk individuals and provide supports and services that promote healthy living and prevent illness. - Work collaboratively with the Community Care Access Centres in the Southwest LHIN. Community Care Access Centres are a key group that support Community Support Services. 4. <u>Vision:</u> Develop a Vision for service provision that includes Community Support Services as an integral component and aligns with the Vision of the LHIN which, in turn, aligns with the Vision of the Ministry of Health and Long-Term Care. Alignment is the key to successful integration. <ul style="list-style-type: none"> - Commitment to a service delivery system that supports living securely and independently at home which prevents hospitalization and institutionalization while acknowledging the individual's right to assume risk. Community Support Services support many people for years in their own homes who otherwise would be institutionalized and yet CSS only receive 2% of the funding allocation for Health in the Southwest LHIN (2003/04) - Commitment to the Psycho-Social Model of Care; - Commitment to a system that supports caregivers - Commitment to sustainable funding for the full range of services required to meet the individual's needs. - Commitment to demonstrate the value of the contribution of volunteers; - Commitment to a system that supports the determinants of health as identified by the World Health Organization. - Community Support Services will be an equal partner within LHIN delivery of services. 5. <u>Philosophy:</u> Develop a Philosophy of service provision that values Community Support Services as an integral component of the transformed system. <ul style="list-style-type: none"> - Start with the Individual - Individuals (clients/consumers) and families must be at the centre of the transformation agenda and must be involved in all aspects of planning, decision-making, implementation and service delivery. - Support employees who are passionate and committed to a transformed system - Value life-long learning - Greater emphasis on individual (consumer/client) -directed and self-managed care -
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		<ul style="list-style-type: none"> - Specialized services for different populations “Uniqueness of the disabled population needs to be recognized within home care programs that are often designed with the elderly population in mind.” - Expand the need for specialized services in all facets of Community Support Services, not just home care (e.g. hearing) <p>6. <u>Principles:</u> Develop Principles that support service provision and ensure Community Support Services are an integral component.</p> <ul style="list-style-type: none"> - The system will be coordinated, responsive and will build on the strengths of individuals, families and communities. - Support will be provided as close to home as possible in the least intrusive way possible. - Access to support for daily living, prevention of illness and promotion of healthy living, supportive housing to allow individuals to live securely at home, support to the caregiver and other social supports are critical to allowing people to remain at home in their community. - Recruitment and retention issues in the community will be addressed. <p>7. <u>Planning Processes:</u> Analyse existing planning processes with a view to better alignment of hospital operating plans with community service plans and integration of different planning processes in the community (e.g. Long - Term Care and Mental Health)</p> <ul style="list-style-type: none"> - establish linkages with other initiatives such as Primary Care Reform, Mental Health and Addiction Services <p>8. <u>Assumptions:</u> Articulate assumptions and then test those assumptions</p> <ul style="list-style-type: none"> - Differences exist among urban and rural service provision; - Increased needs - higher levels of care required in the home; - Increased need for programs for individuals who have Alzheimer’s Disease/dementias; - Transportation is key to an integrated system. - Community Support Services are an integral part of any referral process (including hospital discharge planning, LHIN referral networks, CCAC referrals in the community) <p>9. <u>Communication and Information Systems:</u> Lack of appropriate information systems remains an impediment to the smooth transition from one part of the system to Community Support Services. The need for information technology infrastructure is clear.</p> <p>10. <u>Intersectoral, Interministerial and Cross Sector Collaboration:</u> LHINs must establish linkages and coordination with the broader community of services needed to best support people living at home. (Ministry of Housing, Municipalities, Ministry of Community and Social Services, Ministry of Youth & Children) - Link to transportation</p> <p>11. <u>Education and Awareness:</u> Need for public and other health provider education and awareness of programs;</p> <ul style="list-style-type: none"> - Education and support to maintain health and prevent illness <p><u>Action Plan (Year Two):</u></p> <p>1. <u>Framework Development:</u> By the end of 2006/2007 recommend a framework for organizing services for people with on-going care needs that :</p> <ul style="list-style-type: none"> - fulfills the above Vision, Philosophy and principles - includes Community Support Services as an integral component - includes common evaluation. <p>2. <u>Planning Processes:</u> Planning processes will be aligned</p>
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		<p>3. <u>Funding</u>: Establish an Equitable and Flexible Funding Approach for Community Support Services. - Share full cost/budget information details on LHIN #2 with evaluation of need/benefit, to enable participation in the evaluation of an overall fair distribution of funds.</p>
4	Mental Health and Addiction Services	<p><u>Integration Opportunity</u> To ensure that there is a continuum of accessible, effective and adequately resourced mental health and addiction services, from early intervention to specialized treatment and rehabilitation, which addresses the needs of all citizens across the life span and which is integrated and coordinated with other health care services.</p> <p><u>Action Plan</u>: In order to achieve the above goal, we recommend that the LHIN take the following steps:</p> <ol style="list-style-type: none"> 1. The LHIN assigns mental health and addictions as the exclusive portfolio of a senior executive in the LHIN management team. 2. The LHIN establishes a Mental Health and Addictions Advisory Committee to participate in planning and priority-setting related to mental health and addictions. The Committee meets on a quarterly basis and establishes working groups as required in order to address specific issues and LHIN planning priorities. The Committee is chaired by a member of the LHIN Board of Directors and its membership includes: <ul style="list-style-type: none"> • representatives from Mental Health Networks and Addiction Networks in the Southwest LHIN area • significant representation from consumers and family members, whose participation is supported by financial and practical assistance as required • tertiary care providers • representatives from research and academic organizations (eg. CAMH) • representatives from cross-sectoral planning and advisory bodies. 3. The following vehicles are used to integrate the planning and delivery of mental health and addictions services with each other and with the planning and delivery of other health care services: <ul style="list-style-type: none"> ✓ The LHIN plans and funds integrated mental health and addiction services for concurrent disorders. ✓ The member of the LHIN Executive Team with responsibility for mental health and addictions ensures coordination and consistency between that sector and other health care sectors in the development and approval process for operating plans, budgets and accountability agreements. ✓ Mental health and addiction service providers deliver cross-sectoral training and consultation to other health care providers (i.e. primary care, long-term care, community care), to increase their knowledge and skill in identifying and intervening with those who have or are at risk for mental health or addiction problems. ✓ A shared care approach is implemented by family physicians, mental health and addictions services.

		<ul style="list-style-type: none"> ✓ Mental health and addiction services collaborate with Public Health and other health care sectors to plan and implement health promotion strategies aimed at reducing stigma, increasing awareness and acceptance of mental health and addiction issues and related services and promoting early identification and referral. ✓ Partnerships are established between mental health, addictions, community care and long-term care to provide outreach assessment and intervention with seniors to prevent avoidable hospitalization. ✓ Cross-sectoral working groups and networks are established to identify and address services gaps (i.e. eating disorders, those with moderate mental illness) and capitalize on integration opportunities ✓ The LHIN establishes intra-and cross-sectoral agreements to address the needs of those with mental health and/or addiction problems who also require the involvement of other health care sectors or other Ministries (i.e. dual diagnosis, forensics, homelessness, oncology, brain injuries, youth, and seniors). <p>4. The LHIN ensures that mental health and addiction services receive dedicated, needs based, sustainable multi-year funding. As a first step, current funding levels are protected while the LHIN develops a strategic plan to guide mental health and addiction funding decisions. The planning process includes:</p> <ul style="list-style-type: none"> ✓ review and update of the most recent system planning recommendations for mental health (Southwest Mental Health Implementation Task Force Report) and addictions (“Setting the Course”), relative to: <ul style="list-style-type: none"> a. regional needs and priorities throughout all parts of the catchment area, both rural and urban b. the need for equitable access to specialty services for all citizens, regardless of LHIN boundaries c. unmet and under-met needs, including the needs of those with moderate mental health problems and those at risk, regardless of diagnostic classification, and the need for self-help, peer support and respite care ✓ a strategy to address the differential funding policies and reporting requirements that now exist within the mental health and addiction sector (hospital vs. community providers) and to rectify the associated compensation disparities, human resource issues and eroded administrative infrastructure <p>5. The LHIN mandates and funds Mental Health and Addiction Networks to collaboratively develop and implementation of standardized admission and discharge criteria and protocols, standardized assessment tools and evaluation criteria. Each Network prepares regular service delivery activity reports which are submitted to the LHIN and disseminated to other Networks in the Southwest LHIN.</p> <p>The LHIN allocates dedicated funding for mental health and addictions research and evaluation and establishes formal linkages with universities and research facilities.</p>
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5	Rural Transportation	<p><u>Integration Opportunity</u> To ensure that the SW LHIN community is a leader in the provision of innovative, accessible and cost-effective transportation across our vast rural region.</p> <p><u>Action Plan:</u></p> <ul style="list-style-type: none"> • Assignment of a LHIN staff person, with knowledge and experience of rural transportation issues, to take the lead in this initiative. ▪ An inventory of all service providers and a needs analysis be conducted. ▪ A strategic plan for rural transportation in all areas of LHIN #2 must be prepared as well as a business plan for sustainable operation (including funding requirements). • The SW LHIN must ensure that adequate resources (financial, support staff, information technology, etc.) are assigned to all components of this initiative in order for it to succeed. • Recognition that: <ul style="list-style-type: none"> – transportation is getting an individual safely to his/her destination in the most appropriate vehicle/seat, at the right time, at the best price – expertise currently exists in many local communities across the SW LHIN – the core of volunteer drivers in local communities is <u>critical</u> to transportation needs/service and support for this component of the system <u>must remain at a local level</u> – the cost of transportation provision and the needs for transportation in rural areas is vast different than in more urban areas – the current funding model for transportation needs to be changed – across the SW LHIN, funding for transportation is inconsistent with some areas not receiving any support – the Ministry of Health and Long-Term Care Summary Report on Community Support Services 2002/2003 reveals that the transportation unit cost, per agency across the SW varies from 3.2 to 36.6 dollars • Ensure that every County within the SW LHIN has/creates a Transportation Working Group with: <ul style="list-style-type: none"> – representation across the entire continuum of health care and local Municipal Government (included in this group must be disease-specific services, which may not provide
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	<p>transportation but advocate for it on behalf of their clients, i.e. Cancer, Epilepsy, Mental Health, Heart & Stroke, etc.</p> <ul style="list-style-type: none">- land ambulance use for non-emergent cases must be dealt with and addressed within the context of transportation provision- an understanding that we cannot afford to sustain the existing fragmented systems- a willingness to embrace change and move forward <ul style="list-style-type: none">• Transportation Working Groups will glean the local resources, needs, gaps and issues pertaining to Rural Transportation.• It has been identified that there is an urgent need for documentation and sharing the information of:<ul style="list-style-type: none">- all current transportation options across the SW LHIN- an inventory of existing wheelchair accessible vehicles in the rural areas- availability of this information will assist current transportation service providers, while a new transportation system is being developed <p>All potential sources of funding for transportation must be explored and maximized (currently identified as MOHLTC, MCSS, MTO, Ministry of Children and Youth Services, Counties and Municipalities, ODSP, Ontario Works, WSIB, Integrity Rehabilitation, Thames Valley Children's Center, DVA, CCAC's, Assistance for children with Severe Disabilities, MS Society, Cancer Society, Mental Health and Addictions, Health Units, LTC high needs funding for dialysis, private insurance companies, etc.)</p>
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II. Administrative Support Services Integration Opportunities		
	Priority Opportunity	High-Level Action Plan
1	1 Patient – 1 Record (E-Health)	<p>A number of e-health initiatives are complimentary and can be done in parallel. The key is identifying how these initiatives fit into:</p> <ol style="list-style-type: none"> 1. The framework 2. Align with provincial directives <p><u>Action Plan (Thames Valley Opportunities):</u> The key focus in Thames Valley is developing 1 patient, 1 Record and sharing that information across a continuum of care.</p> <p>The primary initiative would be to implement a common patient care system across the community hospitals that provide primary and secondary care. A copy of the Business Plan is attached. The outcome of this would be to provide roughly 600,000 people with a single record. All Thames Valley hospitals would be sharing a single repository.</p> <p>Currently we are beginning to share this information with the London/ Middlesex CCAC and this could then be quickly expanded to the Elgin and Oxford CCAC's.</p> <p>The second initiative we would begin to pilot (but could be shared across the whole LHIN) would be the development of Mental Health Information.</p> <p>Also important to Thames Valley and LHIN2 is the co-ordination of Cancer Care. LRCP is currently partially integrated (on the business systems side) with LHSC but this needs to be enhanced on the patient care side.</p> <p>The fourth initiative is the development of a pilot for centralized booking across Thames Valley. This certainly ties to the wait list issues and the Minister's of Health focus.</p> <p><u>Action Plan (Grey Bruce Opportunities):</u> As Grey Bruce expands its use of its patient care system to encompass a partial electronic record across 13 community hospitals that focus on primary care and secondary care, they have significant needs to share information across not only their 13 hospitals but also with</p> <ol style="list-style-type: none"> 1. Tertiary centers – due in part to Grey Bruce being both a summer and winter recreation and vacation area 2. Primary care physicians 3. Community agencies – CCAC, mental health & addictions <p>The Business Case for their EPR has been presented to their Board(s) and they are ready to move forward. Key to this initiative for Grey Bruce is:</p> <ol style="list-style-type: none"> 1. A common privacy framework and policies. Some of this may be obtained from Thames

		<p>Valley who are working through these agreements currently.</p> <ol style="list-style-type: none"> 2. Implementation of a common lab system. 3. Common patient Identifier <p>As Grey Bruce moves forward the key to their success (and the LHIN) will be a physician portal and the ability to share information with the CCAC, as well as the ability for the CCAC to share client information with community service providers, long-term care homes and other CCACs.</p> <p><u>Action Plan (Huron Perth Opportunities):</u> Huron Perth consists of 3 distinct groups of hospitals. Their key opportunities in the short term are:</p> <ol style="list-style-type: none"> 1. Building a plan for 2010 2. Full implementation of the Electronic Patient Record for Listowel and Wingham 3. Integration of voice/data and video 4. Connecting with family physicians <p><u>Action Plan (All of LHIN 2):</u></p> <ol style="list-style-type: none"> 1. The key project is the expansion of the Diagnostic Imaging pilot to all of SWO. 2. We support SSHA secure email and improved bandwidth 3. Moving forward we would like to address <ol style="list-style-type: none"> a. Common business systems b. Intersectoral teaching and research c. CCAC review of the Community Health Information Network as an interim solution for sharing of client information d. Expansion of healthlince.ca throughout the Southwest LHIN e. Expansion of telemedicine and videoconferencing capacity to support primary health care integration initiatives.
2	Needs-Based Funding	<p><u>Action Plan:</u> It is critical that the PLANNING of resource allocation begin as soon as possible within the LHIN framework, while STABILITY to current health system funding is maintained at this time.</p> <ol style="list-style-type: none"> 1. Promote the message that development of a Needs-Based Funding methodology is a process NOT an event. Key steps in this process are outlined below. 2. At the provincial level - develop a joint Stakeholder-Ministry of Health LHIN Funding Planning Team. Representation would include: Lead from the Health Results Team and decision support personnel; academic expertise; cross section of health care providers i.e. Long Term Care Facilities, Hospitals-Rural and Teaching, Community Care. <p>Role of the above 'planning team' would be to develop the required provincial funding standards and policies for the local LHIN's to operationalize. Working groups would be</p>

		<p>formed as required but report to the planning team.</p> <p>Planning Team – Key Success Factors:</p> <ul style="list-style-type: none"> ✓ The members of the planning team and working groups would need to be solution oriented ✓ Ministry of Health would need to clearly identify expectations and desired outcomes ✓ Be careful to preserve existing successful examples of needs-based funding already implemented and in operation across the province ✓ Learn from national and international integrated funding experiences ✓ eHealth initiatives are vital to the move toward intersectoral needs-based health funding allocation ✓ ensuring smaller providers are not lost; support and enhance the rural framework ✓ work toward standard/common assessment tools and defined care pathways ✓ correctly placing people within the system is critical ✓ prevention component is important, and needs to encompass wellness and health promotion ✓ LHINs defining and refining for local needs consistency, allow flexibility and enhance accountability -- within the LHIN, between LHINs and with the Ministry. ✓ be rooted in timely, solid data ✓ A balance is required between the dollars needed for patient care and resources required to implement the needs-based funding approach ✓ Overcome geographic challenges (including access and non-critical mass in north) <p>3. Once the planning team has developed provincial funding standards and policies the local LHIN's should be engaged. The LHIN's should develop their own joint funding planning teams. The team would consist of LHIN staff as well as a cross representation of health providers. Their task would be to operationalize the funding standards and policies.</p> <p>This process may include:</p> <ul style="list-style-type: none"> ✓ ASSESSMENT of services currently being provided according to the newly defined LHIN boundaries ✓ CALCULATION of existing funding/resources within the LHIN ✓ IDENTIFY Inefficiencies -- Barriers/Problems ✓ IDENTIFY Efficiencies -- Strengths/Opportunities
3	E-Health and Community/LTC Organizations	<p>This item has been identified, as a priority since integrated information systems is critical for ensuring communication related to enhanced client care. This has the potential to reduce duplications in diagnostics, procedures and medications with the accurate, up to date shared information within the circle of care. A shared access to a defined essential client history reduces anecdotal issues for clients. It would be difficult for LHINs to move forward without this initiative</p>

		<p>and it is a foundation for early success. This is essential to ensure that community agencies and Long Term Care homes are able to capitalize on existing acute care e-health initiatives.</p> <p>In order to capitalize on the potential, the Southwest LHIN should do the following:</p> <p><u>Action Plan (Year 1)</u> Mobilize the interest expressed across the sectors by:</p> <ul style="list-style-type: none"> • Agency analysis of information system readiness (hardware, infrastructure, staff capacity) • Inter-Agency analysis of essential shared data elements to ensure better patient outcomes • Link with SMART Systems for Health • Patient education on implications and benefits for SMART Systems for Health, as well as improved inter-agency / inter-sectoral communication <p><u>Action Plan (Years 2 & 3)</u></p> <ul style="list-style-type: none"> • Use existing models (Thames Valley Hospital Planning Partnership; Mental Health Alliance common client record; Grey Bruce Mental Health Partnership; CCAC common assessment tool) as a starting base to move forward • Define measurable outcomes in terms of group purchasing benefits, shared labour costs, decreasing escalating health dollars, reduction in repetitive tests / sharing of patient information • Develop a template for replication across and within LHINs for community agencies and Long Term Care homes. <p><u>Action Plan (In the Long-Term)</u> Able to use accurate data for service planning / resource allocation</p>
4	Human Resources	<p><u>Recruitment and Retention</u> Develop a Human Resources provincial plan that will deal with common issues across all of the LHIN's targeting the professions that are most in need currently and those that will be needed as the workforce ages. Build in strategies and innovations to prevent "poaching" of resources from LHIN to LHIN. Funding from the Province as well as funding from the LHIN for this incentive to enable all sectors an equal opportunity to partake of the available human resources. Wage inequities need to be looked at to enable all sectors to have an equal opportunity in recruitment and retention issues.</p> <p><u>Education</u> Develop a plan for the Southwest with our academic institutions for training in the professions that are in short supply as well as developing education opportunities to increase the skills of the existing health care workers in view of the changes in their roles as health care continues to evolve. Specialized programs that may be available to a broader area by use of internet classes to train people in their home based areas.</p>

		<p>Maximizing scope of practice for all healthcare providers at all levels. through accessible education programs.</p> <p><u>Managed Competition</u> Evaluation of the impact of managed competition on human resources within the community health care sector. Current practices make it difficult to obtain health professionals.</p> <p><u>Full-Time Positions</u> Evaluation current practices in respect to casual and part-time positions for health care workers. Full-time opportunities are essential to retention issues as well as the health of the workforce. Consultation with the bargaining agents and stakeholders as well as frontline staff.</p> <p><u>Consultation</u> The plan requires consultation with stakeholders, bargaining agents and frontline workers to get a broad perspective of the key issues.</p>
5	Rural Health Networks	<p><u>Integration Opportunity</u> The Ministry-OHA review of the Rural and Northern Health Care Framework (RNHCF) released earlier this year and the government’s new Rural Action Plan for building <i>Strong Rural Communities</i> (www.ruralplan.ontario.ca) together create an implementation action plan for supporting Rural Networks in the Southwest LHIN. The overall goal of both the RNHCF and the health care section of the newer Rural Action Plan is to improve access to health care services for rural residents. This can best be accomplished by health care providers working together in formal networks where the emphasis is on collaboration instead of competition for scarce resources.</p> <p>The provincial review of the RNHCF strongly supports an expanded role for rural networks. While the implementation of the framework has to-date focused on horizontal integration between rural hospitals, the review recommends that the overall goal should: “...continue to be the establishment of broad-based health care networks linking hospital- and community-based service providers, consistent with the government’s priority for greater system integration”. Network structures as a mechanism for improving system integration and coordination was also a key recommendation of the Southwest Mental Health Implementation Task Force, submitted to the previous government in 2003. Similar to the experiences with rural and northern hospital networks, the Southwest Task Force concluded that mental health networks, a number of which already exist in rural districts in the Southwest, would be instrumental in improving access and system coordination for individuals with mental health challenges.</p> <p>In order to capitalize on the potential of these existing rural health networks, the Southwest LHIN should do the following:</p> <p><u>Action Plan (In the Short Term - Year 1):</u></p>

		<ul style="list-style-type: none"> ▪ LHIN reps to sit down with existing rural health networks to determine what level of support they require to accomplish their goals (as they relate to access and integration). Support from the LHIN can take the form of either a modest network administrative budget or the assignment of LHIN staff to support the networks (similar to the support currently provided by DHC staff). ▪ Assist existing networks to apply for government grants, including community-based health care initiatives under the revised Rural Economic Development program. ▪ Assist rural networks with the recruitment and retention of health care professionals; and the development of appropriate rural primary care models, especially for smaller rural communities that have chronic shortages of acute care, long term care and mental health professionals. ▪ Where there are no existing rural networks (or where existing networks are not functional), the Southwest LHIN should work with local stakeholders to develop an action plan to create one or more networks (depending on the rural area to be served and the integration/access problems requiring resolution) and formal network agreements. <p><u>Action Plan (In the Medium Term -Years 2 & 3):</u></p> <ul style="list-style-type: none"> ▪ LHIN needs to develop a comprehensive Rural Health Action Plan for the Southwest area, consistent with the health goals of the government's Rural Action Plan. This comprehensive plan would include: <ul style="list-style-type: none"> ✓ definition of 'core' basket of health services for rural communities ✓ performance targets for rural health system improvements that can be monitored over time ✓ multi-dimensional definition of 'rurality' to assist with the equitable allocation of resources ✓ strategies to create healthier rural communities (based on the determinants of health) ✓ mechanisms to accommodate unique challenges of accessing rural health care services (i.e. transportation, underserved specialty populations, etc.) ▪ Should work with university researchers and rural research institutes to identify and promote innovation and best-practices in the organization and delivery of rural health services.
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D. Unique Characteristics of LHIN 2

- **Role/Responsibility of Academic Health Science Centres**
- **Current Health Networks**
- **Geography**

D. Capturing Unique Characteristics of LHIN 2

Role/Responsibility of Academic Health Science Centres

1. What role should the Academic Health Science Centres play in the LHIN 2 area?

Together with key academic partners, (including the University of Western Ontario [UWO], Fanshawe College and other health care providers), the Academic Hospitals in southwestern Ontario (London Health Sciences Centre [LHSC] and St. Joseph's Health Care [SJHC]) provide care, education and research and have a valuable, unique and essential role in the continued development of the health care system⁸ and LHINs in Ontario. With key partners in two separate LHINs (London in LHIN 2 and Windsor in LHIN 1), effective cross-LHIN partnerships will be a key success factor in maintaining a strong academic centre in the southwest region.

Patient Care

In addition to providing primary and secondary care to its 'local' population, the Academic Hospitals provide tertiary and quaternary care that needs to be available on a broad geographic basis, since these are highly specialized services that are generally not available elsewhere. The ability to make these services available is critical to the LHIN being able to address the full spectrum of health care services needed by its resident population. Given the referral population of Academic Hospitals the people they serve come from beyond the geographic boundaries of a single LHIN and therefore inter-LHIN relationships will be a key area of interest on the part of the Academic Hospitals.

In terms of an academic centre's role in innovation of patient care, it should be noted that the Academic Hospitals in London have an interest in further development of distributive care models for ambulatory care-sensitive conditions (e.g. geriatrics, diabetes) and, through an integrated research plan with UWO, have established 'outcomes evaluation of new care models' as a research priority.

Clinical Education

In addition to providing a broad continuum of patient care services, Academic Hospitals provide an environment for intensive, hand-on clinical education and training for physicians, nurses, technologists and other professionals. SJHC and LHSC provide training to over 4,000 medical, nursing and allied health students each year. While Academic Hospitals are by no means the only setting in which this takes place, they do provide the most extensive and specialized setting, which is fully integrated with the provision of patient care. The capacity of the medical school to maintain its accreditation is directly connected to the capacity of its partner health care organizations to provide a suitable environment, experience and training for its students. Here in the Southwest, the distributed medical school concept has been embraced with medical education taking place in London and Windsor, as well as placements and rotations throughout the region. (See <http://www.med.uwo.ca/education/SWOMEN/> for details) Academic Hospitals also provide the medical human resources develop undergraduate curriculum and the local and regional coordination of medical education.

⁸ For an excellent summary of the role of the Academic Health Sciences Centre see, The Health of Canadians – The Federal Role Final Report Volume Six: Recommendations for Reform Chapter 2 section 2.4 Academic Health Sciences Centres and the Complexity of Teaching Hospitals (go to <http://www.parl.gc.ca/37/2/parlbus/commbus/senate/com-e/soci-e/rep-e/repoct02vol6-e.htm>)

Research (for details see <http://www.lhrionhealth.ca/LHRI/index2.html>)

The faculty members who provide medical education and direct patient care are also often leading researchers in a specific field. The ability to provide an environment in which this research can take place is a key recruitment and retention strategy, without which it would be difficult to function.

The Academic Hospitals have a track record of being the settings in which significant medical breakthroughs take place, and in order to support and nourish this kind of innovation, significant investments from many sources is required. While not all research is clinical in nature, there is no doubt that clinical trials and the introduction of new techniques or equipment require access to patients and a setting that only a hospital can provide. In addition to clinical research, a strong platform of basic research helps to attract the very best researchers from around the world and contribute to important long-term discoveries.

The infrastructure needed to support this work needs a strong clinical-research-education partnership that is central to the role of an academic centre. In London this has been fully integrated on a city-wide basis through the Lawson Health Research Institute (LHRI), which is also affiliated with UWO's Faculty of Medicine and Dentistry and the Robarts Research Institute.

Health System Development

In addition to the three major pillars of an academic centre as outlined above, there is another area in which the academic partners can play an important role, namely health system development. In the same way as the LHINs represent an initiative on the part of the MOHLTC to improve the integration of health services across Ontario and within specific geographic jurisdictions, the academic centre has the opportunity to apply its academic role to this new development. The Academic Hospitals, with their key academic partners and coordinated through the LHIN(s), could undertake third party evaluations of LHIN initiatives (including the development of an appropriate role for academic centres in the LHIN structure) and also integrate research and best practices to its work. A Health System Development Unit associated with an academic centre could bring added value to the LHIN and its role in evaluating and addressing population health needs.

Moving Forward

In terms of moving forward with the development of LHINs, [in particular, Erie St. Clair (LHIN 1) and Southwest Ontario –(LHIN 2)] there is an opportunity to 'start off on the right foot'; namely to recognize and leverage the unique and significant role of the academic centre in this area.

First, it is important there is an opportunity for the partners within the academic centre to work collaboratively together with both LHIN 1 and LHIN 2 in order to maintain the current developments that have taken place in the region (the Southwest Ontario Medical Education Network (SWOMEN) being a primary example. The development of the university-hospital-provider-LHIN relationship will be essential to support the on-going role of the Academic Hospitals in the region.

Second, as noted above, there is the opportunity for the academic center partners to bring their expertise forward and play a supportive role in the LHIN development. This could include the development of a 'Health System Development Unit' or other models (e.g. an affiliation agreement between the LHIN and the university sector supporting cross-appointment of faculty/LHIN staff and/or student placements).

SUMMARY

To summarize, a strong academic centre provides a multitude of benefits, including the list below, and therefore will be an essential component of the new LHIN model in Ontario:

Enhanced recruitment and retention of health professionals

Introduction of new patient care methodologies, advanced technologies, and new devices

Evaluation of practice, procedures and processes and evaluation of health care delivery to improve care and patient safety

The background to provide evidenced-based care and health promotion

An opportunity for inquiry and the development of intellectual property that will provide economic benefit to Ontario and to Canada

Educational components to develop new health care professions and to allow physicians and others to remain current in their practices

Economic spin-off through technology transfer, new industry and high paying jobs.

Current Health Networks

What role should the existing Voluntary Networks play in the LHIN 2 area?

The following is a list of existing network integration activities in the Southwest LHIN. More details available in Appendix 1.

Regional Networks

- Regional Imaging Needs Assessment Project
- Southwest Ontario Digital Imaging Network Project
- VideoCare - Southwest Ontario Telehealth Network
- Mental Health Networks – Regional (proposed as part of Southwest Mental Health Implementation Task Force)
- Regional Cardiac Care Services Network
- Southwest Ontario Geriatric Assessment Network (SWOGAN)
- Southwestern Ontario Medical Education Network (SWOMEN)
- Southwest Ontario Perinatal Partnership (SWOPP)
- South Western Ontario Regional Stroke Strategy
- Community Care Access Centres – Southwest Ontario Executive Director's Group
- Ontario Hospital Association - Region 5
- Regional Health Planning Partnership
- Regional Partnership Leadership Forums

Local Networks (GBHP)

- Grey Bruce Area Providers Forum
- Community Advisory Council of the Huron & Perth CCACs
- Grey Bruce Health Network (GBHN)
- Huron Perth Hospital Network
- Huron Perth Mental Health Network
- Grey Bruce Mental Health Network
- GBHP Dual Diagnosis Committees
- Grey Bruce Human Services and Justice Coordination Committee
- Grey Bruce Huron Perth Addiction Services Network
- Mental Health Grey Bruce
- Adult Day Program Review in Grey-Bruce
- Facility Operator Groups in Grey-Bruce, Huron, Perth
- Aging & Developmental Disabilities Project (Huron County)
- Grey Bruce Children's Alliance
- Local Voices (Perth County)
- Information Management Services Task Group of the Grey Bruce Health Network

Local Networks (Thames Valley)

- Health System Planning Committees
- Thames Valley Hospital Planning Partnership French Services Integration Initiatives
- Virtual Team Pilot Project
- French Languages Services Committee
- Mental Health Network
- Children's Mental Health
- Health Human Resources Planning Committee
- Nursing Steering Committee
 - Recruitment and Retention (R&R)
 - PSW (Personal Support Worker) Workgroup
- Oxford and Elgin Stroke Working Groups
- Long Term Care Integration Initiatives
 - The Palliative Care Implementation Partnership

Geography

Describe any unique characteristics/features of your LHIN that impact upon current and/or future Integrated Health Services planning activity?

Very large territory

LHIN 2 is one of the largest of the newly established LHIN areas in Southern Ontario. While the Southwest has made some important progress in the use of e-health and telemedicine strategies (through VideoCare), travel distances between consumers and providers (especially for Grey-Bruce patients that need to access tertiary care in London) continue to be a significant challenge in the organization and delivery of health services.

Heterogenous mix of rural & urban communities

Rural and urban communities both have special needs and unique issues when it comes to delivering health care. The Southwest LHIN has a very heterogenous mix of communities from large urban (London) to small rural (Parkhill, Exeter, Clinton) to remote (Lions Head, Tobermory). This community diversity presents real challenges in the organization and delivery of health services.

Relationship between LHIN 1 & LHIN 2

Under the Ministry's previous regional boundaries, the Essex, Kent, Lambton (EKL) district was an important part of the former Southwest planning region. Because of the role of the London Hospitals in providing tertiary services to EKL residents and because many current regional planning projects have active EKL representation, it will be important for LHIN 1 & 2 to work collaboratively on these cross-boundary issues.

Transformational Process

Transformational Process

On November 23, 2004, more than 300 health services professionals from various communities within the Local Health Integration Network (LHIN) 2, South West, met in a Community Workshop in London. Through a facilitated process, organized by the Ministry of Health and Long-Term Care, 47 patient care and administrative support priorities were identified by the group as being important for the LHIN's consideration in April 2005. Of those 47, the 5 top Patient Care priorities and the 5 top Administrative Support priorities were determined.

A resource group of local providers self identified for each priority. Pairs of contact leads were identified for each of the ten priorities and an initial teleconference was held to clarify next steps. Various approaches were utilized to complete reports on each priority following a standard template prepared by the Ministry of Health and Long-Term Care's Health Results Team. The Grey Bruce Huron Perth and the Thames Valley District Health Councils volunteered to develop various data and informational components for the overall report and to pull together the final report.

The South West Contact group met again in Toronto in January 2005 with the contact groups from the other LHINs during a provincial LHIN workshop. Final deadlines were established and clarification achieved on structure for the individual priority reports. Some members of the Southwest Contact Group made use of the MOHLTC's e-room for posting draft reports. The Grey Bruce Huron Perth and Thames Valley DHCs compiled the final draft document. The final draft report was circulated to the planning leads during early February for final review and feedback.

The transformational process used to complete the final report for the LHIN was collaborative and efficient while producing a priority list and brief descriptions of ten priority integration initiatives that are logical for the LHIN 2 to focus on in its early planning phase. Although the transformational process identified ten important priorities for the LHIN 2 to address, the process also left several generally accepted priorities off the list, such as waiting times, cancer care, sexual assault counseling, etc. Furthermore, the general public had no input to the process and it is possible that the ten priorities identified are not consistent with the priorities of consumers in this South West area. Still the transformation process has produced a very reasonable and important starting point for the LHIN to embark on its health system planning strategies.

Conclusions

Conclusions

LHIN 2 is expected to be functional starting in April 2005. This report has been prepared through an open and fair process for the purpose of providing LHIN 2 with assistance as it embarks on its mission to improve the delivery of health care and the health status of the diverse populations living in this unique geography. The group of local experts involved in this process advises LHIN 2, through this report, that primary; rural and remote; community; mental health care; and rural transportation are the key patient care issues which will require immediate focus. As well, electronic health records; needs based funding; e-health; human resources and rural networks are administrative issues which if addressed early will enable further integration throughout LHIN 2.

It is important to stress that the providers in the LHIN 2 area are a dedicated and innovative group of health service professionals. They have advanced many integrated and collaborative approaches to improving the delivery of health care throughout the South West. Once LHIN 2 becomes functional, it will best be able to meet the needs of the population by actively engaging and supporting these leaders in planning and implementing local health system integration.

Appendices

Appendix 1

NETWORK INTEGRATION ACTIVITIES IN SOUTHWEST LHIN

A profile of Regional and District Integration Initiatives and Networks

(January 2005)

This document is based on paper originally prepared by:

Steve Elson, Manager,

Integrated Strategic Alliances & Networks (ISAN) division of the London hospitals

And submitted to former Deputy Minister, Phil Hassen, in February 2004 by the Regional Health Planning Partnership.

The Regional Health Planning Partnership is a collaborative health system planning group involving the District Health Councils; Southwest Regional Office, Ministry of Health & Long-Term Care; and, Integrated Strategic Alliances & Networks (ISAN) of the London Health Sciences Centre and St. Joseph's Health Care.

Preamble

In order to have a regional healthcare system that is fully integrated, there are a number of important components that need to be in place.

These include:

1. Having a regional organizational structure and processes to lead and support regional priority setting and decision-making;
2. Having a collaborative management structure and processes that can bring key management staff together to address integration issues and opportunities (clinical, technological etc.) including making decisions regarding the allocation or reallocation of resources;
3. Having the capacity to do system planning and evaluation to ensure the system is evolving as intended and that the protocols etc. put in place to support integration are effective;
4. Having the capacity to integrate clinical support and communications services so that they can support the provision of care on a regional basis, not only within a particular sector of services (among hospitals for example) but also across sectors (e.g., between community services and hospitals);
5. Having the capacity to take a broad systems approach to the provision of health care, especially for those populations that have chronic diseases so that the priority setting and decision-making factors in the full continuum of care - from health promotion and prevention through acute care, rehabilitation and on-going community support services;
6. Having the capacity to support program and service evaluation and to promote and share evidence-based interventions among service providers so that the consistency and quality of care across providers is as high as possible.
7. Having financial incentives in place that promote integrated service delivery and enable regional integration initiatives to be sustained on an on-going basis.
8. Having expertise in change management, facilitation, negotiation and conflict resolution available to provide leadership and support to system and health care integration initiatives.

Basic Prerequisites

Behind each of the networks and integration initiatives listed below are some basic prerequisites that have enabled them to evolve from words and good intentions to action and commitment. These include:

- A recognition that in order to serve the best interests of patients, health care organizations need to collaborate;
- An understanding that collaboration and partnership development is something that requires a set of skills, abilities, attitudes and perspectives, and that these can be learned and developed with learning, time and experience;
- An understanding that individual and organizational interests can be balanced with broader health care system interests; and
- An understanding that there is a responsibility among service providers and organizations for the effective delivery of health care that goes beyond particular boundaries and mandates, and that this responsibility does not fall to government .

Profile of Regional Integration Initiatives in Southwestern Ontario

In terms of addressing the components of regional integration as outlined on the previous page, there are a number of initiatives that have been taken in Southwest Ontario that are important to note⁹:

ENABLING REGIONAL TECHNOLOGY AND COMMUNICATIONS INTEGRATION

The focus of enabling technology is on using technology to improve the integration, quality, consistency and access to health care.

Regional Imaging Needs Assessment Project

This project was undertaken as a region-wide process to assess current and future diagnostic imaging service needs in the region. (to see a copy of the final report visit <http://www.lhsc.on.ca/isan/rip/rip.htm>)

Southwest Ontario Digital Imaging Network Project

This project, currently being implemented among the Thames Valley hospitals, will use digital technology to support the integrated delivery of diagnostic imaging services throughout Southwest Ontario. For more information visit <http://www.lhsc.on.ca/isan/imaging/home.htm>

VideoCare - Southwest Ontario Telehealth Network

VideoCare links all of the hospital sites in Southwest Ontario together through a secure telemedicine network. It supports the regional integrated delivery of clinical services, education and system administration through videoconferencing. For more information go to www.videocare.ca

ENABLING REGIONAL CLINICAL SERVICES INTEGRATION

The focus of clinical services integration is to improve access, communication, collaboration, consistency and use of evidence-based interventions across programs, organizations, providers and the continuum of care.

Mental Health Networks – Local and Regional (proposed)

The Southwest Mental Health Implementation Task Force, whose report was released by the Minister of Health & Long-Term Care (December 2003), has put forward a governance model for the coordination of mental health services in Southwest Ontario. This model calls for the establishment of a number of local networks and a regional network. http://www.health.gov.on.ca/english/providers/pub/mhitf/south_west/south_west.html

Regional Cardiac Care Services Network

This network, while still in its formative stages, is designed to be a regional forum to address the coordination of cardiac services delivery in the region, especially in light of the high mortality rates associated with cardiac disease in Southwest Ontario.

Southwest Ontario Geriatric Assessment Network (SWOGAN)

This is a regional clinical network that brings together agencies that serve elderly persons. Through this network local teams have developed the capacity to undertake the primary assessments of elderly persons who present with health care problems. For more information see <http://www.swogan.ca/>

Southwestern Ontario Medical Education Network (SWOMEN)

The Southwestern Ontario Medical Education Network (SWOMEN) is an initiative of the University of Western Ontario's Faculty of Medicine and Dentistry, the University of Windsor and communities throughout Southwest Ontario. Through SWOMEN rural / regional and Windsor-based medical education and training experience is

⁹ This list of initiatives, projects and networks is not intended to be exhaustive but to capture those with which the author is most familiar.

being provided to undergraduate and postgraduate trainees from the University of Western Ontario. For more information go to <http://www.med.uwo.ca/education/SWOMEN/>

Southwest Ontario Perinatal Partnership (SWOPP)

SWOPP is a clinical network that brings together providers of perinatal services in Southwest Ontario, primarily hospital-based services. Through this network standardized reporting processes and evidence-based protocols for addressing the perinatal needs of mothers and babies have been developed. For more information about SWOPP as well as the Regional Perinatal Outreach Program of Southwestern Ontario go to: www.sjhc.london.on.ca/sjh/profess/periout/periout.htm

South Western Ontario Regional Stroke Strategy

The Regional Stroke Strategy in Southwest Ontario (part of the Ontario Stroke Strategy) is working collaboratively with health promotion, prevention, acute, rehabilitation and long-term care providers throughout the region. The goal is to develop stroke services and protocols that will support improvements in the quality of stroke care throughout the region and help manage expected increases in service demands in the coming years. For more information go to <http://www.lhsc.on.ca/isan/rss/rss.htm>

ENABLING REGIONAL HEALTH SYSTEM DEVELOPMENT

The focus of health system development is on developing the organizational linkages and infrastructure to support regional integration.

Community Care Access Centres – Southwest Ontario Executive Director’s Group

On a monthly basis the Executive Directors of the nine CCACs in the Southwest region meet to exchange information and coordinate their responses to region-wide issues.

Ontario Hospital Association - Region 5

On a bi-monthly basis the Regional Council Executive Committee (RCEC) meets to address OHA -specific hospital issues and well as regional system issues from a regional hospital perspective.

Regional Health Planning Partnership

On a monthly basis, the three District Health Councils in Southwest Ontario, the Southwest Regional Office of the Ministry of Health & Long-Term Care (MOHLTC) and the ISAN portfolio meet to exchange information and coordinate efforts to support current regional planning and coordination initiatives.

Regional Partnership Leadership Forums

Twice a year, with the support of the Integrated Strategic Alliances & Networks (ISAN) portfolio of the London Health Sciences Centre and St. Joseph’s Health Care, London, day-long forums are held that bring senior health care leaders from across the region together to discuss regional health care issues. Past themes have included Telehealth, Genomics, primary health care reform, new models of medical education, laboratory reform and regional initiatives. For more information see <http://www.lhsc.on.ca/isan/partners/partners.htm>

Summary of the fit between regional initiatives and components of regional integration

Integrated Priority Setting and Decision-making	Collaborative Management	Integrated System Planning and Evaluation	Integrated Clinical Support and Communications Systems	Integrated Service Delivery	Integrated evidence-based approaches
VideoCare	VideoCare	Regional Imaging Needs Assessment Project	VideoCare	VideoCare	VideoCare
CCAC Executive Director's Group	CCAC Executive Director's Group	Regional Perinatal Services Project	Southwest Ontario Digital Imaging Network Project	Regional Perinatal Services Project	Southwest Ontario Digital Imaging Network Project
Regional Stroke Strategy	Regional Stroke Strategy	Regional Stroke Strategy	Regional Stroke Strategy	Regional Stroke Strategy	Regional Stroke Strategy
Sub-regional hospital/health networks	Southwest Ontario Digital Imaging Network Project ¹⁰	Regional Health Planning Partnership	Sub-regional hospital/health networks	Regional Cardiac Care Services Network	SWOGAN
OHA Region 5 RCEC	Sub-regional hospital/health networks	Regional Cardiac Care Services Network	Mental Health Networks (proposed)	SWOPP	SWOPP
	SWOMEN		SWOMEN	SWOMEN	SWOMEN
				SWOGAN	
				Mental Health Networks (proposed)	

¹⁰ Collaborative Management at this time only applies to the eight Thames Valley hospitals.

Profile of Local Integration Initiatives in Southwestern Ontario

(supported by the Grey Bruce Huron Perth and Thames Valley DHCs)



<http://www.gbhpdhc.on.ca/>

Local Integration Initiatives in the Grey Bruce Huron Perth District

System Integration Initiatives:

- DHC is a regular participant with 30 other health and social service organizations at a Grey Bruce Area Providers Forum. The Forum meets quarterly and provides an opportunity to learn about new local health initiatives and to engage in collective problem solving. In 2004, the DHC was requested to facilitate several discussions on *health system integration*.
- DHC facilitated a one day forum, "Opening Doors to Shared Commitments", hosted by the Community Advisory Council of the Huron & Perth CCACs. The purpose of the forum was to promote increased communication and linkages of key partners including CCACs, hospitals, long-term care facilities and community support services.

Hospital Network Integration Initiatives:

- DHC provides facilitation and planning support to help the Grey Bruce Health Network (GBHN) achieve its stated goals. The Network is composed of the 3 hospital corporations in Grey Bruce and the Community Care Access Centre. A legal agreement binds the four corporations to collectively develop and implement 'shared deliverables' in the following areas: Clinical Services Planning; Common Physician Credentialing; Health Human Resource Planning (Physicians and other Health Care Professionals); Information Management Planning; Shared Support Services; Clinical Pathways; and a Patient Repatriation Strategy.
- DHC is supporting the development of a comprehensive clinical services plan for the GBHN that looks at all hospital services (acute care, mental health, rehabilitation, complex continuing care) from a population health perspective. Rehabilitation and Mental Health plans were completed in 2003. A draft Acute Care Plan was completed in 2004.

Mental Health Integration Initiatives:

- DHC provided facilitative leadership in the establishment of the Huron Perth Mental Health Network and the initiation of the Grey Bruce Mental Health Network. These Networks provide a forum for information sharing, problem solving, and coordination of services, along with enhancing linkages with other service providers.

- Mental Health Grey Bruce is a legal partnership of four organizations that provide adult mental health services in Grey and Bruce Counties. It was established in 1999 in response to the DHC plan for redesign of the local mental health system. The partners include three community agencies and a Schedule One Hospital. The partnership has enabled these organizations to pool their resources to create multi-agency community mental health teams throughout the District. The roles, responsibilities and mutual accountabilities of the four partner organizations are outlined in a Partnership Agreement. Each partner organization retains governance authority and liability with respect to its programs, services and employees. The partner boards have established a Joint Board Advisory Committee for the purpose of board-to-board communication and system-level planning and problem solving. The partners have established an inter-agency management team of senior managers to oversee the operation of the Teams and the day to day affairs of the Partnership.

The Partnership operates five Teams, each of which provides a comprehensive range of services within a specific catchment area. Team services include intensive case management, outreach housing and community support, mental health counseling and leisure support services. The Teams have access to onsite psychiatry consultation services and liaise closely with the centralized mental health services in the District. Intake to Team services is streamlined and standardized and Team operation is guided by a common set of policies and procedures. The Team model involves the use of joint clinical records, multi-agency consent forms and a common information system. Access to Team services is facilitated by a toll-free number which automatically routes the caller to the closest Team office.

- DHC established the Huron Perth Dual Diagnosis Committee and provided leadership to both the Huron Perth and Grey Bruce committees, which provide a forum for developmental service providers and mental health service providers to work together to coordinate and enhance services for people with a developmental disability and mental illness.
- DHC has providing planning support to child/adolescent mental health service providers and adult mental health service providers in the development of an integrated plan to implement child and adolescent acute inpatient psychiatry beds at the Schedule 1 facility in Grey Bruce.
- DHC initiated the Grey Bruce Human Services and Justice Coordination Committee that brings together stakeholders from various Ministries (i.e., Health and Long Term Care, Community and Social Services/Children's Services, Education, Attorney General and Community Safety and Correctional Services) along with parents. This committee has been established to divert people with a mental illness from the justice systems to the human services systems by improving cross-sector communication, knowledge and coordination of services.
- Grey Bruce Huron Perth Addiction Services Network. The purpose of the network is to facilitate information sharing, consultation and collaboration among addiction service providers in Grey Bruce Huron Perth, the Ministry of Health and Long Term Care and the Centre for Addiction and Mental Health. It also serves as a forum for the identification of needs, trends and issues at the district and system level.

Long Term Care Integration Initiatives:

- DHC has completed an Adult Day Program Review in Grey-Bruce. This project reviewed day program services delivered through long term care community support agencies and hospital corporations. It made a series of recommendations for a future model of integrated primary health care monitoring-social/recreation services to help frail and/or cognitively impaired elderly and their caregivers.

- DHC is playing a leadership role in the Huron County - Aging & Developmental Disabilities Project that brings together developmental service agencies (i.e., Associations for Community Living), long term care community support agencies and long term care facilities in Huron County. These agencies are integrating some of their policies and protocols to help manage the special needs of aging developmentally disabled adults.
- DHC facilitated a process to develop an integrated service delivery model in Grey Bruce to address the needs identified in the DHC's Paediatric Acquired Brain Injury Report.

Human Services Integration Initiatives:

- In partnership with the United Way, the DHC provided support to a Trillium-funded project that examined new partnership models for children service providers in Grey-Bruce. Based on the results of this project, the DHC has provided planning leadership to support the establishment of a new Grey Bruce Children's Alliance; a voluntary coalition of over 25 local organizations dedicated to improving the health and well-being of children and their families.
- DHC has played a leadership role in organizing and co-sponsoring an Annual Local Voices Event in Perth County. This event provides an annual opportunity for volunteers, service providers, community organizations and government to come together to focus on a local issue and develop collective strategies to address the issue. The 2004 event focused on increasing local capacity through innovative volunteerism.
- DHC is playing a lead role in working with key stakeholders (including United Way, Perth County Community Planning Council, local municipalities, Senior Services Network) to establish a new social planning organization for Perth County.

Integrated Information Technology Systems:

- DHC is a key partner in an Information Management Services Task Group of the Grey Bruce Health Network. The Task Group was formed to develop a Common Health Information Management Plan among the hospitals and CCAC.
- The DHC has supported the Bluewater Connects Community network proposal that includes a health care component. This is a network infrastructure project, which will allow connectivity between some of the more remote areas of Bruce and Grey Counties.
- DHC has been a partner in Huron Perth Connect Ontario which offers an opportunity to attract provincial funding to support service delivery priorities and initiatives of health, caring and community organizations in the Huron Perth region. The goals of the project are to: (1) make reliable, affordable high speed, broadband Internet access available to every business and residence in Huron and Perth counties; and (2) provide the capability for local government, institutions, healthcare organizations, businesses, and community organizations to extend and enhance their services through adopting leading edge information and communications technology (ICT).



<http://www.tvdhc.on.ca>

Local Integration Initiatives in Elgin, Middlesex, Oxford and the City of London

The Thames Valley District Health Council (TVDHC) is currently leading the following local integration initiatives.

System Integration Initiatives:

- Health System Planning Committees – Reporting directly to TVDHC, four Health System Planning Committees currently meet regularly in Elgin, London, Middlesex and Oxford to identify and discuss issues of mutual concern and provide a forum for coordination, planning and developing recommendations to Council. Membership includes local providers, consumers and municipal representatives. Current priorities include Primary Health Care, Integration, Information Technology, Children with High Needs, Environmental Scanning, and Health System Monitoring.
- Thames Valley Hospital Planning Partnership: Together with the eight Thames Valley Hospitals, Council helped form and continues to support this Partnership. This Partnership is achieving integration on many fronts including Diagnostic Imaging, Laboratory Services, Clinical Care, and Capital Planning. TVDHC provides the planning support to this major ongoing initiative.

French Services Integration Initiatives:

- The Virtual Team Pilot Project is designed to meet the health and social service needs of Francophone children, ages 0-18, and their families residing in the City of London. It is based on the sharing of French-speaking health and social service providers from among existing health and social service agencies without the creation of a separate infrastructure. TVDHC's French Languages Services Committee and its French Languages Coordinator provide leadership and supporting roles to this unique integration strategy.
- Council's French Languages Services Committee provides a forum for health providers from every aspect of the London Health System to explore integration activities.

Mental Health Integration Initiatives:

- Mental Health Network – Three networks / alliances with core mental health agencies / organizations and community health and social service agencies meet regularly in the Middlesex/London, Elgin and Oxford County communities. TVDHC helped develop and continues to support these networks/alliances. The networks/alliances' priorities include:
 - Enhancing community service capacity for mental health services;
 - Creating a local system that is integrated, accessible and accountable for those with serious mental issues; and,
 - Working with regional office of the MOHLTC and DHC to identify issues and solutions, which can be implemented.
- Children's Mental Health – Staff assist the Ministry of Children Services as they plan for core mental health services for children.

Health Human Resources Integration Initiatives:

- Health Human Resources Planning Committee – Reporting to TVDHC, Committee members, from the four planning areas and most health professional groups, meet to provide leadership and support to committees of Council in the area of health human resources, and support integrated health human resource planning in Thames Valley.
- Nursing Steering Committee is developing local strategies dealing with nursing supply in Thames Valley with an emphasis on recruitment and retention issues.
 - Recruitment and Retention (R&R) Sub-Group of the Nursing Supply Workgroup is responsible for reviewing current Best Practices in Thames Valley in the area of nursing recruitment and retention.
 - PSW (Personal Support Worker) Workgroup (starting in March 2004) - This group has developed a report similar to the Nursing Supply Report .The focus will be on understanding demand, projecting supply and looking at integration improvement strategies.

Other Integration Initiatives

- Oxford and Elgin Stroke Working Groups – These Groups meet to facilitate and coordinate the development of an integrated delivery system for best practice stroke prevention, care and rehabilitation. The Middlesex Alliance is supporting this development in Middlesex.
- Long Term Care Integration Initiatives - The Palliative Care Implementation Partnership chaired by staff is defining a single point of access for end-of-life care, and building a complete database for Information and Referral (I&R) purposes through thehealthline.ca partnership.

Appendix 2

The Southwest LHIN report has been assembled by the following planning team contacts:

INTEGRATION PRIORITY	PLANNING CONTACTS
1. Community Support Services	Judi Fisher Jackie Wells
2. Rural Health Networks	Patty Chapman Jim Whaley
3. Mental Health and Addiction Services	Catherine Hardman Sandy Stockman
4. Primary Health Care	Paul Huras Cathy Goetz-Perry
5. Needs-Based Funding	Ellen Coffey Brent Gingerich Shirley Hodgson
6. Delivery of Rural Remote Care/Services	John Saidak Carolyn Yantzi
7. Rural Transportation	Shirley Hanlon (for Bettianne Hedges) Dianne Lichti (for Angie Woodcock)
8. Human Resources	Georgia McIlwraith Cathie Schalk
9. E-Health and Community/LTC Organizations	Michelle Hurtubise Mary Raithby
10. 1 Patient – 1 Record (E-Health)	Diane Beattie Judy Chalmers