Full Report
of the
Waterloo Wellington LHIN Community Workshop

Friday, November 19, 2004
Waterloo, Ontario

Prepared by:
LHIN Community Workshop Participants

Waterloo Wellington LHIN Community Workshop

November 19, 2004, Waterloo Ontario

Table of Contents

Priority Integration Opportunities

- Index of Topics
- Priority Integration Opportunities Reports #1 to #33
  (Note: #17 not received)

Voting Results

- Complete Voting Results
- Top 5 Patient Care results
- Top 5 Admin results

Planning Contact List

Priority Integration Opportunities

Index of Topics

#	TOPIC	Initiator
1	LHIN-Wide Health Human Resources Plan	Susan Burns
2	Communicable Disease/Infection Control	Liana Nolan
3	Accessible Integrated Electronic Health Records	Sherry Peister
4	Community Care Services Remodeling	Gayle Sadler
5	Accessing Services	Susanne Gillespie
6	Integration of Access, Assessment, Case Management, Case Service Management & Discharge Planning	Kevin Mercer
7	Developing Models of Service that empower individuals to take responsibility for their health and related services	Katherine Soule Blaser
8	Seniors Health – Education of Services	Marianne Walker
9	Patient Care/Service – incorrect terminology	Janice Paul
10	Shift thinking from Continuum of Care to System	Paula Bergeron
11	Hard to Serve Clients – Complex Care Needs	Cathy Donahue
12	Public Reporting and Scorecard Measurement	Randy Peltz
13	Integration of Rehabilitation for People with Disabilities	Bill Laidlaw
14	Admin and Support Opportunities (Other than IT)	Karl Ellis
15	Mental Health Services/System	Carolyn Skimson
16	Integration Community Health with Mental	Toby Harris
17	Health and Addiction Programs	
18	Utilizing of the Provincial Bed and Resource Registry	Trish Simmons
19	Integration of Health Care Providers in the Treatment of Musculoskeletal Problems	Dr. Gregory Bidinosti
20	Integration of Hard to Serve the Younger Adult into LTC	Brenda Nadeau
21	Role of Community Support Agencies in Health Services	Irene O'Toole
22	Recruitment and Retention of Health Human Resources	Suzy Young
23	Conversion of Existing Networking Groups into Action Groups	Nancy Lambert/Nancy Dunbar
24	Funding for Long Term Care Services	Blair Philippi
25	Role of Volunteers in the Health Care System	Deb Gemmell, Paula Bergeron, Janice Paul
26	Patient Populations: Service Delivery in LHINs: Better/Worse?	Laurie Hurley
27	Cross-Sector Training	Jeff Wilbee
28	Fair Funding for Waterloo/Wellington	Dennis Egan

29	Regional Care Maps	Pierre Noel
30	Rural Intersectoral Integration AND Planning for Intersectoral Collaboration for Health promotion, disease prevention, service delivery	Konnie Peet and Denise Squire
31	Multidisciplinary Primary Care	Joe McReynolds
32	Networks	Ross Kirkconnell
33	Ensuring care in the community for people with ongoing chronic needs/conditions	Susan Thorning

Priority Integration Opportunities
Open Space Report #1

Topic/Integration Opportunity: LHIN-Wide Health Human Resources Plan

Check One: Patient Care Opportunity? _X___ Admin Support Opportunity? ____

Topic Initiator: Susan Burns Waterloo Wellington Dufferin District Health Council

Number of Participants: 9

Briefly Describe the Opportunity:

Check One: Existing ____ New Opportunity X____

Develop a LHIN-wide health human resources plan.

Why is it a priority?

The community is now and well continue to be confronted with significant shortages in health human resources disciplines of all kinds. As a LHIN mandated to plan, the issue of health human resources planning is an obvious fit.

Given factors like an aging workforce, shortages in the different disciplines and side variation in wages and benefits paid across the health care sector, there is a need for planning to address these critical issues.

The plan could address three broad areas of interest to all health care personnel employers within the LHIN geography:

1. Identify size and composition of existing work force across all disciplines and sectors;
2. Project future gaps stemming from an aging workforce;
3. Propose strategies to close the gaps in wages and benefits differences across the sectors (i.e. community and institutional differences)
4. Plan to close the gap pertaining to shortages of physician specialities across the LHIN
5. Identify “best practices” in Human Resources recruitment and retention strategies aimed at keeping H.R. resources within the LHIN district and work with employers to develop retention strategies aimed at reducing competition among employers;
6. Link the LHIN H.R. Plan to academic/training centres where appropriate.

Our group :”G” felt that these plan components would go a long way to positioning organizations in the Waterloo-Wellington LHIN for success in serving patients across all health sectors across our LHIN.

List of Participants for Report #1

NAME	ORGANIZATION
Anne Walker	Guelph Services for Persons with Disabilities
Steve Wallis	Guelph General OPSEU 231
Heather Richardson	Cambridge County Manor
Fred Kinsie	Independent Living Centre (Waterloo Region)
Richard Ernst	CEO GGH
Pam Gardiner	Addiction Service, House of Friendship
Toby Harris	Participation House
Suzy Young	Registered Nurses Association of Ontario

Priority Integration Opportunities
Open Space Report #2

Topic/Integration Opportunity: Communicable Disease/Infection Control

Check One: Patient Care Opportunity? __X__ Admin Support Opportunity? _X___ (both apply)

Topic Initiator: Liana Nolan

Number of Participants: 7

Briefly Describe the Opportunity:

Check One: Existing ____ New Opportunity _X___

Opportunity for system wide approach across LHIN regarding communicable disease surveillance, control and prevention.

Includes: planning, resource allocation, standard setting, outbreak response, human resource allocation, policies (eg influenza immunization), communication planning, information sharing, access to services 24/7 including outreach, surveillance, emergency preparedness.

Why is it a priority?

Impacts us all, across the sector. SARS showed us we are not integrated/prepared/ seamless/coordinated.

Need for education and access to services with a comprehensive view, and a view to prevention. Health care providers do not know standards of care consistently eg protocols for treating STDs. Public health must do outreach to special populations to ensure they get the care they need- eg young people, marginalized people. Outreach is currently not 24/7- after hour access to care needed. Don't want penalties in system detrimental to public health, eg penalty when teen goes to outreach for birth control when her own MD gets penalized since this is a rostered practice.

Tracking of staff and patients as they go from institution to institution eg patients transferred from LTC to hospital to LTC, or part time staff who work in multiple institutions. Need standards for health professionals to follow re infection control. Inadvertent impact of economic drivers on communicable disease control- eg staff can only get part time hours so they work in many institutions (a problem during outbreaks), eg funding does not allow negative pressure rooms or private rooms and patients undergo bed bumping (a problem during outbreaks). Funding decisions should include consideration of impact on CD/infection control from system perspective. Human resources could be reallocated with system perspective in mind and benefit of infection control.

Focus on prevention needs standardization, eg immunization policies, infection control procedures, environmental design. Need to think upstream on prevention. It will cost money- investment up front.

Communication- sharing of patient information as it relates to CD control, sharing of standards, protocols, surveillance data, reporting could be improved. Lack of coordination of communication in SARS. Note privacy issues need to be addressed. Need to do better with surveillance, monitoring, reporting, control of Communicable Diseases.

Resource deployment decisions from perspective of system wide impact on CD control.

"System is only as good as its weakest link". In SARS we were thin on the ground. We need stable administration, stable trained staff. Succession planning is difficult. Success partly depends on established relationship between staff- need relationship building. Info technology is a building block but we also need staff collaborating eg Public Health and Emergency room staff during SARS.

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

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

List of Participants for Report #2

NAME	ORGANIZATION
Liana Nolan	Region of Waterloo, Public Health
Sheila Braidek	Kitchener, Downtown C.H.C.
Lynn Beath	Wellington-Dufferin-Guelph Health Unit
Niall Wallace	MOHLTC Health Results Team
Dorothy McCabe	John Milloy, MPP
Dennis Egan	Grand River Hospital
Casey Cruikshank	Waterloo Region Sexual Assault Treatment Centre

Priority Integration Opportunities
Open Space Report #3

Topic/Integration Opportunity: Accessible Integrated Electronic Health Records

Check One: Patient Care Opportunity? _x___ Admin Support Opportunity?x

Topic Initiator: Sherry Peister, Pharmacist, OPAssoc

Number of Participants: 9

Briefly Describe the Opportunity:

Check One: Existing ____ New Opportunity _x___

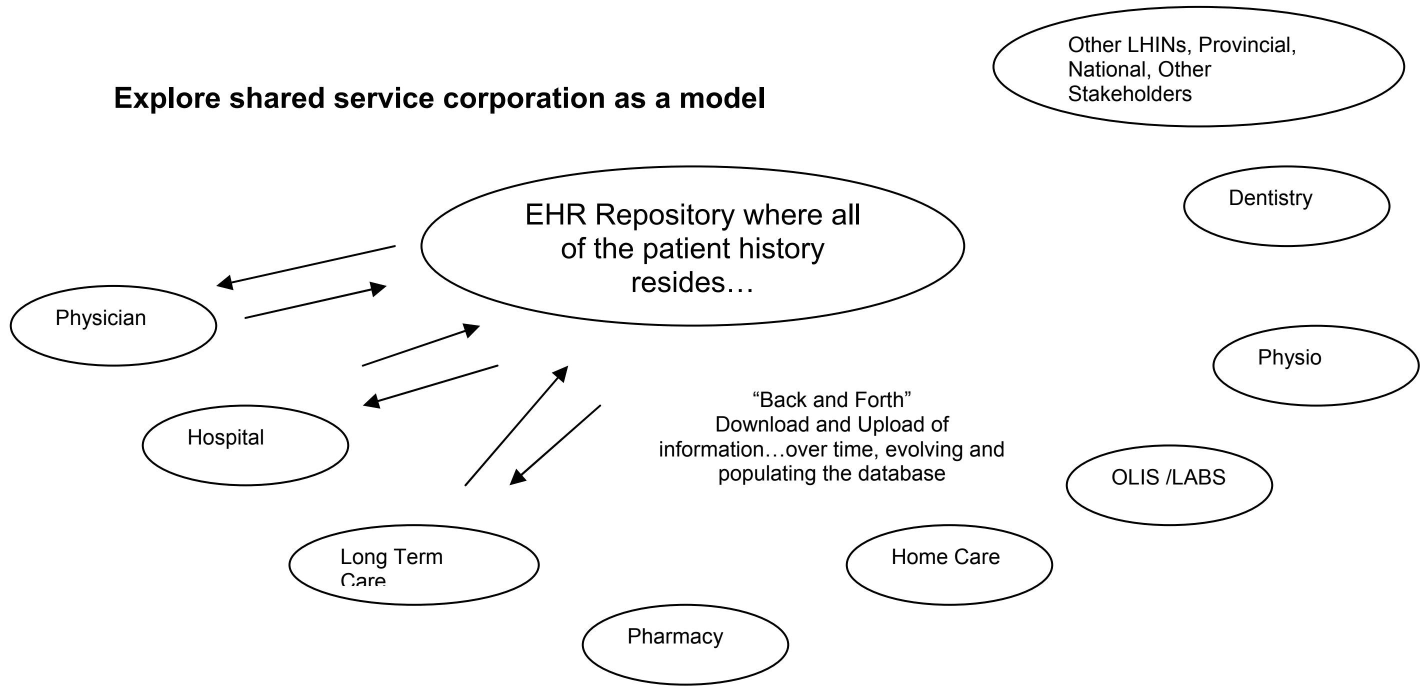
Provides clinical info to stakeholders across continuum, including patients (see below)
Indicators/benchmarks/quality indicators/measuring of trends
Patient information (patient portal) – throughout lifespan
Database to plan, set priorities, track best practices (and use of best practices)

Challenges:
Privacy issues/ regulatory issues
Requires commitment of all parties

Why is it a priority?
Reduce variability of care, improve care
Patient portal = increase patient control and involvement in own care
Patient privacy expected
Reduces duplication
Portability of standards across all LHINS
Evolution and increasing cohesion of information

FOUNDATION OF SYSTEM BEING BUILT – can be used from planning, through to service delivery and evaluation

Explore existing models:
US – California John Muir Mt. d'ablo
UK
Australia
Canada – NB, BC Alta – Calgary Health Authority



List of Participants for Report #3

NAME	ORGANIZATION
Trevor Lee	The Elliott Community
Nancy Berner	MDS Laboratories
Dennis Egan	Grand River Hospital
Joan Kaden	WR Dementia Network
Richard Ernst	Guelph General Hospital
Pierre Noel	North Wellington Health Care
Suzy Young	Registered Nurses Association of Ontario
Steven Harrison	Ont. Medical Association

Priority Integration Opportunities

Open Space Report #4

Topic/Integration Opportunity: Community Care Services Remodeling

Check One: Patient Care Opportunity? __x__ Admin Support Opportunity? x___

Topic Initiator: Gayle Sadler

Number of Participants: 14

Briefly Describe the Opportunity:

Check One: Existing __x__ New Opportunity ____

Community Care Services Remodeling
(Community Care defined as all care and services provided in the community outside of acute hospital care)

Preferred features:

- Client – focused
- Shared operational resources – IT, management, facilities, training, etc
- Funding model changes that provide flexibility to float $$ between community program
- Programs focus on prevention/diversion/delay from acute care services
- Easy efficient access for client/client families
- Minimum standard of access & services
- More consumer choice and involvement including appropriate funding
- Increase flexibility in service options
- Access to broad range of services
- Client's situation (carers, environment, transportation, place – urban or rural, etc) drives the required services
- Central information access (ie Telehealth model for client information)
- Caregiver requirements for support, education, advocacy and emergency plan

Why is it a priority?

- To improve quality and quantity of direct service delivery
- To improve positive health outcomes
- To increase efficiency and effectiveness in order to provide more $ for direct service delivery
- To decrease waste and duplication
- To support consumer responsibility and community accountability

List of Participants for Report #4

NAME	ORGANIZATION
Gayle Sadler, RN	Hospice of Waterloo Region
Kristini McGregor, RRT	Professional Respiratory
Ross Kirkconnell	CCAC of Wellington-Dufferin
Pauline Diemert	Para Med Home Health Care, Guelph
Donna Launslager	Multiple Births Canada
Margaret Wagner	Citizens for Independence in Living and Breathing
Laurie Hurley	The Arthritis Society
Joanne Klausnitzer	Meals on Wheels
Deb Gemmell	RAISE Home Support
Lauren Henry	HLO Health Services Inc.
David Kelly	OFCMHAP
Barb Cawley	COTA
Kevin Bradshaw	Alzheimer Society of Kitchener-Waterloo
Laura Visser	MOHLTC
Joe McReynolds	OCSA

Priority Integration Opportunities
Open Space Report #5

Topic/Integration Opportunity: Accessing Services
Check One: Patient Care Opportunity? _x___ Admin Support Opportunity? _x___

Topic Initiator: Susanne Gillespie

Number of Participants: 7 + 2 part-time participants

Briefly Describe the Opportunity:
Check One: Existing _x___ New Opportunity x

1. *To change the language and approach when thinking about health care to get away from the traditional medical model and move to an integrated health model IE – Consumer Services instead of Patient Care*

health care/community service providers to be effec

The LHINs can provide a new opportunity to examine and resolve the following main issues that continually challenge consumers and service providers alike.

1. *LHINs can be responsible for the planning in a community – identify opportunities and gaps, identify existing resources and reallocate or shift resources. Examples of resources include financial, knowledge, and information.*

2. *Designate funds to the LHINs to be used for accessibility to health services for the community.* This addresses interpreting costs (ASL, language), technical devices for providers to be accessible and for consumers to be able to live independently at home, physical modifications to building and their systems (ie. Phone systems) where services are provided, or to consumer's homes so that they can stay at home. These funds should address issues for consumers who have sight, hearing, physical and developemental challenges and mental health. The funds should also be used to make all information in plain language.

3. *LHINS have the opportunity to support and build on current successes and collaboration in the community, ie community health centres collaborate with hospitals to bring some services into the community* – for example having a community based diabetes clinic.

4. LHINS have the opportunity to create a consumer driven health care system where there is comprehensive and accessible information that consumers can use to make their choices. LHINS can be the navigating system that is user friendly, family, covers a broad spectrum, fully accessible and integrates both medical and community services.

Why is it a priority?

1. This is a priority because the current system is not accessible. The system is fragmented. It is harder to get some services if you are accessing it from the community and not the hospital – ie long term care bed. Information is not clear or easy to find. Access to resources is limited for both consumers and providers. This includes transportation (especially rural areas), co-ordination of services, having the financial means to access services in a timely fashion, language barriers, information is not plain language or alternative formats – ie large print or Braille, physical access barriers, phones, communication – mobility, interpreters etc…. .

2. The current system is based on a medical model and often services can not be accessed without a physician's signature – this requirement also takes away physician's time. Often consumers who need the services the most do not have physicians. In the current system you have to be diagnosed with something to get services.

3. System barriers – the current system limits scope of practice for some professionals ie hospital privileges are limited, access to hospitals, examples include nurse practioners and mid-wives. Lack of knowledge in current system about what other professionals and services provide. Including community based services as part of the interdisplanary team. Limiting hierarchy of health services.

4. Delisting of services has created some of these problems.

5. Lack of infrastructure in the broadest sense – human resources community – formal and information caregivers in the community. Consumer services are not accessible because they can not retain and train people to provide the services.

6. Paperwork and red tape is creating access challenges for consumers and service providers alike – there are too many forms that are too long to be filled out. Ie. 60 page CCAC assessment – physician's having to fill forms out for consumers to obtain other services.

List of Participants for Report #5

NAME	ORGANIZATION
Bill Davidson	Lungs Farm Village Association (Community Health Centre)
Marg Hedley	Guelph Community Health Centre
Dianne Smith	Cambridge Midwives
Jeanette Kuntz	Caressant Care Nursing Home
Wendy Theis	Comcare Health Service
Sue Gillespie	The Canadian Hearing Society
Sue McCarter	The Canadian Hearing Society

xPriority Integration Opportunities

Open Space Report #6

Topic/Integration Opportunity: Integration of Access, Assessment, Case Management, Case Service Management & Discharge Planning

Check One: Patient Care Opportunity? xx____ Admin Support Opportunity? ____

Topic Initiator:Kevin Mercer

Number of Participants: 23

Briefly Describe the Opportunity:

Check One: Existing ____ New Opportunity x____

Potential ways to address access for referral , assessment , care /service management including discharge planning. Re-engineer including the potential integration of roles, to make sure that we have the right care and service at the right time by the right source in the right place. Look at functions which need to happen and then develop form as appropriate. Increase awareness of what is available and simplify access across the system. Really solve the access to family physicians-----family health networks are one option. Community Advisory Councils of the CCAC's with a heightened role could provide the necessary advice and information on the changes required and the priorities in moving forward the objectives of improved access and management across the system. Flexible funding formula----consider the resources following the client.

Why is it a priority?

1. Individuals are not getting the service.
2. Individuals getting care and service in less than an ideal setting
3. High risk clients are falling through the cracks
4. Increased risk situations for clients/patients service providers and formal and informal caregivers
5. System risk in so far as improved coordination and integration of client management is required if the government is to meet the LHIN objectives
6. Cost of the system will continue to rise due to continued duplication of effort
7. Silo mentality will continue
8. Costly crisis management will continue to prevail
9. Patient/ Client safety issues may escalate
10. Specialty services and other programs needed may not get identified because the parts of the process are not linked
11. Dollars continue to be expensed just because and not necessarily where they are needed. Current inefficiencies will continue

List of Participants for Report #6

NAME	ORGANIZATION
Shelly Andrews	MOS Labs
Sue Robertson	Grand River Regional Cancer Centre
Carol Nafziger	Comcare Health Services
Toni Lemon	Pace Homecare
Deb Dalton	Care Partners
Jacqui Dow	Red Cross
Wilma Quiñones-Nitsch	Community Rehab
Laura Melo	The Westmount
Dianne Roy	Hilltop Manor Nursing Home (LTC)
Dianne O'Rourke	Central Care Corporation
Margot Wimmer	Saint Luke's Place (LTC)
Doug Letson	St. Mary's Hospital
Ruth Edwards	Paramed Home Health Care
Paul Ting	VON Canada – Ontario
Glynis Williams	CCAC of Wellington-Dufferin
Veronica MacDonald	Community Care Concepts of Woolwich, Wellesley and Wilmot Townships
Diane Gambacort	Riverbend Place
Fiona Cressman	Riverbend Place
Anne-Marie Rutka	Forest Heights LTC Centre
Nancy Kauffman Lambert	Golden Years Nursing and Assisted Living Centre
Judy Peck	Forest Heights LTC Centre
Sandra Hanmer	COTA Health

Priority Integration Opportunities
Open Space Report #7

Topic/Integration Opportunity: Developing Models of Service that empower individuals to take responsibility for their health and related services

Check One: Patient Care Opportunity? __X__ Admin Support Opportunity? ____

Topic Initiator: Katherine Soule Blaser

Number of Participants: 12-14

Briefly Describe the Opportunity:

Check One: Existing __X__ and New Opportunity _X___

Background Points

- self-directed Care models (e.g., ILC) empowers individuals to direct and take responsibility for their own health services – conundrum is how to balance empowerment with facilitating best outcomes
- 2 issues – sharing knowledge and provision of services, for best outcomes
- self-management model e.g. Arthritis Socite – struggle is getting to clients and how to enhance model and grow to other areas
- once patients discharge from hospital, don't know what resources in community for people to take responsibility for their own health
- rural/urban challenges = re: distribution of services (Waterloo Region services more urban-based, Wellington Dufferin services more broadly dispersed); empowering individuals can be influenced resources availability/location (rural/urban differences)
- access to info at Board level, so organizations understand role of other resources (clearinghouse function)
- future/enhanced clearinghouse role of Public Health?
- Infrastructure challenges re: resources, info, empowerment in rural areas; If there's no place to use as point of delivery, it's hard to provide info, support, empowerment (eg Arthritis Society covers wide area and tough to find/fund community locations)
- Many of these types of models do exist already (e.g, Guelph/Shelldale, Shelbourne Mel Lloyd Centre); these highlight importance of physical location and integration – how to do more of this?
- Many smaller organizations to share space, administration, work jointly
- More opportunities for multi-disciplinary practices (e.g., chiropractors, MDs, physiotherapists) to support health teaching, self-care, empowerment for patient/individuals
- Patient focus/patient empowerment focus changes historical approach to locating/structuring services; usually, we look at locating/connecting services to acute services; but patient focus changes this?

- Complex cases = challenges for community sector to support complex care issues in community – there is the will to do this but need better/stronger integration to do this
- Who's not at the table right now? – physicians – they have an important role/power in the system
- How to have non-partisan (i.e., not a specific agency) access to info to local health resources? E.g. 1-800-## , and control access on LHIN basis, not on province-wide

Summary points about Opportunities (enhancing existing and exploring new)

-shift from medical model to person makes own choices, patient is the expert, respect patient choice
- promote understanding that empowerment = responsibility for outcomes of decisions, and recognition of potential for unsuccessful outcomes
- more community-based (not hospital) co-location, sharing of resources/information
- look at /consider most cost-effective provider/point of delivery for best quality outcomes
- provide/ensure access to info/best practice/evidence-based info for patients, to assist patient to make decisions, have power, take responsibility
- centralized approach for acute care hospitals to help patient access/follow up on community resources

CAVEATS

- Not enough info/clarity re: LHINS to fully appreciate impact, and potential opportunities
- There are financial barriers to opportunities right now
- We are not currently maximizing technology to assist with communication

Why is it a priority?

List of Participants for Report #7

NAME	ORGANIZATION
Katherine Soule Blaser	ILCWR
Karen Gal	Saint Elizabeth Health Care
C. Eliraluch Allan	Raise Home Support
Tina Moland	Community Rehab
Greg Bidinosti	Waterloo Regional Chiropractic Society
Dr. Kendra Brough	Waterloo Regional Chiropractic Society
Lynne Lenke	The Arthritis Society
Troy Herrick	Wellington-Dufferin-Guelph Health Unit
Lisa Gammage	Waterloo Region Self Help
Denise Squire	Woolwich C.H.C.
Dorothy McCabe	John Milloy, MPP
Dennis Egan	Grand River Hospital

Priority Integration Opportunities
Open Space Report #8

Topic/Integration Opportunity: Sealors Health – Education of Services

Check One: Patient Care Opportunity? ____ Admin Support Opportunity? ____

Our group feels strongly that we should not refer to seniors as only patients as many are not, as they are either in the community or in LTC homes.

Promoting Seniors Health

Topic Initiator: Marianne Walker

Number of Participants: 7

Briefly Describe the Opportunity:

Check One: Existing ____ New Opportunity x_

1. Develop an integrated coordinated education program about the services available in the community that support seniors' health.

2. Develop a seniors' single point access to information about the community services available that support seniors' health.

Why is it a priority?

The senior's population continues to grow at a fast pace.
There are many community services available; however, many seniors and their families are not aware of these services.
Supports the transformation of health care in terms of providing community services to keep seniors out of hospitals and LTC as long as possible.
Assists in the identification of the community support needs of seniors.
Eliminates duplication of individual organizations marketing their services.

<u>List of Participants for Report #8</u>

NAME	ORGANIZATION
Monica Wright	Hilltop Manor-Cambridge
Robert Soehner	Community Care Concepts – Elmira
Nancy Kinsie	Fairview Mennonite Home – Cambridge
Debra Gilpin	Allan Reuter Senior Centre – Cambridge
Blair Philippi	Crescent Care Arthur(?)
Paul Nolet	Guelph Wellington Chiropractic Society
Marianne Walker	St. Joseph's Health Centre

Priority Integration Opportunities
Open Space Report #9

Topic/Integration Opportunity: **Patient Care/Service – incorrect terminology**

Check One: Patient Care Opportunity? _x___ Admin Support Opportunity? ____

Topic Initiator: Janice Paul

Number of Participants: 7

Briefly Describe the Opportunity:

The term "patient" is based on a medical model of health and not all consumers of the Health system are patients
Health should be focused on wellness, well-being, quality of life, choice not focused on illness
Should be "individual", "person", care/service or client care/services
Equality cannot exist within the LHINs system if we focus solely on a medical model of care

Why is it a priority?

We need to think beyond medical model and need to focus on individual capacity building rather than individual health deficits
We need a more holistic approach

List of Participants for Report #9

NAME	ORGANIZATION
Janice Paul	K-W Friendship Group for Seniors
Irene O'Toole	Waterloo Home Support
Brent Charette	Hospice Wellington
Lisa Gammage	Waterloo Region Selp Help
Casey Cruikshank	Waterloo Region Sexual Assault Treatment Centre
Paula Bergeron	Cambridge Home Support

Priority Integration Opportunities

Open Space Report #10

Topic/Integration Opportunity: **Shift thinking from Continuum of Care to <u>System</u>**

Check One: Patient Care Opportunity? X   Admin Support Opportunity? ____

Topic Initiator: Paula Bergeron

Number of Participants: 10

Briefly Describe the Opportunity:

Check One: Existing ____ New Opportunity _X

To provide services in a holistic manner (vs. Medical model) to meet individual and changing needs of persons to improve or maintain quality of life, borrowing from lessons learned from successes in coordination and integration in other sectors.

-incubation for innovation funding is required

-human needs do not follow a linear path

-client need not move through the system, rather the system must move around the client

Why is it a priority?

Because it is fiscally efficient and person focused

IT IS THE ONLY WAY TO MAKE THE SYSTEM FUNCTION EFFECTIVELY

<u>List of Participants for Report #10</u>

NAME	ORGANIZATION
Neil Barran	Saint Elizabeth Health Care
Heather Kerr	Stonehenge Therapeutic Community
Heather MacDonald	Woolwich Community Health Centre
Susan Martin	WRWD DHC
Christine Jacobsen	Alzheimer Society of KW
Paula Bergeron	Cambridge Home Support
Susan Thorning	Ont. Community Support Association
Casey Cruikshank	Waterloo Region Sexual Assault/Domestic Violence Treatment Centre
Irene O'Toole	Waterloo House Support Services
Janice Paul	K-W Friendship Group for Seniors

Priority Integration Opportunities
Open Space Report #11

Topic/Integration Opportunity: **Hard to Serve Clients – Complex Care Needs**

Check One: Patient Care Opportunity? __X__ Admin Support Opportunity? ____

Topic Initiator: Cathy Donahue

Number of Participants: 8

Briefly Describe the Opportunity:

Check One: Existing _X___ New Opportunity ____

Many clients both in the community and in institutions have complex care needs and are difficult to provide service to

Why is it a priority?

It is a priority because about 10% of the population are difficult to serve. How do we deliver a high standard of care for our most complex population across all sectors, and maintain quality service to the other 90% when the smaller population uses the majority of resources? Most of the discussion concentrated on providing integrated services and specialized care that could service the individuals in question enhancing their quality of life while still servicing the larger group effectively. The goal is to increase quality of life of the hard to serve individual with complex needs and empower staff with enhanced knowledge to provide care.

List of Participants for Report #11

NAME	ORGANIZATION
Brenda Fraser	Wellington County Hospital Network (Proj. Coord)
Nancy Dunbar	Leisureworld
Cathy Joy	PSMP
Cathy Donahue	Caressant Care Fergus (LTC)
Kate LS Blaser	ILCWR
Lorna Miller	Mental Health and Wellness Network

Priority Integration Opportunities
Open Space Report #12

Topic/Integration Opportunity: **Public Reporting and Scorecard Measurement**

Check One: Patient Care Opportunity? ____ Admin Support Opportunity? Yes

Topic Initiator: Randy Peltz

Number of Participants: 11

Briefly Describe the Opportunity: Public Reporting & Integrated Scorecard – Measurement & Evaluation

Check One: Existing Yes (partial) New Opportunity ____

Why is it a priority?

The LHIN model is considered the new "structural" cornerstone in transforming the provincial Health Care System, and should heighten public and provider expectations for (1) improved system performance, and (2) improved service delivery.

Therefore, if LHIN's are to be held accountable for making a fundamental difference in system performance and delivery, then we need to measure "it" and report on "it" in an integrated, balanced scorecard fashion at start-up ~ baseline data is essential, creating a level playing field. Is the LHIN making a difference over time? How do we know? Once we know, what do we do with it ? Who Needs to Know?

What are We Trying to Measure? & Why?

Considerations include:

1. Population Health *and or*
2. System Success/Performance *and or*
3. Benchmarking between and across LHIN's *and or*
4. The need to inform planning & evaluation activities *and or*
5. Individual Agency Performance *and or*
6. Cost-Effectiveness of the LHIN model – Administrative driver *and or*
7. Patient Experience with the System – Consumer driver, including Satisfaction measures *and or*
8. Influence the Funding Model

Starting Points & Challenges to Developing a LHIN Scorecard System

- Identifying common core indicators & definitions across the continuum
- Indicators must relate to system indicators
- Core set of indicators should feed into Governance performance for each LHIN, and well as management performance
- Start with Population-based needs – derive the core set of indicators from existing data
- Existing Opportunities = build on the work of Universities, professional and trade Associations, professional Colleges, District Health Councils *Health System Monitoring Project* – take this a giant leap forward – give it credibility and usefulness

But How Do You Measure Integration? How do you draw a correlation between Health Outcomes and Integration?

- Look to known & validated population-health outcomes – keep it simple, meaningful
- Consideration to be given to controlling for other key variables/determinants – housing, education, socio-economic status, health child development, etc

Requirements for Success

- Accountability agreements with agencies funded by the LHIN which contain a set of integrated core indicators (expectations for performance) – i.e. the core indicators become the deliverables – individually and jointly between agencies
- Clear accountability/feedback loops – the key will be how data is collected, analyzed, and presented back to make a meaningful difference
    - Feedback & accountability to all participating stakeholders/agencies to e.g. improve performance, share learnings
- Intra & Inter LHIN data collection methodologies – must be standardized, cost-effective, accessible, and sustain data-integrity
- The enabler will be the chosen Information Technology system
- Scorecard to be balanced – work aggressively to link cause and effect
- Should enable comparability between LHIN's in order to recognize the differences between LHIN communities e.g. quality/access to housing, urban-rural characteristics
- Based on retrospective and prospective data collection methodologies
- Timeliness of information & analysis

Potential Outcomes – Uses of Balanced Scorecard

- Sharing best practice – clinical and administrative – continued local innovation – new definitions of "integration" as we evolve
- Create platform for inter-agency dialogue – to meet everchanging health needs of populations served, and characteristics of population (changing cultural diversity, demographic shifts) – a system-wide approach
- Create agile agencies i.e. ability to shift when requirements dictate – timeliness

<u>Public Reporting – Does the Public Care?</u>

- YES – but they need information & comparisons that make sense
  - Public reporting/scorecard cannot mislead public – many times taken out of context, becoming *sensational* news rather than information
  - Challenges definition of "meaningful" information
  - Public reporting should help focus essential issues and inform/educate

- YES – particularly for factors that affect them on an individual basis e.g. access to services

<u>Public Reporting – Does the Funder Care?</u>

- May be operating very effectively and efficiently, yet for factors outside the control of the LHIN, be seen as a poor performer

<u>Finally, What Will be the Incentive to be an Effective, Efficient LHIN?</u> **Why extend the effort to measure & evaluate performance?**

- Dependent upon the funding model between LHIN and MOH – for example, if we can't retain the savings, then why try to measure performance?

<u>List of Participants for Report #12</u>

NAME	ORGANIZATION
Helen Eby	RMOW – Sunnyside Home
John Enns	CCAC Board
Jim Whaley	Grey Bruce Huron Perth DHC
Daniela Catallo	Victorian Order of Nurses
Sue Moore	H.L.O. Health Services
Patrick Gaskin	Cancer Care Ontario
Zora Arcese	Waterloo Region Wellington-Dufferin District Health Council
Fred Kinsie	Independent Living Centre
James Meloche	Health Results Team, MOHLTC
Marion Bramwell	St. Mary's General Hospital
Konnie Peet	Guelph Community Health Centre
Randy Peltz	Regency Care

Priority Integration Opportunities
Open Space Report #13

Topic/Integration Opportunity: **Integration of Rehabilitation for People with Disabilities**

Check One: Patient Care Opportunity? ____ Admin Support Opportunity? ____

Topic Initiator:Bill Laidlaw CNIB

Number of Participants: 5

Briefly Describe the Opportunity:

Check One: Existing ____ New Opportunity 1____

There is no integration for people with physical disabilities into the health care system. This must be addressed.
Need for a service navigator in a navigable system.
There needs to be incentives in the system for providers and clients
General practioner needs to be the common thread that overlaps acute, rehab and community services for each client/patient.
Need for rehab providers to partner and better understand each others service
Need for leadership in this process.

Why is it a priority? It is a priority because there is a lack of integration for people with physical disabilities into the main stream of health care.

List of Participants for Report #13

NAME	ORGANIZATION
Bill Laidlaw	CNIB
Susan St. John	CNIB
Al Raftis	St. Joseph's, Guelph
Linda Kinny	CPAO

Priority Integration Opportunities
Open Space Report #14

Topic/Integration Opportunity: Admin and Support Opportunities (Other than IT)

Check One: Patient Care Opportunity? ____ Admin Support Opportunity? _X___

Topic Initiator: Karl Ellis

Number of Participants: 9

Briefly Describe the Opportunity:
Check One: Existing __X__ New Opportunity _X___

In integrating Admin and Support Services, there are probably a number of "untouchables"

- Financial reporting to governors
- Possible matters impacted by privacy legislation
- Bargaining group differences – avoiding all wage rates from migrating to the highest common denominator

Ability to provide support to the small non-profit and volunteer organizations (e.g. Alzheimers Society e.g. space, computers, payroll, financial support, general admin support currently absent or provided by volunteers. Allow use of very scarce resources for more patient care

Common systems and approaches and sharing of resources for:

- Payroll processing
- Accounts Payable
- Human resources expertise
- Collective bargaining
- Communications and public relations
- Purchasing and materials management

Shared service contracts with other organizations in close proximity eg. Backup generator maintenance,

Creative use of facilities with other publicly funded facilities eg. Using university or schools for classroom space in "off seasons"

Shared transportation services, both support, staff and patient transfer

Dietary systems, Meals on Wheels or Wheels to Meals

Shared Laundry services

Transcription services, pooled approach, transcriptionists working from home

Language services

Health records coding and abstracting

Clinical, Biomedical engineering services

Waste disposal services/systems

Capital bulk purchasing, lifts, beds, stretchers etc

Fundraising expertise, support to Foundations

Legal services

Human Resources

- Recruitment and retention
- HR Planning
- WHIMS training
- Occupational Health Services
- Workplace violence training
- Benefit plans – co-ordinated bids/purchasing power
- Employee Assistance Plans

Why is it a priority?

Financial savings in order to re-invest in care
Benefits to community
Must recognize/respect community uniqueness e.g. rural/urban, small urban/large urban e.g Hospitals are the centre of the health care system in most small, rural and northern communities i.e. care is already being provided in the community. Can effectively use existing staff in Hospitals and other health care settings to improve primary care, work with family health teams and still comply with government policy to provide more care in the communities.
Expectations of community – realistic, affordable and attainable

List of Participants for Report #14

NAME	ORGANIZATION
Karl Ellis	North Wellington Health Care
Anne Scragg	Groves Memorial (Chair of Board)
Stewart Boecker	Grand River Hospital
Lois White	Fairview Mennonite Home
Joanne Bertrand	Alzheimer Society of Guelph-Wellington
Irena Borg	Hospice of Waterloo Region
Harriet Lenard	W/W Children's MH Networks
Mark Beadle	Ontario Physiotherapy Association
Lou Reidel	Ontario Hospital Association

Priority Integration Opportunities
Open Space Report #15

Topic/Integration Opportunity: Mental Health Services/system
Check One: Patient Care Opportunity? __X__ Admin Support Opportunity? X____

Topic Initiator: Carolyn Skimson

Number of Participants: approx 15

Briefly Describe the Opportunity:
Check One: Existing _X___ New Opportunity ____

Long term care facilities care for:
- young people with mental health issues
- older adults with complex (identified) psychiatric problems need appropriate settings and services

Shift primary focus from institutions to community services
- align resources to increase community services
- integrate community services with institutional services in areas where sharing of resources/capacity can benefit the client.
  - Education of staff
  - Videoconferencing
  - Recreation
  - Social supports

  Create a seamless continuum of care/support facilitating ease of movement through the system and the community

Opportunity to integrate the community as a whole (education, church, community services, workplace, etc.) to reduce stigma against mental illness, promote inclusion.
- These are key enablers/drivers to achieve change in core values of the community.
- These changes require education, public relations

New system design should be:
- based on the needs of individuals, with a focus on the whole person (not just a diagnosis)
  - some individuals have complex, competing needs (physical challenges, mental health needs, forensic issues, addictions, etc)
- built on the extensive, existing work on policy/recommendations for recent regional planning in mental health (pull information out, review, build on the excellent work which is relevant.)
- Able to support a better flow, transition of children into the adult system. This involves funding and programs of different ministries

Create timely access to acute mental health services, when they are needed

- develop a system to access services/beds needed from LTC homes, from community /hospitals
- define services/beds available and needed, with agreements for access
- work with MOHLTC to ensure supply of required beds/services
- develop an integrated system with Criticall once beds/service access protocols is established among organizations
- transport patients in appropriate manner (EMS/police)
- have a separate triage system for mental health crises/ or execute a best-practice mental health triage system

Establish and meet “benchmarks” (agreed-upon standards) for spectrum of mental health services:

- assess services/gaps (draw upon existing work)
- cannot have “integration” without adequate services

Cross-ministerial integration is required, involving MOHLTC, MCYS, MCSS, MET

Knowledge transfer among all community sectors about mental health issues

- develop skills of police, physicians, community agencies, education, institutions, etc.
- develop navigational skills for accessing services, assessment of individual needs
- know where to get and how to share resources from the formal and informal sectors

Develop a collective voice for mental health issues with the LHIN

- integrate within the LHIN
- consider the merits of a single Mental Health Planning and Advisory Committee for Waterloo-Wellington (combining the two existing PAC’s)

LHIN’s need to integrate across the province for

- provincial policies/resources to benchmark levels of service
- develop a broad system of understanding, forming a provincial framework

Need congruence provincially re the mental health system and regulated systems in order for LTC homes and other organizations to meet expected standards within their area of practice.

Why is it a priority?

There is a crisis in trying to meet critical needs of people with mental health issues.

- Many organizations are working to do their best, but are not integrated or aware of all related services
- There are solutions among service providers, and synergy in working together more closely
- Presently we are not serving people in the best way and service providers re burning out.

List of Participants for Report #15

NAME	ORGANIZATION
Barbara Horvath	Children's Rehab Services Steering Committee
Trish Simmons	Ontario CritiCare Program
Shelley Nicol	Eden House Care Facility
Gord Beckenhauser	Volunteer
Tracey Demolder	Wellington-Dufferin Homes for Psychiatric Rehab
Keith Lymburner	Torchlight Services
Joe Fourer	Homewood
Vernon Lediett	Community Mental Health Clinic
Brenda Nadeau	St. Andrew's Terrace LTC Community
Lara Fiche	Caressant Care LTC
Karen Keleher	Homewood Health Centre
Wendy Czarny	Waterloo Regional Homes for Mental Health Inc.
John Jones	CMHA
Betty Boomer	Canadian Mental Health Association
Lorna Miller	Mental Health and Wellness Network

Priority Integration Opportunities
Open Space Report #16

Topic/Integration Opportunity: Integrating Community Health with Mental Health and Addiction Programs

Check One: Patient Care Opportunity? __x__ Admin Support Opportunity? ____

Topic Initiator: Toby Harris

Number of Participants: 13

Briefly Describe the Opportunity:

Check One: Existing ____ New Opportunity ____

Why is it a priority?

This is a priority because of a number of reasons:

Currently there are many silos that could benefit from integration. For example Mental Health and Addictions could benefit from collaboration and further integration, but these services do not flow out in to the Health Services Community. Adults with physical disabilities or brain injuries are often subject to mental health or addictions issues. Also there is a serious lack of funding, recognition and as a matter of fact alienation of mental health services within the overall system.

Current Strengths:

- A number of agencies have already amalgamated, so will make further integration of systems simple.
- Willingness to work together
- Commitment to client base and health care
- Existing structures can be built upon
- Existing stardard tools that can be drawn upon. We have the tools to assist with integration/ coordination/ assessment/ treatment
- District wide problem solving already exists through the DHC

Challenges:

- Current funding models do not support integration
- Lack of Physicians and Psychiatrists
- Silos in all areas – funding, communication, training, problem solving, etc
- Transportation
- Accessibility
- Rural nature of much of the LHIN area

Opportunities:

- Present work being done by ASG regarding proposal for a NP to serve clients
- Realignment of agencies with similar mandates consistent with the Transformation Agenda
- Be innovative with resources, such as training staff (HR)
- Integrate equity seeking groups
- Build on current sector groups, join for preliminary meetings for planning
- Client involvement in meaningful ways
- Develop peer support systems
- Utilize Provincial Assoc. and Planning bodies
- Reduce duplication of service delivery while simultaneously identifying service needs
- Bring together the services geared to both mental health and physical health need (ABI, Physical Disabilities) to integrate and alternate treatments (desegregate)
- Make decisions in more localized ways bottom vs. top down approach
- Identify the determents of health
- Streamline accountability/reporting process of LHIN (one report for all)

Questions/ Challenges for MOH

- How are LHIN's going to serve the diverse networks? (How will we?)
- How can we preserve what good work we have accomplished?
- Important to have a good balance in decision making between community and funders
- We need access to senior decision makers
- How does the Mental Health/Addictions sector ensure visibility in such a large structure
- Need to intersect across into other Ministries
- How do we ensure equitable funding?

List of Participants for Report #16

NAME	ORGANIZATION
John Enns	Waterloo Region CCAC Board
Kevin Bradshaw	Alzheimer Society of K-W
Lauren Henry	HLO Health Services Inc.
Shelly Andrews	MDS Labs
Marianne Walker	St. Joseph's Health Centre
Charlene Winger	North Halton Mental Health Clinic, Halton Health Dept.
Nancy Kinsie	Fairview Mennonite Home
Joe Fourer	Homewood
Pam Gardiner	Addiction Services – House of Friendship
Mary Wilhem	Homewood Community Alcohol and Drug Services
Trevor Lee	The Elliott Community
Stephen Wallis	Guelph General Hospital, OPSEU 231
Stewart Boecker	Grand River Hospital
Patrick Gaskin	Cancer Care Ontario
Coba Moolenburgh	St. Mary's Counseling Service
Toby Harris	Participation House
Tracey Demolder	Wellington-Dufferin Homes for Psych. Rehab

Priority Integration Opportunities
Open Space Report # 18

Topic/Integration Opportunity: Utilization of the Provincial Bed and Resource Registry

Check One: Patient Care Opportunity? ____Admin Support Opportunity? _X__

Topic Initiator: Trish Simmons

Number of Participants: 1 (one)

Briefly Describe the Opportunity: Improved utilization of the provincial Bed and Resource Registry

Check One: Existing __X__ New Opportunity ____

- secure online resource registry (www.criticall.com) available to all hospitals in Waterloo Wellington
- reflects (among other things) Medical, Surgical and Specialty bed availability, oncall physicians, ICU/CCU status, Perinatal status, ED status and 'Admit to No Bed' patients
- numerous report capabilities available to hospital staff and administration which can assist in short and long term planning, decision making and resource management
- various levels of hospital 'participation', i.e. inputting and updating of resource information specific to that hospital
- information input by hospitals currently used by the Ontario CritiCall Program's call centre (as well as other resources at its disposal) for physician-to-physician consultations concerning critically ill patients– generally transfers or consults from community to tertiary centres
- information can also be utilized by hospitals in the same region for the transfer or consult of non-critical patients (when the call centre is not needed) – for example, who's on call for what service at which facility for a nonurgent patient

- SEPARATE BUT LINKED ISSUE…
- CritiCall's call centre cannot currently assist with mental health referrals for hospitals – there are no referral protocols, transfer processes or identification of resources in place to provide CritiCall with the information it would need to facilitate mental health referrals (unlike Trauma, Perinatal or Cardiology specialties for example)

Why is it a priority?

The provincial Bed and Resource Registry is an established resource readily available to hospitals in Waterloo Wellington. The Registry when used effectively and efficiently by hospitals can help to bridge the knowledge gap of resource availability between acute care facilities (including availability of beds, specialties and physician specialists) as well as provide valuable planning, decision making and resource management information. Accurate and timely information in the Registry could help physicians to better manage patients within their own LHIN.

List of Participants for Report #18

NAME	ORGANIZATION
Trish Simmons	Ontario CritiCare Program

Priority Integration Opportunities
Open Space Report #19

Topic/Integration Opportunity: **Integration of Health Care Providers in the Treatment of Musculoskeletal Problems**

Check One: Patient Care Opportunity? _X___ Admin Support Opportunity? ____

Topic Initiator: Dr. Gregory Bidinosti

Number of Participants: 4

Briefly Describe the Opportunity:

Check One: Existing _X__ New Opportunity ____

Integration of health care providers in the treatment of musculoskeletal problems.

Why is it a priority?

Musculoskeletal disorders are the 2nd leading cost of illness in Canada, with the biggest portion of these costs going to back pain.

Government and health care providers / payors must acknowledge that different professions / professionals have different strengths in the treatment of musculoskeletal disorders. I.e. chiropractors, physiotherapists, physicians etc.

There must be a willingness of care providers to defer treatment to the professionals which have demonstrated through evidence-based research effectiveness and cost-effectiveness of care. This lack of understanding and cooperation is a major barrier to integrated health care, as is the lack of appropriate funding.

One major barrier which has been identified in numerous discussions today is the extreme reluctance and/or ignorance of medical physicians to acknowledge and/or refer patients to the various treatment options based on the available evidence.

The LHIN's, in cooperation from the provincial professional health associations, must disseminate appropriate literature to their counterparts as a means of rectifying the apparent lack of understanding about the strengths of each profession.

The LHIN's must then provide the appropriate (full) funding to the professions / professionals for the treatment of musculoskeletal disorders based on the evidence. There is far too much emphasis on the utilization of extremely costly medical services; typically care rendered after musculoskeletal disorders have advanced beyond a preventable and easily manageable stage.

The costs of preventative care must be thoroughly evaluated in relation to the costs of treating preventable disorders.

The public should be made very clearly aware of the costs associated with treatment. I.e. disclosure of medical and hospital fees as a means of educating people what burden their condition place on the health care budget – to be used as an educational tool for promoting better health, lifestyles and use of preventative services.

Solutions:

Acknowledgement of all evidence-based research and data regarding musculoskeletal disorders

i.e. WSIB Program of Care for Acute Low Back Injuries – 2004 data regarding treatment costs and return to work statistics.

i.e. The Manga Reports regarding the effectiveness and cost-effectiveness of chiropractic care.

i.e. Archives of Internal Medicine (Oct. 2004) – *Comparative analysis of individuals with and without chiropractic coverage*.

Conclusion: Systematic access to managed chiropractic care not only may prove to be clinically beneficial, but also may reduce overall health care costs.

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

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

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

List of Participants for Report #19

NAME	ORGANIZATION
Greg Bidinosti	Waterloo Regional Chiropractic Society
Kendra Brough	WRCS
Paul Nolet	Wellington Chiropractic Society
Stephen Wallis	Guelph General Hospital, OPSEU 231

Priority Integration Opportunities
Open Space Report #20

Topic/Integration Opportunity: **Integration of Hard to Serve the Younger Adult into LTC**
Check One: Patient Care Opportunity? x____ Admin Support Opportunity? ____

Topic Initiator: Brenda Nadeau

Number of Participants: 4

Briefly Describe the Opportunity:
Check One: Existing x____ New Opportunity _x___

Integrating younger adults into Long Term Care Communities. Clients with like needs are currently being supported separately in the community and in long term care homes. The opportunity exists to co-ordinate services to better meet their needs no matter where they live. Mechanisms need to be developed and put in place to share resources to include dollars, specialized care and services, training of support staff, and physical surroundings. Co-funding of programs would better meet the needs of these clients both in the community, group homes and long term care homes.

Why is it a priority?
The current funding for Long Term Care clients does not support the social, and diverse emotional needs of these younger clients. The staffing ratios required and specialized treatment needs are different than those of the traditional long term care client.

List of Participants for Report #20

NAME	ORGANIZATION
Dave Silverstone	Forest Heights
Brenda Nadeau	St. Andrew's Terrace LTC Community
Judy Peck	Forest Heights
Lois White	Fairview Mennonite Home
Nancy Kinsie	Fairview Mennonite Home

Priority Integration Opportunities
Open Space Report #21

Topic/Integration Opportunity: Role of Community Support Agencies in Health Services

Check One: Client Care Opportunity? _x___ Admin Support Opportunity? ____

Topic Initiator: Irene O'Toole

Number of Participants: 6

Briefly Describe the Opportunity:

Check One: Existing _x___ New Opportunity _x___

Community support services are an integral component of the health care system and need to be recognized in the development of LHINs because:

- More direct linkage and integration within the LHIN services
- Fiscally efficient
- Community ownership and community supported
- Participation builds individual and community capacity
- Family engagement a key in retaining healthy families, healthy communities
- Maintaining family/community engagement is extremely cost efficient more so than re-integration
- Volunteers provide a pivotal bridge in community services

Why is it a priority?

- It is a prevention service – reduces cost of care, prevents acute situations and chronic situations
- Greater availability of service
- Direct intervention (service and support)
- Client focused and client driven service – client retains some autonomy
- Need to have service diversity accessible in the community
- Speaks to the philosophy of health being more than a medical model – needs to be client driven
- Community support is low cost, high availability vs. medical services are high cost, low availability

<u>List of Participants for Report #21</u>

NAME	ORGANIZATION
Joanne Klausnitzer	Meals on Wheels K-W
Heather Kerr	Stonehenge Therapeutic Community
Sheila Braider	Kitchener Downtown Community Health Centre
Deb Gilpin	City of Cambridge Day Program, Friendly Visiting
Liana Nolan	Region of Waterloo Public Health
Irene O'Toole	Waterloo Home Support

Topic/Integration Opportunity: **Recruitment and Retention of Health Human Resources**

Check One: Patient Care Opportunity? _X___ Admin Support Opportunity? _X_

Topic Initiatiator: Suzy Young, Registered Nurses Association of Ontario

Number of Participants: 13

Briefly Describe the Opportunity:

Check One: Existing _X___ New Opportunity _X___(opportunity for improvement)

Why is it a priority?

- reality is we need health human resources for patient care and meet the needs of the community -
- human resources must be qualified
- need a consistent criteria for provider qualifications
- human resource disparities in all sectors – acute vs. community vs. chronic care and urban vs. rural vs. and primary care vs. acute care
- wage disparities exist in all sectors between like care providers
- some communities go without care/services due to lack of provider who may be a specialist and community cannot recruit that provider due to resource allocation
- lack of timeliness in care provided because of human resource deficiencies
- current staffing processes/staff assignments not always condusive to good patient care – based on visits (similar to piece working)
- experiences for health care professionals should reflect expertise – a lot of professionals are working outside their scope as they are the only ones available for the patient/client
- huge competition for salary and benefits for the same health professionals – the sector with the most money "wins" – those that have the resources for advanced recruitment benefit more than others

Suggestions:

- take inventory of existing disparities and what is working for companies who are successfully recruiting and retaining
- competition drives wages and benefits – examine current practices within sectors
- clients at risk due to inappropriate/inexperienced/unavailable care providers – train and provide experts within the LHIN that could be shared amoung sectors
- support education and training of health care providers that is evidence based, accessible and timely
- maintain workplace environments that support recruitment and retention initiatives

- all health care providers work together for the population of the LHIN where appropriate – sharing of resources that benefits the caregiver and the client including specialists like wound care or other specialties to create full time employment – integration of practitioners to avoid imbalances
- make system attractive to recruit providers – offer realizable incentives including flexible scheduling and other initiatives
- share call centres in community care or link with acute call centres in the community to better utilize resources
- recruitment of students to the health care sector
- link with colleges/universities to ensure appropriate, varied clinical experiences – be creative with clinical placements
- maintain # health care professionals trained and available = # needed
- ensure educators in the different health care sectors have equal level of skill
- consider paid internships in underserviced areas
- control poaching which sets employees up to be transient
- continue to work with small communities to ensure access is equal and appropriate

Possible actions/recommendations:
1. Central bureau for recruitment – pros – dollars saved for individual recruitment initiatives; cons – union issues possible
2. All sectors work together to share specialist resources such as wound care, intravenous access, testing, and education - pros – continuity of providers, services and education provided to clients; cons – potentially difficult to manage and roll out
3. Initiate workplace environments that support the retention of health care professionals that prevents poaching - pros – dedicated, consistent providers; cons – element of movement of workers inevitable
4. Maintain education within the LHIN that ensures adequate numbers of health human resources who are appropriately prepared – pros – benefits the population to have care providers that are adequately educated and enough supply to meet the demand; cons -

List of Participants for Report #22

NAME	ORGANIZATION
Suzy Young	Registered Nurses Association of Ontario
Cathy Joy	PSMP
Ruth Edwards	Paramed Home Health Care
Pauline Diemert	Paramed Home Health Care
Jacqui Dow	Red Cross
Susan Burns	DHC
Anne Scragg	Groves Memorial – Board Member
Deb Dalton	Care Partners
Dianne O'Rourke	Central Care Corp.
Carol Nafziger	Comcare Health Services
Bill Laidlaw	CNIB
Sue Moore	HLO Health Services
Wilma Quiñones-Nitsch	Community Rehab

Priority Integration Opportunities
Open Space Report #23

Topic/Integration Opportunity:
Check One: Patient Care Opportunity? _X___ Admin Support Opportunity? ___

Topic Initiator: NANCY LAMERT & NANCY DUNBAR

Number of Participants: 9

Briefly Describe the Opportunity:
Check One: Existing __X__ New Opportunity ____

The Public should not be considered as "looking In" but must be recognized as "being In". It is their Health Care System. The people of Ontario have said that they want the system fixed.

There are existing community advisor councils and community networks that have the knowledge and expertise required by the LHIN. The individuals that are on these committees have previously identified opportunities for integration and innovation, but have not been given the authority or opportunity.

It must be mandated that client/community representatives are on these committees . Examples of such networks are: CCAC community council; CCAC long term care network committee; and a difficult to serve committee.

Why is it a priority?

There must be a formalized process of inputting knowledge to the LHIN. Converting or utilizing the present networks is a savings in resources. In other words we are not re-inventing the wheel. This would also be leverage to the relationships in place and refresh mandates.

List of Participants for Report #23

NAME	ORGANIZATION
Nancy Dunbar	Leisureworld
Anne-Marie Rutka	Forest Heights LTCC
Margot Hummer	Saint Luke's Place LTC
Nancy Kauffman-Lambert	Golden Years Nursing and Assisted Living Centre
Diane Gambacort	Riverbend Place
Fiona Cressman	Riverbend Place
Sheila Braidek	Kitchener Community Health Services
Kevin Mercer	CCAC
Barbara Horvath	Children's Rehab. Implementation Steering CHC

Priority Integration Opportunities
Open Space Report #24

Topic/Integration Opportunity: Funding for Long Term Care Services

Check One: Patient Care Opportunity? __X_ Admin Support Opportunity? _X___

Topic Initiator: Blair Philippi

Number of Participants: 6

Briefly Describe the Opportunity:

Check One: Existing ____ New Opportunity _X___

LIHNS should organize a more consistent, efficient placement system that reflects the needs of individuals. This could ease the wait times and unnecessary usage of hospital beds.

Additionally there is a need to equalize and create a consistent funding mechanism that reflects current resident needs in long term care facilities; through the adoption of the MDS system. Quarterly reporting which is tied to funding and accountability for budgets can be addressed. Utilization of the MDS could also benefit LHINs across the province by tracking care levels in each facility. There is an additional opportunity to create a classification system that is wellness based, to reward facilities for rehabilitating resident's health and wellbeing.

There is an opportunity for Long Term Care Homes to specialize their care and human resources to specific populations and disciplines. Such examples include mental health, short term stroke and Hip fracture rehabilitation, palliative and hospice care. Better interdisciplinary utilization of specialty services in LHINs can lead to more coordinated and efficient uses of financial and human resources.

Why is it a priority?

Long wait times and unnecessary hospital stays are the result of an inefficient long term care placement system. There are gaps in acute, mental-health and rehabilitation services in the community, which result in residents not receiving them in the long term care system.

A new classification system can lead to a more equitable and fair system for all residents in long term care homes across all LHINs.

List of Participants for Report #24

NAME	ORGANIZATION
Blair Philippi	Caressant Care Arthur
Heather Robinson	Caressant Care Cambridge
Al Raftis	St. Joseph's Guelph
Lara Riehl	Caressant Care Arthur
Laura Melo	Westmount, Kitchener
Jeanette Kuntz	Caressant Care Harriston
Shelley Nicol	Eden House, Guelph

Priority Integration Opportunities
Open Space Report #25

Topic/Integration Opportunity: **Role of Volunteers in the Health Care System**

Check One: Patient Care Opportunity? _x___ Admin Support Opportunity? _x___ adding Governance Opportunity __x____

Topic Initiator: Deb Gemmell, Paula Bergeron, Janice Paul

Number of Participants: 12

Briefly Describe the Opportunity:

Check One: Existing ____ New Opportunity _x___

The opportunity for the provincial government to listen and better understand the unrealistic expectation of the voluntary sector - are there sufficient volunteers to carry through on the LHINs model?
Need the realization that volunteer management does cost money.
Currently the shortfall in ministry funding in the sector is being picked up by volunteers.
The process of rolling out the LHINs does not value volunteer participation.
The Selection committee process needs to be transparent and there needs to be sharing of the criteria for appointment accountability, skill set, expertise, etc.
Informal/volunteer sector are not valued in the consultation or development process and caregivers are invisible in the process. (caregivers are all volunteers)
There is an opportunity to benefit from several reports already produced on volunteerism either produced locally through the DHC, or nationally.
Service provision in the system is dependent on volunteers and there needs to be recognition of the values and contributions of volunteers.

Why is it a priority?

Health care dollars that go to the voluntary sector are the most cost effective and efficient dollars in the whole health system

It is a priority if the whole LHIN process is going to work

Volunteers make up the entire "net" of the system and hold the whole system in place; the medical model is a small portion of the entire system of Health care

There needs to be clearly defined accountability and responsibility and expectations of the LHIN board so that they can develop the vision based on the community needs, wishes and desires. This is critical for buy in from the LHIN board and the community stakeholders.

List of Participants for Report #25

NAME	ORGANIZATION
Janice Paul	K-W Friendship Group for Seniors
Paula Bergeron	Cambridge Home Support
Deb Gemmell	RAISE Home Support
Marg Hedley	Guelph Community Health Centre
Susan Martin	WRWD DHC
Joanne Bertrand	Alzheimer Society of Guelph-Wellington
Bob Soehner	Community Care Concepts, Elmira
Marshall Draper	Community Mental Health Clinic, Guelph
Gord Beckenhauser	WRWD ASG
Donna Launslager	Multiple Births Canada
Brent Charette	Hospice Wellington
Irena Razanas-Borg	Hospice of Waterloo Region

Priority Integration Opportunities
Open Space Report #26

Topic/Integration Opportunity:Patient Populations: Service Delivery in LHINs: Better worse?

Check One: Patient Care Opportunity? __x__ Admin Support Opportunity? ____

Topic Initiator:Laurie Hurley, The Arthritis Society

Number of Participants: 8

Briefly Describe the Opportunity:

Check One: Existing __x__ New Opportunity x___

Why is it a priority?

Currently local, provincial and national organizations support special patient populations. Regional health authorities treat rural/urban populations, victims of violence, conditions with small volumes, often using committees, associations, or advocate societies. Needs can be met through letter writing campaigns or special community efforts to fund special services or one time needs.

Needs can be

- Short term/long term
- Inpatient or Outpatient, community, long term care: cross continuum of care
- Often overlap or led by Social Service organizations
- Often high risk populations that require early interventions
- Can have representation or are driven by consumers
- Staff often alone with patient, responsible for wide ranging referral, linkage to other community agencies

These patient populations want a voice in developing the LHINS and put forward to the LHIN executive that consumers should drive this process. Consumers in this context could be an Association for a particular condition, a patient, member of the public or client. ASK US WHAT WE WANT. WE'LL TELL YOU WHAT WE NEED, WE HAVE DATA.

Concerns:
A common model implemented across LHINS may impact special patient populations negatively.
Funding envelope could be driven by consumer as per Britain model for community services; basket that they determine
Funding and services need to be flexible re structure and expectations. Need to be accountable and patie/consumer needs to be accountable.

Suggested purchase/Provider model principles

- Accountability
- Responsiveness
- Driven by consumer
  - Consumers need to be mobile, vote with their feet. They want reasonable, affordable and available options for care.
  - Consumers want one stop shopping to find care
- Info given immediately on identification of problem for consumer to make informed choices.
- Realize we need to do this within same overall funding
- Need to build in outreach, effective access for rural populations
  - Move hospital to community care whenever possible.
  - Link services in outreach clinics/busses
- Priorities based on consumer needs analysis

Indicators of need

- Wait lists a crude indicator of need; are you measuring a need or a bottleneck?
  - For midwifes, palliative care, there can be no wait. There is refusal. There is data. Special populations associations/groups can give it to you.
- Some waits artificially generated from short term solutions to meet budget deficits, bed closures, eqpt breakage, internal shrinkage. Inefficiencies. Increasing accountability can save money.
- Define accountability across community organizations and link to funding

Opportunities

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

Common themes that repeated are the opportunity to

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

explored and episode is not closed until they are satisfied or goals are reached.
  - Reform current community system where patient is own care coordinator when needing complex services in the community. If CCAC is to assume this role, they must significantly broaden their eligibility requirements.

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

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

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

List of Participants for Report #26

NAME	ORGANIZATION
Laurie Hurley	The Arthritis Society
Helen Eby	RMOW – Sunnyside Home
Troy Herrick	Wellington-Dufferin-Guelph Health Unit
Casey Cruikshank	Waterloo Region Sexual Assault/Domestic Violence Treatment Centre
Dianne Smith	Cambridge Midwives
Susanne Gillespie	The Canadian Hearing Society
Dianne Roy	Hilltop Manor Nursing Home (LTC)
Kristine McGregor	Professional Respiratory

Priority Integration Opportunities
Open Space Report #27

Topic/Integration Opportunity: **Cross-Sector Training**

Check One: Patient Care Opportunity? _x___ Admin Support Opportunity? ____

Topic Initiator: Jeff Wilbee

Number of Participants: 6

Briefly Describe the Opportunity:
Check One: Existing ____ New Opportunity __x__

The opportunity will ensure that members of the health community are aware of and utilize, as required, all health resources within the LHIN.

Considerations:
1. Each provider has a different strengths, skills, perspectives
2. Identification and sharing of expertise/skills/competencies
3. Opportunities for team problem-solving at the community level
4. Identification and sharing of best practices

How to Achieve
1. LHIN website that acts as a portal – agency info., training, models, news, best practices, needs
2. LHIN becomes a clearing-house of training information
3. Agency commitments to collaboration in providing staff training,

Why is it a priority?

1. Creates a seamless system, to increase quality of service
2. Added value without added dollars
3. Recognizes complexity of individual needs
4. Coordinated efforts are more likely to result in success
5. Encourages prevention and early intervention
6. Players in the system have expertise to share

List of Participants for Report #27

NAME	ORGANIZATION
Jeff Wilbee	Addictions Ontario
Anne Walker	Guelph Services for Persons with Disabilities
Katherine Soule Blaser	Independent Living Centre for Waterloo Region
Margaret Wagner	Citizens for Independence in Living and Breathing
Heather MacDonald	Woolwich Community Health Centre
Helga Allan	Support and Housing, Halton

Priority Integration Opportunities
Open Space Report #28

Topic/Integration Opportunity: Fair Funding for Waterloo/Wellington

Check One: Patient Care Opportunity? __x__ Admin Support Opportunity? ____

Topic Initiator: Dennis Egan, Grand River Hospital

Number of Participants: 10

Briefly Describe the Opportunity:

Check One: Existing ____ New Opportunity _x___

Fair share of provincial health care resources for waterloo/Wellington residents.

- transparency and consultation in the development of a new funding formula (equitable basis for distribution of funds)
- population needs based (e.g., based on age, sex, socioeconomic status, etc)
- supports a fair allocation of human resources --- e.g., psychiatrists, techs, etc
- allow to address gaps in services
- allow reinvestment of savings from integration into LHIN priorities (to the extent that not over funded)
- query how funding formula will deal with vulnerable populations and may have to address on a province wide basis
- require drilling down on the population characteristics and health needs
- encourage investment in prevent ion strategies to avoid downstream needs (needs to be supported and encouraged)

Why is it a priority?

- all people deserve access to quality care and information deemed worth providing by the provincial government
- without additional resources, there will be a tendency toward continuation of a silo mentality
- current inequities exist across the province and in waterloo/Wellington (according to current funding formulas)
- public expectations
- provides an incentive to do things effectively and efficiently
- expectation that “delisted services” impact on government funded providers
- ability to attract and retain clinicians requires fair starting point
- because we are Canadians who value fairness and equity (as opposed to US where a well insured community will have vastly superior services to one supported by medicare and medicaid)
- need resources to do preventive work (kick start it)
- we are competing in a global marketplace and businesses expect support from local health care providers
- growth in our region has not been adequately addressed in past funding (also patient demographics)
- without fairness there will continue to be ”have and have nots” which will be perpetuated if not addressed early on

List of Participants for Report #28

NAME	ORGANIZATION
Monica Wright	Hilltop Manor Nursing Home
Doug Letson	St. Mary's Hospital
Sandra Hammer	COTA Health
Marion Bramwell	SMGH
Cathy Donahue	Caressant Care, Fergus
Mark Beadle	Ontario Physiotherapy Assocation
Bill Davidson	Lungs Farm Village Association (Community Health Centre)
Karen Gal	Saint Elizabeth Healthcare
Lara Riehl	Caressant Care LTC Facility

Priority Integration Opportunities
Open Space Report #29

Topic/Integration Opportunity: **Regional Care Maps**

Check One: Patient Care Opportunity? _X___ Admin Opportunity? _X___

Topic Initiator: Pierre Noel

Number of Participants: 9

Briefly Describe the Opportunity:
Check One: Existing __X__ New Opportunity ____

Care maps that would seamlessly move patients/clients between care environments (within and across sectors)

- Hospital to hospital
- Hospital to LTC or homecare
- Physician specialist to family practitioner
- Tertiary centre to LHIN/local community

Why is it a priority?

- To make "handoffs" more seamless
- Model = stroke strategy care map
- Model = St. Elizabeth wound care in London
- Ability to create a central repository of best of breed care maps (minimize duplication and re-work)
- Enhance patient care / client satisfaction / provider satisfaction
- Increase throughput in hospitals and service delivery agencies
- Builds accountability
- Enhances accessibility
- Clarifies communication
- Known integration tool
- Patient centred
- Evidence to support it
- Promotes best practice
- Breaks down silos
- Effective deployment of resources
- Promotes transformational change
- Allows for the measurement of outcomes
- Could mobilize the grassroots to initiate creative models through LHIN funding support and flexibility
- Guidelines to enhance good clinical judgment not replace it
- LHIN would enable care map planning and allow shifting of funding to the most appropriate service provider

- LHIN to identify top priority region-wide care maps (criteria = high volume / high costs / gaps in service / hard to serve / probability of success and early wins / leverage other transformation priorities such as hips and knees)

ENABLERS:

- Innovative funding approach
- Front line service providers need to be involved / driving the process
- Cross organization credentialing
- Access to primary care in the first instance
- Need to maintain patient focus within care maps
- Assurance that we are not moving toward a US style of managed care
- Need to be focused on outcomes
- Need to build appropriate community capacity
- Need to build capacity in all parts of the system
- Need to engage participants (e.g. surgeons)
- Not just integration of the existing parts but looking at new and creative solutions
- Need to recognize and reward good patient hand offs

List of Participants for Report #29

NAME	ORGANIZATION
Pierre Noel	North Wellington Health Care Corporation
Richard Ernst	Guelph General Hospital
Tina Moland	Community Rehab
Sue Robertson	Grand River Regional Cancer Centre
Neil Barran	Saint Elizabeth Health Care
Linda Kenny	Canadian Paraplegic Assoc of Ontario
Jim Whaley	Grey Bruce Huron Perth DHC
Carolyn Shemsor	Groves Memorial Community Hospital

Priority Integration Opportunities
Open Space Report #30

Topic/Integration Opportunity: Rural Intersectoral Integration (Group J) AND Planning for Intersectoral Collaboration for Health promotion, disease prevention, service delivery (Group G)

(combined groups G and J)

Check One: Patient Care Opportunity? _X___ Admin Support Opportunity? ____

Topic Initiator: Konnie Peet and Denise Squire (rural)

Number of Participants: 14+

Briefly Describe the Opportunity:
Check One: Existing __X __ and New Opportunity _X___

Why is it a priority?

Opportunities for Rural and Urban
- LHIN could bring together sectors beyond health – education, housing, income, public health – broad determinants of health focus
- LHIN could place greater priority on health promotion
- Cross-LHIN sharing of health promotion resources, materials, focus
- LHIN can promote community-based/focused health promotion
- New funding formula could be opportunity to support health promotion, to look for/support partnerships in home, businesses, community and build on existing
- LHIN focus on "patient community" could support focus on unique patient groups
- LHIN could provide way to meaningfully included non0health and non-funded (voluntary) organizations, resources, groups, etc.
- Potential to combine small funded program to make better use of small dollars, more funds to service, combined admin.
- Potential to coordinator, enhance transportation across sections [transportation is key to many services/access]
- LHIN have role to help population to know about/access resources, health promotion
- LHIN could create opportunities for planning for space/location, admin. Support, infrastructure, for smaller health promotion-focused organizations to co-location, focus on service, not on looking for place to work
- LHIN itself presents opportunity for community-based collaboration, ensure resources for collaboration to happen
- Opportunity to promote "one stop" access to community-based resources, intersectorally
- LHINS can share "wisdom" about existing models of intersectoral collaboration, sharing within LHIN and among LHINS

- Potential to resource many different locations to deliver programs (smaller organizations not have to use resources to deliver services at many different sites)

Risks/Challenges for Rural and Urban

- losing what has worked so far in cross-sector work; different Ministries are not doing this
- challenge of a new funding formula that will support/fund health promotion/illness prevention
- risk that funding formula is so restrictive that prevents responsiveness at individual LHIN level
- LHIN's focus on "incenting change" could be challenge/risk
- Reliance on volunteers, in agencies and on LHIN Board, can be a risk; need to have paid positions to make sure that critical work gets done, need to support volunteers (training, volunteer management, etc.) - if not good support, could lose volunteers, not get needed work done

Rural-Specific Opportunities

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

Rural-Specific Risks/Challenges

- risk losing access to rural health planning support for small, rural agencies
- rural communities could "fall off the radar" if urban population "drives" LHIN decision-making

List of Participants for Report #30

NAME	ORGANIZATION
Vernon Lediett	Community Mental Health Clinic, Guelph-Well-Duff
Sherry Peister	Ontario Pharmacists Association
Veronica MacDonald	Community Care Concepts of Woolwich, Wellesley and Wilmot
Glynis Williams	CCAC of Wellington-Dufferin
Barbara Cawley	COTA
Lynn Beath	WDGHU (Wellington-Dufferin Guelph Health Unit)
Colleen Cudney	Wellington Terrace Long Term Care Facility
Daniela Catallo	Victorian Order of Nurses
Susan St.John	CNIB
Cheryl Batty	DHC
Zora Arcese	Waterloo Region, Well-Duff-District Health Council
Lorna Miller	Mental Health and Wellness Network
Konnie Peet	Guelph Community Health Centre
Lynne Tintse	The Arthritis Society
Helga Allan	Support and Housing - Halton
Denise Squire	Woolwich Community Health Centre

Priority Integration Opportunities

Open Space Report #31

Topic/Integration Opportunity: Integrated Primary Care

Check One: Patient Care Opportunity? __x__ Admin Support Opportunity?__??__

Topic Initiator: Joe McReynolds

Number of Participants: 7

Briefly Describe the Opportunity:

Check One: Existing _X__ New Opportunity ____

Build on what we know in the community to bring together the right service by right people at the right time

Reach individuals who require minimum intervention before they require more costly services. Minimum intervention to include:
- access to family doctor
- coordination of service and support
- crisis response resource
- link existing community mental health and support services to professional services in a client focus manner; no referrals, just have staff that respond to client needs
- major issue is funding; current community resources are without the flexibility to change resources to respond to a need as their agency needs demand all available resources.
- need to prove early intervention results in savings in health care.
- funding formulas must support integrated broad-based primary care models that respond to variety of needs of clients including marginalized individuals.
- the distinction between family health teams for general population and community health for marginalized must be challenged. Costs may not be factor if integration of existing services occur in family health teams.

Let us build on existing best practices.
Answer is to ensure community services receive priority funding.

Why is it a priority?

Without an integrated broad-based primary care system, integration of health care system will not be achieved.

List of Participants for Report #31

NAME	ORGANIZATION
Bill Hdair	
David Kelly	
Monica Wright	
Laura Visser	MOHLTC
Joe McReynolds	
Plus 2	

Priority Integration Opportunities

Open Space Report #32

Topic/Integration Opportunity: Networks

Check One: Patient Care Opportunity? __x__ Admin Support Opportunity? __x__

Topic Initiator: Ross Kirkconnell

Number of Participants: 17

Briefly Describe the Opportunity:

Check One: Existing __x__ New Opportunity ___x_

Why is it a priority?

There are many effective networks already in place and it will be important for the LHIN to capitalize on the expertise that the current networks bring to the local area.

We identified an inventory of at least several dozen existing networks, both localized and LHIN region wide. We expect there are many more that were not discussed.

LHIN Action Plan:

LHIN's should conduct an environmental scan to understand the scope and roles of the existing networks in the region.
In the context of the LHIN strategic plan and government priorities the LHIN's should evaluate the networks. Among the questions to be asked include:

- How do the networks enhance care?
- How do the networks liaise with other networks/broader community?
- Why do the networks exist?
- Do they provide a cost benefit to the system?
- What would happen if they disappeared?
- Which networks should LHIN region wide verses local?
- How might networks be organized (diagnostic grouping, demographics, etc)

It is recommended that LHIN health care providers be responsible for identifying networks required in the LHIN.

List of Participants for Report #32

- unavailable -

Priority Integration Opportunities
Open Space Report #33

Topic/Integration Opportunity: Ensuring care in the community for people with ongoing chronic needs/conditions

Check One: Patient Care Opportunity? _x___ Admin Support Opportunity? ____

Topic Initiator: Susan Thorning

Number of Participants: 6

Briefly Describe the Opportunity:
Check One: Existing ____ New Opportunity __x__

Provide information systems and resources to collect data that looks at the impact of care in the community for people with ongoing, chronic needs/conditions.

Collect data from across funding silos:

- Community support services (home help/homemaking, adult day programs, etc. etc.
- Canadian Hearing Society
- March of Dimes
- Independent Living Centres
- CNIB
- CMHA
- Community Based Mental health and Addictions
- CCAC
- AIB
- Alzheimer Society

Look at data and results from other jurisdictions.

Use this information to allocate funds.

The resources for care in the community currently support post acute, post hospital care or end-of-life care. The intent is to shorten the length of stay and reduce hospital costs.

More resources should go into the pre-acute, pre-hospital care to divert people from hospital and institutions.

The people with ongoing chronic needs/conditions:

- Frail elderly (age related conditions, stroke, dementia, mental health issues etc)
- Children with chronic illnesses

- Physically disabled adults
- ABI
- Multiple chronic conditions
- Mental health
- Addictions
- Etc.

The services that are available to these people are inconsistent (quality, level of service, accessibility) and are decreasing due to increased need (demographics).

Why is it a priority?

We do not have the information needed to make decisions at the moment.

Care for chronic, ongoing conditions is important:
- Prevents premature institutionalization
- Diverts needs from acute care services
- Supports caregivers (respite, & case coordination)

- LIVING AT HOME IS A VALUE TO OUR SOCIETY
  - MAINTAINS QUALITY OF LIFE & CONTROL OF LIFE
  - PROMOTES INDEPENDENCE, SELF WORTH
  - COMMUNITY BENEFITS FROM CIVIC PARTICIPATION, VOLUNTEERISM
  - IT IS THE RIGHT THING TO DO

List of Participants for Report #33

NAME	ORGANIZATION
Gene Borman	C of W – Day Program
Joan Kaden	WR Dementia Network
Fred Kinsie	Independent Living Centre
Sue McCarter	Canadian Hearing Society
Charlene Winger	North Halton Mental Health Clinics (Halt Health Dept)
Susan Thorning	OCSA

Waterloo Wellington LHIN
Community Workshop

November 19, 2004, Waterloo Ontario

Complete Voting Results

#	TOPIC	Initiator	Patient Care Votes	Admin. Votes
1	LHIN-Wid Health Human Resources Plan	Susan Burns	20	26
2	Communicable Disease/Infection Control	Liana Nolan	10	17
3	Accessible Integrated Electronic Health Records	Sherry Peister	23	55
4	Community Care Services Remodeling	Gayle Sadler	9	12
5	Accessing Services	Susanne Gillespie	11	36
6	Integration of Access, Assessment, Case Management, Case Service Management & Discharge Planning	Kevin Mercer	51	5
7	Developing Models of Service that empower individuals to take responsibility for their health and related services	Katherine Soule Blaser	35	9
8	Seniors Health – Education of Services	Marianne Walker	8	20
9	Patient Care/Service – incorrect terminology	Janice Paul	20	5
10	Shift thinking from Continuum of Care to System	Paula Bergeron	23	3
11	Hard to Serve Clients – Complex Care Needs	Cathy Donahue	15	0

12	Public Reporting and Scorecard Measurement	Randy Peltz	**11**	**77**
13	Integration of Rehabilitation for People with Disabilities	Bill Laidlaw	**5**	**7**
14	Admin and Support Opportunities (Other than IT)	Karl Ellis	**4**	**50**
15	Mental Health Services/system	Carolyn Skimson	**35**	**13**
16	Integrating Community Health with Mental Health and Addiction Programs	Toby Harris	**44**	**23**
18	Utilization of the Provincial Bed and Resource Registry	Trish Simmons	**1**	**15**
19	Integration of Health Care Providers in the Treatment of Musculoskeletal Problems	Dr. Gregory Bidinosti	**8**	**0**
20	Integration of Hard to Serve the Younger Adult into LTC	Brenda Nadeau	**11**	**2**
21	Role of Community Support Agencies in Health Services	Irene O'Toole	**39**	**9**
22	Recruitment and Retention of Health Human Resources	Suzy Young	**12**	**24**
23	Conversion of Existing Networking Groups into Action Groups	Nancy Lambert / Nancy Dunbar	**16**	**7**
24	Funding for Long Term Care Services	Blair Philippi	**7**	**13**
25	Role of Volunteers in the Health Care System	Deb Gemmell, Paula Bergeron, Janice Paul	**10**	**21**
26	Patient Populations: Service Delivery in LHINs: Better worse?	Laurie Hurley	**18**	**0**
27	Cross-Sector Training	Jeff Wilbee	**19**	**10**

28	Fair Funding for Waterloo/Wellington	Dennis Egan	**34**	**14**
29	Regional Care Maps	Pierre Noel	**41**	**39**
30	Rural Intersectoral Integration AND Planning for Intersectoral Collaboration for Health promotion, disease prevention, service delivery	Konnie Peet and Denise Squire	**27**	**7**
31	Multidisciplinary Primary Care	Joe McReynolds	**13**	**8**
32	Networks	Ross Kirkconnell	**9**	**38**
33	Ensuring care in the community for people with ongoing chronic needs/conditions	Susan Thorning	**25**	**12**

Top 5 Patient Care Results

#	TOPIC	Initiator	Patient Care Votes
6	Integration of Access, Assessment, Case Management, Case Service Management & Discharge Planning	Kevin Mercer	51
16	Integrating Community Health with Mental Health and Addiction Programs	Toby Harris	44
29	Regional Care Maps	Pierre Noel	41
21	Role of Community Support Agencies in Health Services	Irene O'Toole	39
7	Developing Models of Service that empower individuals to take responsibility for their health and related services	Katherine Soule Blaser	35
15	Mental Health Services/system	Carolyn Skimson	35

Top 5 Admin Results

#	TOPIC	Initiator	Admin. Votes
12	Public Reporting and Scorecard Measurement	Randy Peltz	77
3	Accessible Integrated Electronic Health Records	Sherry Peister	55
14	Admin and Support Opportunities (Other than IT)	Karl Ellis	50
29	Regional Care Maps	Pierre Noel	39
32	Networks	Ross Kirkconnell	38

Planning Contact List

Developing Models that Empower Individuals

Name	Organization	Contact Information
Konnie Peet	Guelph Community Health Centre	
Katherine Soule-Blaser	Independent Living Centre of Waterloo Region	

Mental Health Service Systems

Name	Organization	Contact Information
Helga Allan	Halton Housing and Supports	
Charlene Winger	North Halton Mental Health Clinic	

Fair Share of Resources

Name	Organization	Contact Information
Susan Burns	District Health Council, Executive Director	519-836-7440
Blair Philippi	Caressant Care Nursing Homes of Canada, Arthur, Administrator	519-848-3795 848-2273

Admin and Support (Other than IT)

Name	Organization	Contact Information
Stewart Boecker	Grand River Hospital	749-4300 X4202 stewart.boecker@grhops.on.ca
Mark Beadle	St. Mary's Hospital	749-6639 mbeadle@smgh.ca
Karl Ellis	North Wellington Health Care	323-3333 x 2279 kellis@nwhealthcare.ca

Networks

Name	Organization	Contact Information
Ross Kirkconnell		823-2551 x 2225
Nancy Dunbar		669-5777

Role of Community Support Services in the Health System

Name	Organization	Contact Information
Heather Kerr		519-837-1470 x 230
Joanne Klausnitzer		519-743-1471

Improving Management, Coordination, Case Management, Access and Discharge, Planning, Referral/Assessment

Name	Organization	Contact Information
Kevin Mercer		883-5576
Toni Lemon		519-576-3570 x 228 toni@pacehomecare.com
Nancy Lambert (Alternate)		519-653-5493

Care Path (Mapping) – Group 1

Name	Organization	Contact Information
Susanne Gillespie		519-886-6298 sgillespie@chs.ca
Kristine McGregor		886-0202 kmcgregoreproresp.com

Care Path (Mapping) – Group 2

Name	Organization	Contact Information
Neil Barran		nbarran@saintelizabeth.com 905-940-9655 x 2103
Marianne Walker	St. Joseph's Health Centre	mwalker@sjhh.guelph.on.ca 519-824-6000 x4403

Untitled

Name	Organization	Contact Information
Glen Kearns	CIO Grand Hospital	Glen Kearns
Grant Hollett	District Health Council	ghollett@wrwddhc.on.ca 836-7440
Gayle Sadler	Hospice Waterloo	gls@campana.com 747-5222 x 313
Suzy Young	RNAO	519-749-6578 x 1953 syoung@smgh.ca