Hamilton Niagara Haldimand Brant
LOCAL HEALTH INTEGRATION NETWORK

RÉSEAU LOCAL D'INTÉGRATION DES SERVICES DE SANTÉ
de Hamilton Niagara Haldimand Brant

Quality Care in Community Hands. Planning the Future Together.

Quarterly Report

In this report:

Status of the Integrated Health Service Plan

Hamilton Niagara Haldimand Brant
Local Health Integration Network

First Quarter
August 2006

Ontario

Executive Summary

The development of the Integrated Health Service Plan (IHSP) for the Hamilton Niagara Haldimand Brant Local Health Integration Network (the LHIN) is consistent with the MOHLTC requirements of the IHSP: focus on relationship building, start with the identified health system priorities, report on progress for MOHLTC priorities e.g. wait times, and identify readiness for Health Human Resources (HHR) planning.

The scope of our inaugural IHSP is a function of available (lean) staff resources, minimal use of consultants as the "first face" of the LHIN, and availability of data and information. IHSP outcomes are related to the LHIN principle to build on the readiness and self determination of community members, stakeholders and providers to advance feasible ideas and solutions for health system improvement. IHSP directions in year 2 are being shaped by the LHIN's growing awareness about the importance of building capacity of all stakeholders to work together differently to accomplish real change.

Community Engagement

The goal of our LHIN's community engagement activities in year 1 is relationship building to set the longer term stage for collaborative solution building for health system improvement. The range of activities undertaken by our LHIN has been diverse. All activities are in some way informing IHSP processes and outcomes.

Board members and the Chief Executive Officer (CEO) have been meeting with community members, stakeholders and providers, and all MPPs, since August 2005. Some 250 meetings have been logged. The high level learnings and outcomes of these meetings have confirmed already identified priorities for health improvement and signalled new and emerging priorities for focus.

Senior Staff are working with the Steering Committee for LHIN 4 Priorities and by extension each of the member champions' networks for planning and solution building. For example, information, communication and technology was one of five administrative/enabling priorities identified in November 2004 and reported to MOHLTC in a February 2005 report. Our current e-Health project is a substantial component of IHSP activity; initiatives have included a survey of all health service providers, key informant interviews, an expert panel, and three workshops.

Thirteen open houses (See Appendix 1) have formally introduced the Board members and the organisation to communities across the LHIN. The open houses have been co-sponsored by community based organisations, including for example, a YMCA, the United Way, and a Social Planning Council. The open house sessions have been an opportunity for all visitors to meet and speak in person with Board members and staff, and to share salient issues about their health system, their communities and their aspirations for the future.

Finally, the LHIN leadership team is engaging with stakeholder and provider groups to define ways of working together. These include, among others: mayors, MPP constituency assistants, community health centres, the academic health science centre partners, discretionary granting organizations. In addition, an approach is underway to meet with health service provider governors and executives (approximately 800 persons) to begin the dialogue on new ways of work, recognizing

both the fiduciary responsibility and shared health system responsibility that Boards have.

Generally, the reception received by LHIN Board and Staff has been warm, generous, helpful and honest. The Board has set the stage for frank and forward looking discussions and this is creating cautious confidence in the ability of the LHIN to create a safe environment for problem solving.

Key Resources

The range of resources contributing to the development of the IHSP include:

- Seconded (1) and contracted staff (1);
- External consultants to support the engagement processes, the e-Health strategic plan, and collaboratory models for shared responsibility;
- Health Service Provider groups;
- The Steering Committee for LHIN 4 Integration Priorities;
- Ad hoc stakeholder groups advising the LHIN on approaches to ways of work with governances, networks, performance measurement approaches to LHIN 4 priorities;
- McMaster University Faculty resources with the Centre for Health Economics and Policy Analysis (CHEPA) re: community engagement theory and practice;
- Systems Linked Research Unit (SLRU), McMaster University to design a pilot opportunity to measure the scope, depth and breadth of integration;

The range of tools and references, among others, sourced to support the IHSP include:

- The Road Map to the Integrated Health Service Plan;
- The Report of the Steering Committee for LHIN 4 Priorities (February 2005);

- Various reports of the former District Health Councils, and local reports;
- HNHB LHIN Open House Survey outcomes;
- Population Health Framework(s);
- Health Services Information Partnership (HSIP) publications; and
- Ministry of Health and Long-Term Care resources
  - Provincial Health Planning Database, a data warehouse that provides access to ambulatory, acute, chronic and rehab hospital clinical information, Stats Canada population projection and census data, physician billing information, etc.
  - The MOHLTC Health Information Portal provides a one-stop window for LHINs to request information from a variety of ministry databases and data sources
  - Web-based tools and databases.

Preliminary list of local issues, directions, and priorities

The principle focus of this first Integrated Health Service Plan for health improvement solutions is the set of clinical and administration/enabling opportunities identified in November 2004. (See Appendix 2). The champions for each of these priorities are working with respective stakeholders, networks and interested parties and identifying improvement opportunities; these opportunities will be either feasible directions for implementation, or additional planning requirements, both with milestones and timelines. A key feature of the plan is our e-Health strategy, with a series of three year goals under review by the e-Health Steering Committee.

A sampling of issues emerging from meetings with stakeholders and discussions at open houses that will guide ways of work and collaboration with the broader human services sector includes:

- Access to primary care;
- Lack of available and accessible (distance, cost, eligibility criteria) transportation in both urban and rural communities within the LHIN;

- Frustration with lack of action in the past on multiple health planning reports and proposed health improvement solutions in many sectors;
- General lack of attention to healthy development in children and youth; and
- Requirement for ease of access to care and support among programs and services with shared clients/patients, both within the health sector and across sectors.

At the same time, we are learning about how well the health system responds in many instances to people's needs and the successful collaborations among stakeholders.

Ministry of Health and Long-Term Care Priority: Wait Time Strategy

The 12 hospitals in the Hamilton Niagara Haldimand Brant Local Health Integration Network entered into a formal agreement that lays the groundwork for the individual hospital organizations, and ultimately, the Executive Director of the amalgamated Community Care Access Centre, to work together on shared initiatives. The agreement will guide the leadership of these organizations as they begin working together to achieve high quality, seamless services for patients while further ensuring that operations related to providing these services are cost efficient and effective.

Continuing this collaborative effort, the LHIN requested that hospital and CCAC leaders nominate an empowered individual within their organization to participate in quarterly meetings to discuss progress in meeting Wait Time Strategy targets and other key deliverables. The first meeting of this group will take place on August 18, 2006.

Lessons Learned

Our LHIN anticipated challenges to developing the IHSP given community and stakeholder high expectations of LHINs, the lag in LHIN staff recruitment, and the Minister's expectations of the IHSP in year 1. At the same time, we grew increasingly aware of the high readiness for change in our LHIN, and the momentum among some stakeholder groups for designing and implementing health improvement solutions. Subsequently, our strategy has focused on relationship building, requirements of shared responsibility and health system improvement (capacity building), and supporting collaboratives and their early change strategies. With respect to the latter, our LHIN's approach has been one of encouraging collaboratives to get on with the business of improvement where there are outcome benefits to clients and patients, benefits to providers as they deliver care, evidence of best practice, and high degree of consensus on the solution(s).

Observations and lessons learned to date include:

1. Readiness for change and health improvement is high; enthusiasm must be sustained with evidence of real change supported and implemented where feasible.

2. Relationships make a difference; face to face and personal contact with community members by the LHIN organization Board and Staff are acknowledged as valuable.

3. Operationalizing some of the LHIN's core business (planning and engagement) without a "core" team has been challenging. Current strategies (contracted and seconded resources) do not maximize the learning and intelligence of the organization for the longer term.

4. Managing the divergent expectations of providers for change and those of the MOHLTC for "setting the stage for change" in year 1 has been challenging.

5. Health improvement strategies are being developed in the community by the community for each of the identified priorities. Subsequently, the LHIN has adopted high risk tolerance for outcomes, given varying levels of readiness, pace and expertise among communities, stakeholders and providers for problem solving.

6. The scope and magnitude of issues and challenges for the health system and health outcomes that lie outside the mandate of the MOHLTC and LHINs are considerable. This will necessitate considerable boundary spanning by the LHIN for solution building with other sectors, for example, transportation, housing/ shelter, MCSS, and health human resources (as part responsibility of Ministry of Colleges and Universities).

7. Access to timely information for planning and monitoring remains a concern. A LHIN must still rely on a third party to provide a majority of the hard data and analysis of information warehoused by the MOHLTC. As LHIN responsibilities increase over time, it will be necessary to improve and enhance LHIN access to an even broader spectrum of MOHLTC data sources.

Next Steps

Over the next three months, the HNHB LHIN will:

- Finalise a stand alone report on our Open House initiative;
- Initiate the first series of dialogues with Governor and Executive leadership among health service providers;
- Sponsor a LHIN wide health human resources forum;
- Consolidate the health improvement action strategies and planning requirements for each of our identified priorities for Board review;
- Deliver the e-Health Strategic Plan;
- Sponsor quarterly meetings with LHIN hospitals to review and discuss achievement of MOHLTC priorities, e.g. wait time strategy, critical care;
- Complete a summary progress report on MOHLTC priorities; and
- Identify key work plan activities subsequent IHSP submission in October.

Appendix A:
Open House Schedule

Schedule - All sessions are from 3 p.m. – 8 p.m.

Community	Date	Host	Location
St. Catharines	May 25	YMCA of Niagara	YMCA Niagara 25 YMCA Drive
Grimsby	May 30	Trinity United Church	Trinity United Church 100 Main Street West
Brantford	May 31	City of Brantford	Brantford and District Civic Centre 69-79 Market Street South
Hamilton	June 8	Settlement and Integration Services Organization	SISO 360 James Street North LIUNA Station Lower Concourse
Niagara Falls	June 13	YMCA of Niagara	YMCA of Niagara 7150 Montrose Road
Hamilton	June 15	Social Planning and Research Council	Dominic Agostino Riverdale Community Centre 150 Violet Drive
Brantford	June 20	City of Brantford	Best Western Brantford 19 Holiday Drive
Cayuga	June 27	United Way of Haldimand & Norfolk	Royal Canadian Legion 11 Talbot Street (at Ottawa Street)
Burlington	June 29	YMCA of Hamilton Burlington	Ron Edwards Family YMCA 500 Drury Lane
Burlington	July 5	YMCA of Hamilton Burlington	Tansley Woods 1996 Itabashi Way
Hamilton	July 6	YMCA of Hamilton Burlington	Sackville Hill Senior's Recreation Centre 780 Upper Wentworth Street
Port Colborne	July 12	Port Cares	Friends Over 55 Senior's Recreation Centre 554 Fielden Avenue
Simcoe	July 25	United Way of Haldimand & Norfolk	Simcoe Fair Grounds-Junior Farmer Building 172 South Drive

All sites are wheelchair accessible. Please advise within 24 hours if you have other special needs.

For more information please contact:
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Appendix B: Integration Priorities for the Hamilton Niagara Haldimand Brant Local Health Integration Network

November 2004

1. Promote healthy lifestyles.
2. Focus on children and youth.
3. Assist seniors and persons with disabilities to live independently in the community.
4. Support persons with mental health and addictions problems to live full lives in their communities.
5. Enhance care and support for frail elderly persons.
6. Improve quality care at the end of life.
7. Develop an electronic health information system that ensures the right patient information is available to care for people at the right time, in the right way.
8. Encourage decision makers in health, housing, social services and education to work together to promote healthy people and healthy communities, (promote integrated human services planning).
9. Measure how well the health system is meeting people's needs.
10. Promote shared accountability among providers for available, accessible and acceptable services.
11. Engage and learn from the community (continue the LHIN 4 dialogue).
12. Promote integration of service, education and research for a sustainable health system.

Source: Integration Priorities for Hamilton Niagara Haldimand Brant LHIN. February 2005.

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1 October 2005
2 September 2005

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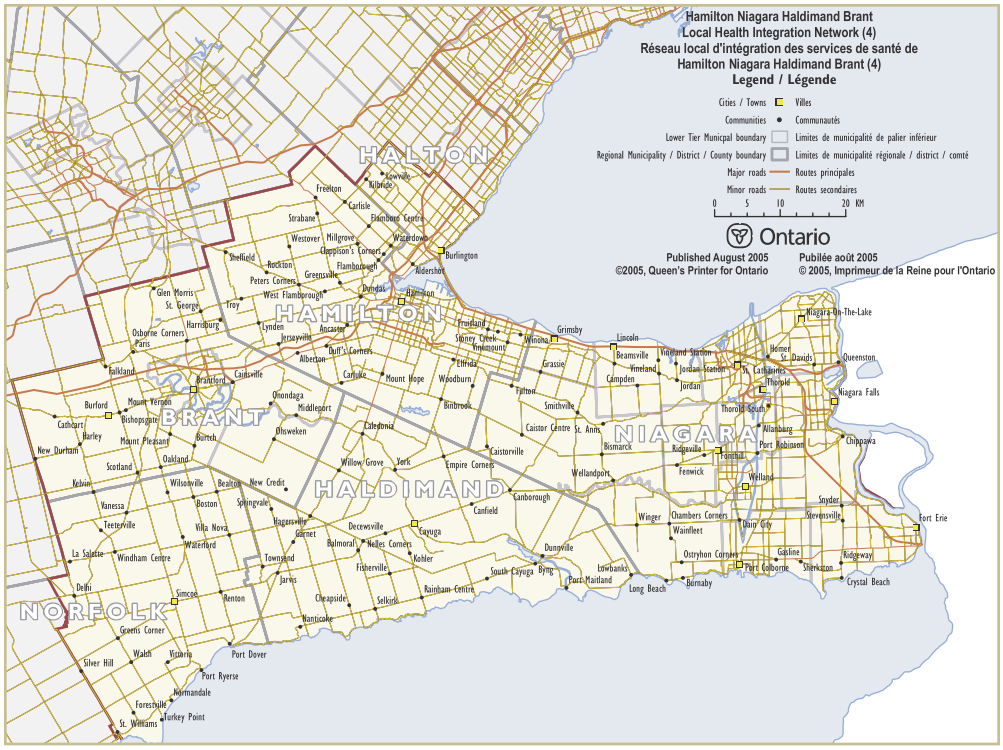

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