

Northwest Local Health Integration Network (LHIN 14)

Opportunities for Health System Integration

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Introduction and Background

Introduction

The Northwest Local Health Integration Network (LHIN 14) is comprised largely of the current region of Northwestern Ontario. Northwestern Ontario, with a land mass of almost 60% of the province of Ontario, extends from White River in the east to the Manitoba border in the west, to James Bay and Hudson Bay in the North and to the United States border to the south. The distance between the eastern and western boundaries is slightly over 1,000 km.

With a land mass of 526,355 square kilometers, Northwestern Ontario consists of the districts of Thunder Bay, Kenora and Rainy River. The total population of Northwestern Ontario represents only 2% (234,770) of the population of Ontario and has a density of 0.5 persons/km² compared to 12.5 persons/km² in Ontario. The population living in the Census Metropolitan Area of the city of Thunder Bay represents 52% (121,390) of the population of Northwestern Ontario. The other three largest cities in Northwestern Ontario with populations between 8,000 and 16,000 are Kenora, Fort Frances and Dryden. Almost ¼ of the population reports their ethnic origin as North American Indian.

Northwestern Ontario is comprised of numerous small towns and First Nation communities spread throughout rural and remote areas. The geographic location of these towns and communities creates numerous challenges in planning, delivering and accessing health services. Many First Nation communities in Northwestern Ontario are not accessible all year around. At various times of the year people in Northwestern Ontario are also exposed to hazardous weather and road conditions, and traveling delays when they are required to travel long distances to receive health care.

System Integration Opportunities Identified at December 10, 2004 Workshop

At a consultation hosted by the Ministry of Health and Long-Term Care on December 10, 2004, integration priorities were established for the Northwest Local Health Integration Network (LHIN 14).

Using open-space technology, participants were asked to identify priority integration opportunities facing Northwestern Ontario. The following priorities (in no particular order), recorded verbatim from the consultation session, were identified:

- An integrated strategy for the frail elderly across the continuum of care
- Accès aux services de santé en français. - Access to French language services
- Provide back office functions to smaller organizations that do not have the capacity or funding to do
- Role of extended class nurse in delivery of care within the LHIN
- Northern health information and communication technology planning
- Integration of mental health and addiction services within healthcare
- Provide a framework for LHIN members to come together around a plan for service delivery that continues to utilize provincial specialized services
- Sharing of services for hospitals and long-term care
- Cross sector integration of services
- To make LHIN 14 truly local and accountable to the community
- Opting out
- Regional (distributed) LHINs education
- Access: linking service across the continuum
- Challenging communication silos to facilitate seamless the seamless continuum of client care
- Linking and creating long-term care resources for First Nations population in rural and remote communities
- Integrated, client focused, network of holistic services from diagnosis through to bereavement support for families/caregivers in city and region
- Services -care close to home
- Population/public health in rural and remote First Nations communities
- Community support services such as supportive/supported housing/living, transportation services, personal and family support services (such as respite, personal care in the home, meals to wheels & meals on wheels, etc.)
- Timely access to services, both care and prevention
- Provide homecare and other health professional services (PT, OT, SLP) to remote communities using existing e-health technologies (model already exists but needs to be expanded)

- Use existing systems to communicate information within and between LHINs (e.g. CritiCall Bed Registry)
- Rationalization of the hospital sector
- Ensuring that consumers and clients are involved in the LHIN process
- Volunteers – making sure they are part of the process
- Immediate cross Ministry integration project
- Integration of services/care of children and youth
- Integration/coordination of health human resources planning
- Reducing distance (realities of NWO) using innovation, technology focus on client, family, caregiver and professional
- Access to basic physician/medical services by rural/remote communities
- Systemic sustainability/multi-year funding
- Access to rehabilitation services (OT/PT/SLP/Chiro/RMT)
- Communications: one common clinical tool for all levels of care
- Intersectoral integration: different Ministries, agencies etc. cross provincial (Manitoba) to improve health status through the utilization of a health determinants model
- Wellness and disease prevention model of health care for the Northern LHIN
- Opportunities for collaboration at the federal, provincial, local and First Nations levels
- Aboriginal issues: 1) recognition is a priority, 2) interpretation of integration, 3) separate sector
- Stakeholder accessibility to health care services which are publicly funded

Top 12 System Integration Opportunities

After priority integration opportunities were identified, participants were asked to identify the top 10 priority integration opportunities (5 for patient care and 5 for administration) facing Northwestern Ontario. The priorities identified did not include a priority specifically addressing First Nation/Aboriginal health. Those attending the session unanimously supported the addition of a priority related to First Nation/Aboriginal health. In Steering Committee meetings, the First Nation/Aboriginal health was identified, by its leads, as both a patient care and administration priority, resulting in the following twelve priorities (in no particular order) for LHIN 14.

Patient Care Priorities

- 1 Integration of mental health and addiction services within healthcare
- 2 Access: linking service across the continuum
- 3 An integrated strategy for the frail elderly across the continuum of care
- 4 Community support services such as supportive/supported housing/living, transportation services, personal and family support services (such as respite, personal care in the home, meals to wheels and meals on wheels, etc.)
- 5 Services - care close to home
- 6 First Nations/Aboriginal health – LHIN 14

Administrative/Support Priorities

- 1 Systemic sustainability/multi-year funding
- 2 Northern health information and communication technology planning
- 3 Regional (distributed) LHIN education strategy
- 4 To make LHIN 14 truly local and accountable to the community
- 5 Integration/coordination of health human resources planning
- 6 First Nations/Aboriginal needs-based funding

System Integration Opportunities

Introduction to Templates A through E

The top 12 priority integration opportunities (6 for patient care and 6 for administration) facing Northwestern Ontario, as determined by the consultation session held on December 10, 2004 are outlined in consolidated **Templates A/C and B/C**. For each priority area, multiple stakeholders were consulted, with at least 400 individuals being included in the process. The leads (members of the Steering Committee) for each priority area identified key components and high level action plans that would be central to developing/expanding upon integration initiatives.

Priorities that were identified, but not ranked in the top 12 are included in the Appendices in the same format as Templates A and B. Although not in the top 12, they are priorities that should be considered in future health integration planning.

Although some of the priorities for LHIN 14 are similar to those identified in other regions, the unique characteristics of LHIN 14 are outlined in **Template D**. In particular, the low population density, geography and large Aboriginal population in Northwestern Ontario represent opportunities and challenges to providing quality healthcare.

The process and approach used to develop the 12 integration priorities for the Northwest LHIN are outlined in **Template E**. Strengths and weaknesses and key learnings identified during this process are outlined Template E, as well as a list of those organizations consulted during the development of the 12 integration priorities.

Common Themes Identified throughout Integration Priorities

The top integration priorities identified cannot be viewed as mutually exclusive. During the LHIN 14 Steering Committee discussions and consultations with various stakeholders, a number of themes recurred. The following themes permeated discussions:

- The need for stable, multi-year funding. Funding formulas do not often reflect the resources required to provide healthcare in Northwestern Ontario.
- First Nations/Aboriginal health is a priority for LHIN 14.
- Mental health and addictions are pervasive and impact all priorities.
- It is essential to build on strengths and innovations present in this region.
- It is important to build on leveraging the linkages/networks existing in Northwestern Ontario.
- Access to care closer to home is a major challenge with a landmass that is 60% of Ontario.
- Information and Communication Technology is vital for access to healthcare in this vast geography.
- Inter-ministerial integration is required to provide healthcare across the continuum of care.
- Northwestern Ontario is historically under-serviced with respect to health human resources. The recruitment and retention of healthcare providers, training and education, and wage disparities represent ongoing challenges that warrant special attention.

Templates A/C: Patient Care/Services Integration Initiatives and Priority Setting

A/C-1. Description of Patient Care/Services Integration Initiative

Title of patient care/service initiative: Mental health and addiction services integrated as core components of the health care system.		Type of integration (more than one box can be checked) <input checked="" type="checkbox"/> Horizontal <input checked="" type="checkbox"/> Vertical <input checked="" type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:
Existing or new initiative? <input checked="" type="checkbox"/> Initiated/existing integration activity* <input checked="" type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	List of partners involved: All mental health and addiction services in the Northwest Region; providers of other health and cross sector services which impact or may be impacted by mental health and/or addiction issues (social services, criminal justice, housing, municipalities).	
Please briefly describe the initiative. We propose that clinical and non-clinical <i>Mental Health and Addiction Services</i> be integrated as core components of the health care system in the Northwest LHIN to ensure a holistic, consumer and family focused, coordinated approach to care. Mental health and addiction problems (including problem gambling) affect a significant proportion of the population of Ontario and indirectly affect all citizens of the province. Mental health and addiction issues represent a tremendous burden for those who are directly experiencing problems and for family members, the larger community and the health care system as a whole. Many individuals with a medical condition have co-occurring mental illness or serious substance abuse issues. Persons with serious mental illness and/or addictions are more likely than the general population to have a serious medical disorder and often have a substance abuse problem. The health care system in Ontario is poorly equipped to serve those with a co-occurring problem, particularly for those with long-term needs. Therefore planning, funding and policy decisions of LHIN 14 must demonstrate that <i>Mental Health and Addiction Services</i> are core components of an integrated health care system for the Northwest LHIN. Despite growing prevalence rates of mental health and addiction problems within Northwestern Ontario, and despite the numerous and persuasive planning documents that have illustrated the need to prioritize these issues, they have historically been marginalized within the health care system. The Northwest LHIN is well positioned to reverse this trend and provide these issues and those affected by them with the attention and services they require. The Northwest Region is a vast geographical area and home to many diverse communities and cultures. As a region, we have consistently demonstrated a commitment to creative collaboration and working together to achieve collective goals. Within our geographical isolation we face many challenges including the recruitment, retention and training of professionals, scattered resources and technological difficulties. Population based funding formulas do not adequately consider the challenges in service access for rural and remote communities throughout the Northwest Region nor the cost of doing business in this vast geography. Accessibility to mental health and addiction services is extremely limited, particularly in the northern part of the province. Additionally, census data is inaccurate as not all First Nation communities participate in the census. Culturally appropriate (traditional) healing methods are neither recognized nor adequately funded. This initiative will require strengthening of the system to support service integration, an expansion of current resources and building new capacity to respond to the complex needs of Aboriginal people, deaf people, persons with disabilities, older adults, transitional age youth and individuals struggling with concurrent issues.		
Rationale for Integrating Mental Health and Addiction Services as Core Health Care System Components The prevalence of mental health and addiction problems and their impact on other health issues demands that they be prioritized within the health system: <ul style="list-style-type: none"> Canadian Health Network states that 10% of adult Canadians report problems with their drinking and 50% report problems with someone else's drinking (Ontario Federation of Community Mental Health and Addiction 		

Programs). Applying these Federal benchmarks to Northwestern Ontario, results would suggest that 23,477 Northwestern Ontario citizens would report problems with drinking and 117,385 citizens would report problems with someone else's drinking.

- 20% of Canadians (46,953 Northwestern Ontario citizens) will experience a mental illness in their lifetime (Health Canada Report, 2002).
- Lifespan for men with schizophrenia is 10 years shorter than the national average; for women it is 9 years.
- One in eight Canadians (29,348 Northwestern Ontario citizens) will be hospitalized for mental illness at least once in their lives, more than are hospitalized for cancer or heart disease (Joint Paper of CAMH, OFCMHAP and CMHA).
- Ten percent of Canadians surveyed by Statistics Canada in 2002 reported symptoms consistent with alcohol or illicit drug dependence and 5% reported problem gambling or at risk behaviour (Canadian Community Health Survey, 2002).
- Research reflects a high rate of co-occurring addiction and mental health problems and shows that people who have such concurrent disorders experience poor treatment outcomes, high rates of relapse, suicide and homelessness.
- It is estimated that in 2005, 3,350 people in Northwestern Ontario over the age of 65 (10.4%) will be affected with Alzheimers Disease and/or related dementia. Two-thirds live in the Thunder Bay District and 1/3 live in the Kenora Rainy River District (NWODHC calculations).

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

- Alcohol and illicit drug abuse accounted for \$4.9 billion in lost productivity due to illness and premature death, \$1.7 billion in law enforcement and \$2.1 billion in direct health care costs (Kirby Report, November, 2004).
- Mental illness costs \$6.3 billion in direct health care costs and \$8.1 billion in lost productivity due to illness and premature death (Kirby Report, November, 2004).
- 90% of suicide victims have a diagnosable mental illness or substance use disorder (Kirby Report, November, 2004).
- One untreated problem gambler represents an economic burden of \$56,000.
- 22% of homeless persons claimed that mental health (4%) or substance abuse (18%) was the reason for their becoming homeless (Kirby Report, November, 2004).

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

- Research has shown that the longer psychotic symptoms are left untreated, the worse the prognosis and there is greater evidence of brain damage in persons who experience long, untreated psychotic episodes than in those who experienced shorter, more efficiently treated episodes (Kirby Report, November, 2004).
- It has been found that by two years following treatment for substance use there are significant declines in the use of health services, resulting in considerable cost savings (\$4 to \$12 for each dollar spent) to the overall health care system (Ontario Federation of Community Mental Health and Addictions, 2003).

Other significant benefits to the integration of mental health and addiction services as core health system components include:

- Clear communication to consumers, family members and the organizations that serve them that their need for an effective, responsive and adequately resourced and accessible mental health and addiction system is essential to their health and well-being.
- Identification of mental health and addiction issues as health care priorities will significantly reduce the stigma associated with these problems.
- Opportunities exist to enable LHIN 14 to build on the mental health and addiction system planning efforts and commitments of the provincial government (Mental Health Implementation Task Force and "Setting the Course").
- Opportunities to develop a comprehensive mental health and addiction strategy within the health care system that secures dedicated funding for mental health and addictions, builds system capacity, ensures the availability of core services throughout the Northwest LHIN, promotes formalized partnerships and linkages with clearly defined roles and accountability framework and promotes an accessible, client-centred and family-focused service.
- Collaboration within the health care system with respect to health promotion, identification and early intervention with at risk populations.
- Enhanced service delivery for individuals struggling with co-occurring mental health and addictions problems and an integrated approach to other health problems which are impacted by mental health and/or addiction issues.

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

- Better understanding of mental health and addiction issues throughout the health care system and improved capacity to identify those with problems and those at risk.
- Improved outcomes and quality of care for medical conditions for persons with a serious mental illness or addiction.
- Responsiveness to mental health and addiction issues from all components of the health care system, which work together to ensure timely and appropriate referrals, accessibility provisions, service coordination and continuity of care.
- Increased awareness, acceptance and use of mental health and addiction services.
- More appropriate use of acute care services (bed utilization, emergency services, etc) and reduced costs as a result of more efficient and effective use of resources.
- Mental health and addiction services are geographically and physically accessible, culturally appropriate, responsive, coordinated and comprehensive.
- Decreased stigma and discrimination.
- Increased client satisfaction with medical and mental health/addiction treatment.
- Standardized delivery of mental health and addiction services across the Northwest LHIN (standardized admission and discharge criteria and protocols, assessment tools and evaluation framework).

High Level Action Plan:

Priority Opportunity:

Integration of Mental Health and Addiction Services within the health care system to ensure a holistic, client focused, coordinated approach to care. The full range of integrated services must also include non-clinical supports, including faith based supports and culturally appropriate community support services, providing opportunities for lateral and cross sectoral integration.

- Recognize current integration initiatives and evidence based practice innovations within the Northwest Region and utilize established regional networks and advisory groups to support strategic planning for this patient care priority.
- Secure, dedicated, needs based, multi-year funding to support evidence based service delivery and strategic planning and address differential funding policies and reporting requirements across the health care sector.
- Ensure meaningful representation of consumer and family members in all aspects of strategic planning through the establishment of a Consumer/Family Advisory Group and provide compensation for consumer participation.
- Implement recommendations arising from the Northwest Implementation Mental Health Task Force (with the exception of recommendations regarding the recommended governance structure) and implement recommendations as highlighted in provincial publications such as "Setting the Course".
- Enhance current resources through partnerships with Health Canada and build upon current initiatives such as Homelessness Initiatives, Ontario Works Addiction Treatment Initiative and Shared Care which support cross sectoral opportunities for establishing integrated, client focused, and coordinated care.
- Establish cross sectoral working groups to identify and address system pressures and service gaps throughout the region with consideration for rural areas and access to specialized services and enhance non clinical community support services, including faith based supports which promote cross sectoral integration and care closure to home.
- Secure funding to support a full continuum of accessible, effective, efficient and adequately resourced clinical services which are responsive to special needs populations (e.g. Concurrent disorders, dual disorders, physical disabilities, older adults, Aboriginal people, transitional age youth, women and youth) and individual needs regardless of an identified diagnosis and ensure timely access to culturally appropriate, non-clinical support services throughout the continuum of care (e.g. Supportive housing, respite, peer support services).
- Establish an allied services group to promote public awareness and reduce stigma associated with mental illness and addictions.

<p>If this is an initiated/existing activity... What is the current status? NWO District planning groups for mental health and addiction services have made significant efforts toward system/service integration. These current efforts should be recognized and supported by the LHIN 14 Board.</p>	<p>What are the outcomes/lessons learned (if any)? The process of integration requires dedicated resources, broad consultation with key stakeholders and a collective vision. It has been demonstrated that service integration does improve coordinated access and enhances service delivery but should not be viewed as a "cost saving" panacea. Community based mental health and addiction services have faced significant attrition due to more than a decade of inadequate funding. The core service system must be stabilized in order to move forward with the process of service/system integration.</p>
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Title of patient care/service initiative:		Type of integration (more than one box can be checked)	
Access - Linking Services Across the Continuum.		<input checked="" type="checkbox"/> Horizontal <input checked="" type="checkbox"/> Vertical <input checked="" type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:	
Existing or new initiative?		List of partners involved:	
<input type="checkbox"/> Initiated/existing integration activity* <input checked="" type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>		People we serve, Peers and Colleagues in Community, Hospitals and CCACs in Thunder Bay, Kenora and Rainy River Districts, LHIN 14 Workshop Attendees as well as LHIN Community Planning Forum Attendees, Community Services (professional, volunteer, caregivers), Physicians, Woit's Pharmacy, Allied Health, Mental Health and Addictions, Ministry of Health and Long-Term Care, Care Giver Support Network, Dementia Network, K-Net.	
Please briefly describe the initiative.			
Enhance processes and develop integrated teams that link services for health care planning and delivery to facilitate quality, client focused, seamless service. This opportunity supports clients in navigating the systems of health care and accessing the right service, at the right time, and at the right place, by the right person.			
High Level Action Plan:			
<ul style="list-style-type: none"> • Establish cross-sectoral service planning teams that build up from the local to the LHIN levels; i.e. Functional integration, which would require regular forums and transparency, Community Care Team, Hospital Care Team (e.g. Community Response Team for Individuals w/ Fetal Alcohol Spectrum Disorder). Cross reference Primary Health Care Reform strategies. • Develop advanced connectivity solutions to facilitate the research, adoption and common utilization of evidence based documentation tools (e.g. Smart Systems for Health Agencies). • Support and build on existing Case Management Services to provide system navigation across the sector. • Identify beginning steps to integration (i.e. strategy mapping - validate consumers issues and needs and match with the provider best able to meet these needs). • Develop processes (linked with LHIN vision) with clients, to identify the gaps in accessing services along the continuum and in maintaining continuity of care. • Review and enhance existing structures to ensure the client is linked across the continuum (e.g. strategy/care mapping). • Build on the integration efforts of the existing Northwest Network to support connectivity (requires provincial support). • Develop a process for shared accountability. • Develop a process for ongoing monitoring and evaluation. • Develop a communication strategy to examine privacy and establish a protocol for intersectoral information sharing. • Define project outcomes and scope for the short, medium and long-term. 			

<p>If this is an initiated/existing activity... What is the current status? Although not an existing initiative, "Linking Services Along the Continuum" ties into existing projects such as "Northern Health Information Communication Technology Planning", "Keewaytinook Okimakanak Telehealth (KO Telehealth)", as well as the "New Northern Ontario Hospitals Back Office Services Project" (NOHBOS). Implementation of this initiative would also enhance two other identified LHIN priorities: Integration of Mental Health and Addiction Services and Providing services for the Frail Elderly.</p>	<p>What are the outcomes/lessons learned (if any)?</p> <p>Lessons Learned:</p> <ul style="list-style-type: none"> • (W)Holistic care must be placed at the centre. • "Linking Access Across the Continuum" is a core priority issue for all sectors. • Requires an accountability structure. • Must incorporate best practice guidelines. • A strong ongoing commitment to this and other LHIN 14 priority initiatives exists. • Implementation of this initiative would require a phased approach. <p>Challenges:</p> <ul style="list-style-type: none"> • The usual (silos, technology, funding, geography). • Implementation requires cross sectoral integration. • Requires fostering and enhancing awareness, and respect for each caregiving role to maximize collaboration. <p>Facilitating Factors:</p> <ul style="list-style-type: none"> • Northern (community) Spirit. • Interest, willingness and openness to integration strategies. • Inherent Client focus. • Potential to increase efficiencies (best use of resources). • Existing initiatives: (e.g. NW Network, KO Telehealth, CCAC and hospital share resources in northern communities, tele-networking).
<p>Lead contact person:</p>	
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A/C-3. Description of Patient Care/Services Integration Initiative

Title of patient care/service initiative:		Type of integration (more than one box can be checked)	
An Integrated Strategy for the (Frail) Elderly Across the Continuum of Care.		<input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input checked="" type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:	
Existing or new initiative?	List of partners involved:		
<input type="checkbox"/> Initiated/existing integration activity* <input checked="" type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	Bethammi Nursing Home Comcare Health Services Community Care Access Centre of the District of Thunder Bay Dawson Court Home for the Aged Northwestern Ontario District Health Council Grandview Lodge Home for the Aged Hogarth Riverview Manor Hospice Northwest LHINs Steering Committee Nipigon District Memorial Hospital PR Cook Apartments Rainycrest Homes for the Aged St. Joseph's Care Group Thunder Bay Regional Health Sciences Centre Versa-Care Centre		
Please briefly describe the initiative:			
<p>A smooth continuum of care that is person-centred is required for the elderly. There will be an ability to access needed services in a timely manner. Sustainable sufficient funding is required to be available to support the person in the setting of choice. Care and resources should follow the person and not be divided into silos by different agencies. This is often not the case in LHIN 14 where clients are moved from their home community to another community to receive care. Also where First Nations people and people living in rural and isolated communities do not have access to services, distance is often a barrier. Care for the elderly can be depicted as an umbrella which includes: primary care, acute care, community care, complex continuing care, long-term care, palliative care, behaviour management, psychogeriatric, respite care, rehabilitative care and dementia care. People needing this care may present as frail elderly, developmentally disabled and disadvantaged persons with barriers to access.</p> <p>The umbrella will incorporate collaboration and cooperation of partners into the continuum of care. The Integrated Strategy for the Frail Elderly will be enhanced by the development of a Geriatric Network for LHIN 14 as well as the other 13 Ontario LHINs.</p> <p>The underlying principles of the Integration Strategy include illness prevention, disease management and treatment, chronic disease management, end-of-life care, health promotion and education. The communications strategies to be used for the integration for the frail elderly will be diverse with methods of communications varying from in-person assessments to videoteleconferencing.</p>			
Key Components:			
<ul style="list-style-type: none"> • There needs to be connectivity and infrastructures to support the elderly in all settings. • Systems and technology need to support elderly in their own health care management and well-being. Seniors want to be involved in their care. • In supporting elders and their caregivers to manage care, there needs to be an investment in current and future technologies, such as videoconferencing and outreach education which can support formal and informal caregivers in their communities. • Often the elderly and their caregivers, formal and informal, are confused and bewildered by the complexity of the system. It is therefore suggested that a System Navigator could support the elderly accessing the continuum and connecting the client from one setting to another: mental health, community care, acute care, and palliative care. • Access to the system should be expanded to a broader range of health care professionals. Various health care 			

professionals can assist the elderly in achieving optimal functional health. In order to achieve this goal there needs to be increased enhancement of the roles of other health care professionals and a discontinuation of the current limitations to accessing the system.

- Ultimately the key component in the above can be assisted by increased enhancement of strategies to expand electronic health information records across the continuum settings: primary care, acute care, continuing care, end-of-life care, remote communities throughout the LHIN 14 region.
- Key barriers for persons accessing care are often related to issues of substance abuse, mental health, and behaviour management. Current strategies do not manage or meet the needs of these populations.
- Strategies are not in place to assist Aboriginal seniors who have been moved from their communities to institutions. These person often face cultural and language barriers that cause a rapid deterioration in their condition.
- There should be an assessment of the dedication of resources and monies to elderly care in various levels. At present there is a large discrepancy between the resources and monies that is provided in hospital care and those that are provided in long-term care.
- A study done by the Northwestern Ontario District Health Council ("Supportive Housing in Northwestern Ontario: A Needs Assessment" January 2004) identified needs for more supportive housing for the elderly in the Region. There is a responsibility to explore the initiatives of the recommendations of this study.

High Level Action Plan:

- Enhance network connectivity and infrastructures such as development of Geriatric Networks.
- Develop technologies and systems to support client involvement in the management of their health and well-being by means such as Seniors Advisory Committees.
- Utilize current and future technologies to automate processes across the continuum of care through means such as videoconferencing and outreach education.
- Create the role of a System Navigator to support elderly accessing care throughout the continuum. This would allow care to be provided to the person across settings rather than the existing brokerage model.
- Develop a model for Wellness Clinics to deliver health promotion and illness prevention strategies that can be implemented in communities of various sizes, from densely populated to remote.
- Establish interconnectivity of the Geriatric Networks with other existing networks such as the Rehabilitation, Dementia, Palliative Care and Psychogeriatric Networks.
- Establish strategies to manage chronic disease.
- Reinforce the models of interdisciplinary and transdisciplinary care by enhancing availability of support in all settings, including long-term care homes.
- Develop a regional LHIN 14 educational strategy for care management and service delivery for the frail elderly.
- Explore the development of a common assessment tool for accessing service across the continuum of care.
- Engage the LHIN 14 CEO and Board of Directors in a dialogue for sustainability and funding allocation based upon individual needs. Funding should follow the patient.
- Develop a strategy for support of volunteer programs within the Integrated Strategy for the Frail Elderly.
- Develop recognition strategies and sustainable systems for caregivers by development and enhancement of systems such as financial reimbursement and respite both in the home and institutions.
- Develop elderly sensitive indicators and positive outcome measures in agencies managing care of the frail elderly.
- Increase the field of various health care providers that can allow access to the continuum in the provision of assessments, treatments and referrals. As has been noted in the key components this should be broadened and expanded beyond our current methods.
- Develop a strategy to support behaviour management.
- Develop a strategy to support disadvantaged individuals with barriers to access. This would include clients experiencing mental health and substance abuse issues being able to access services on the continuum such as long-term care.
- Develop plans to analyze the resources and monies required to meet the needs of elderly persons along the continuum of care in their setting of choice.
- Dedicate resources to follow up the assessment of the Northwestern Ontario District Health Council on supportive housing needs in LHIN 14.
- Develop strategies to assist Aboriginal seniors who experience cultural and language barriers when accessing the continuum of care in places other than their home communities.
- Revisit and improve access to services provided in the community to avoid moving elderly persons to other communities to receive care. Moving persons to other communities removes them from the support of family and loved ones.

<p>If this is an initiated/existing activity... What is the current status?</p> <p>This is a new integration opportunity.</p>	<p>What are the outcomes/lessons learned (if any)?</p> <p>The anticipated outcome is that the client will receive the right services at the right time. There will be an ability to move smoothly from one setting to another. Barriers are removed between providers, persons and available resources. Resources and care will follow the person. This will allow clients to age in the setting of their choice to the best of their potential.</p>				
<p>Lead contact person:</p> <table border="0"> <tr> <td data-bbox="107 468 487 558"> <p>Name: Tuija Puiras Title: Executive Director Telephone: 807-345-7339</p> </td> <td data-bbox="781 495 1412 558"> <p>Organization: CCAC of the District of Thunder Bay Email address: Tuija.Puiras@tb.ccac-ont.ca</p> </td> </tr> <tr> <td data-bbox="107 590 760 680"> <p>Name: Darlene Harrison Title: Program Manager, Specialized Geriatrics Telephone: 807-346-2327</p> </td> <td data-bbox="781 617 1278 680"> <p>Organization: St. Joseph's Care Group Email address: harrisod@tbh.net</p> </td> </tr> </table>		<p>Name: Tuija Puiras Title: Executive Director Telephone: 807-345-7339</p>	<p>Organization: CCAC of the District of Thunder Bay Email address: Tuija.Puiras@tb.ccac-ont.ca</p>	<p>Name: Darlene Harrison Title: Program Manager, Specialized Geriatrics Telephone: 807-346-2327</p>	<p>Organization: St. Joseph's Care Group Email address: harrisod@tbh.net</p>
<p>Name: Tuija Puiras Title: Executive Director Telephone: 807-345-7339</p>	<p>Organization: CCAC of the District of Thunder Bay Email address: Tuija.Puiras@tb.ccac-ont.ca</p>				
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A/C-4. Description of Patient Care/Services Integration Initiative

<p>Title of patient care/service initiative:</p> <p>Community support services are integral to the transformed healthcare system. These include: respite care, supportive/supported housing, transportation and other services designed to support individuals to remain in the community, thereby diminishing pressure on the acute care and LTC sectors.</p>		<p>Type of integration (more than one box can be checked)</p> <p><input checked="" type="checkbox"/> Horizontal <input checked="" type="checkbox"/> Vertical <input checked="" type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:</p>
<p>Existing or new initiative?</p> <p><input checked="" type="checkbox"/> Initiated/existing integration activity* <input checked="" type="checkbox"/> New integration opportunity</p> <p><i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i></p>	<p>List of partners involved:</p> <p>Community Support Services Agencies funded by the MOHLTC in the Districts of Thunder Bay, Kenora & Rainy River (list attached). Providers of other health and human services that impact on or are impacted by community support service issues; services funded by other Ministries with which there are multi-jurisdictional and complex needs and issues (child and youth services, mental health and addictions, social services, District Social Services Administration Boards, housing, criminal justice, Lakehead University - Centre for Education and Research on Aging and Health, etc.).</p>	
<p>Please briefly describe the initiative.</p>		
<p>Key Components:</p> <ul style="list-style-type: none"> Community Support Services are a critical component of the transformed health care system in the Northwest LHIN. Community Support Services are typically small, consumer-driven, charitable, not-for-profit organizations who provide a flexible range of personalized programs and services designed to meet the unique needs of local communities. Many of the services are delivered by volunteers, such as faith-based agencies, Meals on Wheels, Hospice Northwest, etc.. Northwestern Ontario has higher proportions of populations accessing community services as a result of disease, advanced age, lifestyle factors and disability, than Ontario (refer to Template "D"). These individuals represent a tremendous burden for their families, the community and the health care system. Eighty percent (80%) of care in the community is provided by informal family caregivers. Further, seniors in First Nations communities face a disproportionately higher number of serious health problems than most Canadians (In Twenty Short Years, OCSA, 2001). Without Community Support Services, seniors and individuals with disabilities often over utilize high cost acute resources and/or may be institutionalized prematurely. Care in institutions for seniors is estimated to be ten times more expensive than care in an individual's home. However, the Community Support Service sector is extremely under funded resulting in a significant waiting list for services and precluding agencies from fulfilling their potential cost-effective role in the overall health system. Service gaps and waiting lists for Community Support Services are no less important than post-acute services delivered by CCACs. Therefore planning, funding and policy decisions of LHIN 14 must demonstrate that Community Support Services are core components of an integrated health care system for the Northwest LHIN. Despite the numerous and persuasive planning documents that have illustrated the need to prioritize these issues, they have historically been marginalized within the health care system. LHIN 14 is well-positioned to ensure that Community Support Services are funded to better reflect the reality of service needs. Individuals and families must be at the centre of the transformation agenda, and involved in all aspects of planning, decision-making, implementation and service delivery. Without investments in respite care services for family caregivers, supports for daily living, supportive/supported housing, transportation and other community-based supports, the government's transformation agenda cannot fully address the needs of older adults and persons with chronic disease and disabilities. Such an investment is in keeping with the broader determinants of health (e.g. nutrition, accommodation, poverty, social isolation, personal health practices, etc.). All Community Support Service Agencies must have the capacity for accessibility and accommodation for 		

language, communication and cultural differences.

High Level Action Plan:

- Dedicate Community Support Services planning responsibilities exclusively to one senior executive position within the LHIN.
- Establish strong effective linkages with existing community advisory networks for the dual purpose of advising LHIN 14 and acting as a communication conduit back to those bodies.
- Build the capacity of Community Support Services by allocating sufficient resources on a needs-based, multi-year funding model and ensure the sustainability of services for individuals and their families.
- Develop protocols, agreements and contracts across agencies to ensure seamless access to services for individuals that is community focused and the least intrusive.
- Implement an equitable, person-centred funding formula to ensure LHIN 14 residents have seamless access to the quality community support services that enable them to maximize their ability to function independently in their homes and communities.
- Establish incentives to maximize resources for complex, multi-jurisdictional individuals receiving services funded by various ministries to improve efficiencies and integration (e.g. aging people with physical, mental and/or developmental disabilities, increasingly complex needs of the frail elderly population living in the community, etc.).
- Identify minimum service requirements and develop plans and service structures to ensure that individuals who require respite services, Meals on Wheels, health related transportation, supportive housing and other community supports, will receive these services wherever they live within LHIN 14, including remote communities.
- Ensure linkages are established between federal and provincial initiatives related to Community Support Services for Aboriginal communities, in keeping with Treaties, culture and traditional healing.
- Advocate for equitable needs-based funding.
- Provide incentives for the development of creative partnerships and sharing of resources such as administrative functions and/or employees to respond effectively to the unique needs of smaller, isolated communities in the delivery of Community Support Services.
- Accelerate the efforts to address workplace leaves of absence for family caregivers who provide care for individuals with chronic and/or palliative conditions. Caregivers are stressed out and physically and mentally exhausted. Juggling jobs and family responsibilities put the health and economic security of family caregivers at risk. Loss of time at work is a loss in productivity to the community as a whole (In 20 Short Years, OCSA, 2001).
- Enhance the potential capacity for Community Support Services through the use of telehealth and video technologies.
- Encourage individuals and businesses to take responsibility for healthy lifestyles that prevent illness/disability. Healthier lifestyles, a cleaner environment and attention to the other broader determinants of health will reduce pressure and help sustain our health care system.

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

What is the current status?

In larger communities these activities have been initiated, however, they need to be enhanced significantly to realize full integration potential. In smaller and remote communities, services are seriously lacking.

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

The anticipated outcome will be a strengthened capacity in communities to provide the required community support services, thereby reducing the demand on more costly facility-based care.

Lead contact person:

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Title of patient care/service initiative: Services and/or care close to home.		Type of integration (more than one box can be checked) <input checked="" type="checkbox"/> Horizontal <input checked="" type="checkbox"/> Vertical <input checked="" type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:
Existing or new initiative? <input checked="" type="checkbox"/> Initiated/existing integration activity* <input type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	List of partners involved: Northwest Local Health Integration Network (LHIN 14) Steering Committee Ministry of Health and Long-Term Care Hospital Staff and Physicians Regional Cancer Centre Northern Diabetes Network Thunder Bay Regional Health Sciences Centre Regional Cardiac Services Lake of the Woods District Hospital Senior Administration	
Please briefly describe the initiative. The vision of care close to home. People in rural, remote communities will not be disadvantaged by their geographic location. Through planning and budgeting processes, the people in LHIN 14 can expect to have "close to home" services that will be based on community needs, recognizing that not all services can be provided within every community (e.g. MRI, CT Scan, dialysis). Key Components: Why is this important? <ul style="list-style-type: none"> • The Northwest is experiencing a decline in its population base. • The Northwest is experiencing a rapidly increasing aging population, many of whom have to leave their community to access LTC facilities in other communities, leaving their family and support systems, and relocating to communities at distances from 1 to 4 or more road hours away. Far Northwest has access by air only and at excessive costs because there are no LTC facilities in the Far Northwest. • In other areas of the LHIN, elderly people are reaching retirement, thereby increasing the number of elderly citizens who require care related to aging population. • The Northwest is experiencing an out migration of youth. • Some areas of LHIN 14 are experiencing an increase in the Aboriginal youth population, as evidenced by increased Aboriginal birthrate (which is well documented in statistics for the Kenora District). • The determinants of health indicate that individuals in the Northwest are experiencing a higher rate of suicide amongst their youth, diabetes is at epidemic levels, smoking and alcohol consumption are higher than the rest of the province, resulting in higher rates of lung cancer, cardiac illness, addictions issues, etc.. • Many of the Far Northern communities do not have basic health care services. Most do not have physician services, except for visiting physicians; their health centres are staffed by nurses. We need to ensure that professionals work appropriately within their scope of practice to provide these services. • People in rural, remote communities have to travel long distances, often during inclement weather and poor road conditions for approximately 6 months of the year. Many Far Northwest communities only have air access which may not be available due to inclement weather and therefore people are denied access in an expeditiously manner for emergency care or tertiary centre services. High Level Action Plan: <ul style="list-style-type: none"> • Increase protocols and regional policies that further assist in keeping patients who require emergency transfer closer to home. • Develop communication strategies that facilitate patient transfers from primary care facilities to tertiary care facilities within the geographical area that the patient resides, and which supports current interprovincial/international partnerships and transfer patterns. Design an automatic interface with hospital Admissions Discharges Transfer systems and registry that can provide timely information on available beds. Coordination and support from the federal government through non-insured health benefits needs to take place. • Stakeholders need to set the priorities for their communities based on the needs of the community. 		

- Stakeholders have to investigate possibilities of clustering and/or pooling of services/resources.
- Stakeholders have to work with other Ministry groups, such as the Ministry of Colleges and Universities, to be creative in addressing our health human resource needs (e.g. "Home Grown Professionals").
- Continue to develop the Telehealth Network to bring specialist services to communities. Funding mechanisms will need to be implemented, placing telehealth equipment in specialists offices to provide easy access to services by the people.
- Utilize successful models for programs such as Outreach Oncology to develop services close to home. This needs to be done through partnerships with community agencies and tertiary care centres.
- Develop a meaningful and collaborative communication strategy within LHIN 14 and between the tertiary centres (such as Thunder Bay, Winnipeg, International Falls) and the community hospitals.
- Increase ability for point of care testing at the community level.
- Increase utilization of Advanced Practice Nurses (Nurse Practitioners and Midwives) in the extreme northern communities.
- Repatriate acute care cases that can be safely and efficiently cared for in local, community hospitals with appropriate human resources.

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

What is the current status?

Currently care close to home is a reality for some services in some communities. Opportunities need to be explored through a regional planning effort to expand and provide the service specific to the needs of the people in their communities.

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

- The right services, delivered at the right time to the right people is desired by individuals living in northern, rural and remote communities.
- Models of care close to home have been developed and been successful. These need to be mirrored and expanded.
- A cookie cutter approach across the province will not be the solution to many communities' healthcare needs.

Lead contact person:

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Title of patient care/service initiative: First Nations/Aboriginal Health - LHIN 14.		Type of integration (more than one box can be checked) <input checked="" type="checkbox"/> Horizontal <input checked="" type="checkbox"/> Vertical <input checked="" type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:
Existing or new initiative? <input type="checkbox"/> Initiated/existing integration activity* <input checked="" type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	List of partners involved: Aboriginal Health Access Centres Thunder Bay Aboriginal Interagency Council Northern Ontario School of Medicine Nishnawbe Aski Tribal Council Treaty Three Tribal Areas Kenora Chiefs Council Robinson Superior Treaty Area Ministry of Health and Long-Term Care First Nations and Inuit Health Branch Northwestern Ontario Hospitals Community Care Access Centres Northwestern Independent Living Services	
Please briefly describe the initiative. Key Components: <ul style="list-style-type: none"> • First Nations and Aboriginal peoples must have a role in the governance of health programs and services in agencies and institutions. • Patient care and services must include the wholistic approach through all the developmental stages of life which will guide Aboriginal health programs and services. • To provide a coordination of services, recognizing the cross sector services within the overall health system. High Level Action Plan: LHIN 14 <ul style="list-style-type: none"> • To ensure a mechanism for meaningful Aboriginal participation of health planning, including development of policies, programs, services, allocation of resources and selection of representatives on LHIN planning bodies. • To develop a series of protocols between First Nations/Aboriginal communities, health authorities, Aboriginal health access centres and the LHIN 14 Board to clarify roles, responsibilities, facilitate planning, and support co-ordination of regional health programs and services. • To develop a system for ongoing assessment and evaluation of First Nation/Aboriginal health status, including socio-economic indicators, and this must be jointly developed to facilitate planning and resource allocation. • To develop a system for joint assessment and evaluation of existing First Nation and Aboriginal health programs and services as well as mainstream health programs and services serving Aboriginal peoples. • Health Care programs and institutions providing services to Aboriginal people must create an Aboriginal responsive health care system which includes cultural interpreters, translators, Aboriginal health advocates, Aboriginal navigators, cross cultural training of health professionals and the provision of culturally appropriate health care. • To develop a comprehensive action plan integrating traditions, values, culture, practices and languages of Aboriginal peoples in Northwestern Ontario. A comprehensive action plan will support and facilitate Aboriginal healing and practices in the continuum of care. • To develop a culturally specific continuum of care based on the World Health Organization model framework; health promotion, disease prevention; community needs based screening; diagnosis; treatment; follow up/recovery/rehabilitation/long-term care; palliative care; training; infrastructure. • To ensure First Nation and urban Aboriginal peoples' meaningful participation in the design, development, implementation, and evaluation of the LHIN 14 action plan. • To acknowledge and respect an Aboriginal person's choice of services. Traditional Aboriginal approaches to wellness, including the use of traditional resources, traditional healers, medicine people, midwives and elders are recognized, respected and protected from government regulation. They enhance and complement 		

- mainstream programs and service.
- Equitable access to provincial and federal health services must be assured for all Aboriginal people, regardless of residency.
- To ensure that quality of care is foremost.

<p>If this is an initiated/existing activity... What is the current status? Recommendation: To review and adapt the components of the Aboriginal Health Policy - New Directions that are consistent with Patient Care services.</p>	<p>What are the outcomes/lessons learned (if any)?</p> <ul style="list-style-type: none"> • Acknowledgement and recognition of Aboriginal approaches. • Federal/Provincial linkage is going to take time.
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<p>Lead contact person:</p>			
<p>Name:</p>	<p>Judy Morrison</p>	<p>Organization:</p>	<p>Weechi-It-Te-Win</p>
<p>Title:</p>	<p>Community Liaison Worker</p>	<p>Email address:</p>	<p>jamorrison@yahoo.com</p>
<p>Telephone:</p>	<p>807-274-3201</p>		

Templates B/C: Administration Support Services Integration Initiatives and Priority Setting

B/C-1. Description of Administrative Support Services Integration Initiative

Title of administrative support service initiative: System sustainability through multi-year funding.		Type of integration (more than one box can be checked) <input checked="" type="checkbox"/> Horizontal <input checked="" type="checkbox"/> Vertical <input checked="" type="checkbox"/> Intersectoral <input checked="" type="checkbox"/> Other, describe: Federal and Provincial Ministries
Existing or new initiative? <input checked="" type="checkbox"/> Initiated/existing integration activity* <input checked="" type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	List of partners involved: Financial managers in various health care sectors Senior health care administrators LHIN 14 attendees Rainy River District Mental Health Network Fort Frances Interagency Committee Kenora-Rainy River District Addictions and Mental Health Network	
Please briefly describe the initiative. Key Components: System Sustainability Issues Specific to LHIN 14: <ul style="list-style-type: none"> • Creation of a flexible funding formula that will ensure LHIN 14 can design services that meet our needs. • An equitable funding system cannot be population based – Template D outlines demographic considerations specific to LHIN 14 which result in higher-cost health care (vast geographic area, low population, severe physician shortage, LTC beds fully utilized, higher operating/capital costs for similar services compared to Southern Ontario) – LHIN 14 requires higher funding on a per capita basis than other LHIN's. • Bringing several under-resourced sectors together prematurely is doomed to failure. Importance of getting the funding for our LHIN sooner versus later – we require early and priority attention to stabilize the sectors to avoid defensive conflicts among the stakeholders. • Recognized need for both reallocation and increased resources. Current programs are at or over capacity in most sectors; capacity needs to be addressed by adequate funding adjustments to sustain service levels to our population. System Sustainability Issues Pertaining to All LHIN Regions: <ul style="list-style-type: none"> • Any per capita rate must be weighted (at a minimum) with a number of factors including: demographics, factors associated with the determinants of health (e.g. education, income, nutrition, housing, etc.), health promotion/disease prevention, labour/service costs, and utilization patterns. • Limited effectiveness of this initiative without Drug Plans, OHIP, and Rehabilitation funding – Ministry must combine all funding envelopes. • Multi-year funding commitment to ensure service commitments and expectations can be long-term. • Need for financial incentives to advance health goals and ensure affordable health care. • Financial risk is an important LHIN management activity. • Choice of provider payment method. Funding should not always go to the lowest bidder in the competitive bidding process for health care services; cost of services should only be one factor in the various factors to be considered in the selection process. Integrating All Funding Silos: <ul style="list-style-type: none"> • Allocation must be person – centered and ensure resources follow the individual. • Some sectoral funding envelopes may need to be protected (Ring-fencing) for some time. • Reallocation mechanisms to ensure resources can be moved easily between existing envelopes within agencies as well as across sector boundaries. Current Ministry practice is to fund different sectors in silos – need a system where the LHIN can allocate funds between sectors according to the real needs of the LHIN region – this system would include the ability to access federal funding currently allocated for First Nations Manitoba, and Quebec. • An equitable funding system ensures funding equity between all health care sectors (including community-based services); this will enable consistent delivery of services across the region - a mechanism will have to be developed to flow funds to communities and institutions. 		

- Pluralistic financing opportunities exist that have potential to provide both the mechanisms and source(s) of funding.

High Level Action Plan:

System Sustainability Issues Specific to LHIN 14:

- Develop a sustainable funding mechanism specific to LHIN 14 with the assistance of the expertise of a Consultant.
- Tinker (Ministry) with the formula from time to time due to significant changes in the variables on which the formula is based or when quantifiable evidence suggests there are unmet needs.
- Create (Ministry) transitional-funding envelopes both to stabilize under-resourced Sectors (e.g. Addiction and Mental Health) and prevent chaos and gaps in service.
- Base budgets in all Sectors require the development of annual adjustments indexed to the Inflation rate at March 31st.
- Stop the practice of prescriptive and rigid Federal/Provincial priority funding (e.g. Mental Health Accord funding does not fit very well with Regional priorities).
- Development of measurable funding targets and benchmarks to ensure we can determine the extent that overall goals and reallocations have been met.

System Sustainability Issues Pertaining to All LHIN Regions:

- Establish longer terms for Transfer Payment Agencies, Operating Plan Processes and Request for Proposals (e.g. 3, 5, 7, 10 yrs).
- Stop the practice of funding Pilot, Demonstration and One-time Projects that result in direct services to people. Do support initiatives with a phase that promotes innovation and partnership.
- Create incentives to move towards new System by (Ministry) placing 1 year Moratoria on: Operating Plan Processes, flowing New funding, and responding to Special Interest political pressure.
- Legislation (Federal and Provincial) to ensure all Basic Services are provided by our LHIN without financial implications to consumers.
- Create shared risk pool for all LHINs and pay premiums to cover catastrophic losses.
- Liability for deficits, but permit to retain operating surpluses – not generated at expense of access, quality or outcomes. The retention of operating surpluses will assist in enabling multi-year capital planning.

Integrating All Funding Silos:

- Allow for Global movement of funding between staffing, supplies, and administration for all Transfer Payment Agencies and Ministry allocation streams (include ability for Inter-Ministerial flow of funds).
- Build on incentives to savings via administrative efficiency and surplus that can be reinvested in clinical resources, contingency management, and implementation of relevant Ministry Best Practices recommendations.
- Ensure mechanism(s) developed to create capacity/opportunity to provide access across Primary - Tertiary continuum in the Region.
- An equitable funding system needs to address administrative, information technology, replacement/retrofit, staff training, and travel costs. Assess the cost of compliance (especially for smaller organizations/communities) of Ministry back-room and regulatory expectations.
- Establish sustainable funding systems to assist in retention of staff over the longer term; this includes progressive employment levels and ongoing staff training.
- Ensure funding continues for Underserved Area Program incentive grants and Site-visiting (HR priority).
- First Nations to negotiate funding/pooling of resources of 4 – levels (Federal, Provincial, Local, and First Nations) to improve effectiveness.
- First Nations to develop mechanisms to flow funding to community level.
- Explore/Research alternative sources of funding to provide or supplement the Basic Funding for our LHIN including: Behavioral Insurance Tax, Disability Management, First Ministers Accord, Natural Resource Extraction (%), Private Insurance, Provincial Health Care Premium, Respite Care (tax credit/%) and User Fees.
- Create opportunity for Health Practitioners to form Health Team(s) to provide for a comprehensive range of services and negotiate accountability/funding with the LHIN (decentralized payment schemes).

<p>If this is an initiated/existing activity... What is the current status?</p> <p>Work on these issues has been proposed/underway for some time on an ad hoc or Sectoral basis, but not in the comprehensive and systemic manner proposed here. Some examples of this include: Integrated Delivery Systems Thinktank (July'96), Ontario Nurses' Association lobbying, resolutions of the Kenora-Rainy River Addiction and Mental Health Network, Senate Committee Reports on Mental Health, Mental Illness and Addiction, Submissions to the Standing Committee on Finance and Economic Affairs, work of the Joint Policy Planning Committee (Ont. Hospital Association) on rates, and workdone on capitation for Comprehensive Health Organizations.</p>	<p>What are the outcomes/lessons learned (if any)?</p> <p>There is a high level of consensus and support for this initiative based on the results of the Community Planning Workshop and input from the broad spectrum of stakeholders we have heard from. Getting the financing right from the outset is clearly a high priority and crucial to the success of the other initiatives of LHIN 14 so we have tried to echo/incorporate the financial advice from all of them into this report. However, we must also note that there is strong and lingering sense of cynicism that these proposals will be rejected by stakeholders vested in the status quo, or resisted by the Ministry of Health and Long-Term Care.</p>				
<p>Lead contact person:</p> <table border="0"> <tr> <td data-bbox="105 646 673 741"> <p>Name: Jon Thompson Title: Director Telephone: 807-274-4807 Fax: 807-274-4833</p> </td> <td data-bbox="779 678 1494 741"> <p>Organization: Riverside Community Counselling Services Email address: j.thompson@rhcf.on.ca</p> </td> </tr> <tr> <td data-bbox="105 772 673 867"> <p>Name: Barry Potter Title: VP Finance & Corporate Services Telephone: 807-343-2422 Fax: 807-345-4994</p> </td> <td data-bbox="779 804 1274 867"> <p>Organization: St. Joseph's Care Group Email address: potterb@tbh.net</p> </td> </tr> </table>		<p>Name: Jon Thompson Title: Director Telephone: 807-274-4807 Fax: 807-274-4833</p>	<p>Organization: Riverside Community Counselling Services Email address: j.thompson@rhcf.on.ca</p>	<p>Name: Barry Potter Title: VP Finance & Corporate Services Telephone: 807-343-2422 Fax: 807-345-4994</p>	<p>Organization: St. Joseph's Care Group Email address: potterb@tbh.net</p>
<p>Name: Jon Thompson Title: Director Telephone: 807-274-4807 Fax: 807-274-4833</p>	<p>Organization: Riverside Community Counselling Services Email address: j.thompson@rhcf.on.ca</p>				
<p>Name: Barry Potter Title: VP Finance & Corporate Services Telephone: 807-343-2422 Fax: 807-345-4994</p>	<p>Organization: St. Joseph's Care Group Email address: potterb@tbh.net</p>				

Title of administrative support service initiative:		Type of integration (more than one box can be checked)	
Northern Information and Communications Technology (ICT) Planning		<input checked="" type="checkbox"/> Horizontal <input checked="" type="checkbox"/> Vertical <input checked="" type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:	
Existing or new initiative?		List of partners involved:	
<input checked="" type="checkbox"/> Initiated/existing integration activity* <input checked="" type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>		<p>The Northern ICT Blueprint (Phase 1) involved 52 agencies covering 7 sectors: all Northern Ontario hospitals (40), Community Care Access Centres (9), Community Health Centres (6), Regional Cancer Centres (2), specialized inpatient mental health facilities, educational providers (e.g. Northern Ontario School of Medicine) and existing ICT initiatives (NEON, NORrad and Northwest Health Network). A proposed Phase 2 would involve over 200 agencies covering eight sectors: Mental Health and Addictions, Long-Term Care, Primary Care, Public Health, Children's Rehabilitation and Private Laboratory and Diagnostic sectors. Due to the scope of such a project, an additional phase may be necessary to include all other sectors of the health system</p> <p>Phase 1 engaged a workgroup comprised of 34 individuals from across the entire North as well as numerous attendees of workshops held across the North.</p>	
Please briefly describe the initiative.			
<p>The <i>Northern Information and Communications Technology Blueprint</i> (ICT) planning initiative involves the following goals:</p> <ul style="list-style-type: none"> • A common vision and strategic blueprint for action for ICT in Northern Ontario. • Improving the coordination, quality and consistency of healthcare delivered to clients through the provision of electronic health information to clinicians. • Utilizing collective, aggregate data to assist LHIN partners in evaluation, planning, and further system development of LHIN 14 health services to design an infrastructure which supports the development of improved disease management strategies. • Building on the work done to date by the Northwest Health Network, CCACs and others. 			
Key Components:			
<p>The following core strategies form the foundation of the Northern Ontario ICT Blueprint:</p> <ul style="list-style-type: none"> • Build the Northern Electronic Health Record (HER) that will support patient referral patterns and leverage current investments. • Build the content of the organizational EHR across all sectors to include advanced clinical applications. • Address requirements of integrated services (e.g. oncology, mental health, dialysis). • Integrate the diagnostic components/PACS. • Invest in technology for the regional EHR across the continuum of care. • Support work effectiveness. • Implement decision support and business systems. • Leverage web-based technologies. • Respond to consumer needs and consider access requirements (e.g. culturally deaf). • Support research and education. • Build the infrastructure. • Leverage current and future investments and technologies. • Optimize available funding. • Establish and maintain a strong, effective governance structure which oversees projects of common interest to both the Northwest and Northeast. A Northwest ICT Steering Committee will oversee implementation in the Northwest. 			

High Level Action Plan:

- Build upon the work of the *Northern Ontario Information and Communication Technology Blueprint*. Use the Blueprint as a strategic document.
- Expand work that was done in the Northern Ontario ICT Blueprint to include the broader health system. (Phase 1 included hospitals, CCACs, regional in-patient mental health programs, regional cancer centres, and current regional ICT initiatives. Phase 2 would include sectors beyond these agencies).
- Integrate current initiatives with Keewaytinook Okimakanak K-Net telehealth and ICT initiatives.
- Identify opportunities to partner and strengthen ICT linkages between Northern healthcare providers and sectors.
- Coordinate and manage strategic parallel processes that may be occurring in ICT to ensure integration and coordination.
- Obtain and optimize funding opportunities through various sources.
- Broadly communicate findings of the *Northern Ontario Information and Communication Technology Blueprint*.

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

What is the current status?

The Northern ICT Blueprint has been finalized and supported by the three sponsoring Northern District Health Councils as well as the Northwest Health Network. The plan is being submitted to the Ontario E-Health Council, the North Region Branch of the MOHLTC, FedNor and the two Northern LHINs.

An interim Northern ICT coordination body is being established to further a number of proposals to the MOHLTC's E-health Office and Canada Health Infoway that are a direct result of the planning project.

The Northwest Health Network has developed and implemented shared PACS and is in the process of implementing a regional EHR.

Thunder Bay Regional Health Sciences Centre and St. Joseph's Care Group currently share an information services department. Other parallel processes are occurring with CCACs and with regional organizations.

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

The following outcomes/lessons were learned through the process:

- Importance of leveraging existing investments.
- 'Champions' to drive the process are pivotal.
- Creation of a compelling vision can drive the process and foster buy-in.
- Importance of communication.
- Importance of strategically positioning the Northern ICT project with the e-Health Strategy with both levels of government (federal and provincial).
- Successful ICT ventures (such as NORTH Network) can catapult the success of other projects due to its compelling vision and demonstrated success.
- Core infrastructure components such as bandwidths are essential.
- Adequately resourcing ICT is important (e.g. financial and HR) and should not come at the expense of other pressing health system needs.

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Title of administrative support service initiative:		Type of integration (more than one box can be checked)	
Regional (Distributed) LHIN Education Strategy.		<input checked="" type="checkbox"/> Horizontal <input checked="" type="checkbox"/> Vertical <input checked="" type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:	
Existing or new initiative?		List of partners involved:	
<input type="checkbox"/> Initiated/existing integration activity* <input checked="" type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>		Hospitals CCACs Community Support Service Agencies Long-Term Care Homes Post-Secondary Educational Institutions (College, University) Mental Health & Addictions Service Provider Organizations throughout 3 Districts Municipalities First Nations Public Health Units	
Please briefly describe the initiative:			
<p>Goal of the Strategy: To improve the quality of and access to health care services for people living in Northwestern Ontario by implementing a coordinated, regional, distributed (decentralized), education strategy that targets interdisciplinary health care providers, and the general public.</p> <p>Rationale:</p> <ul style="list-style-type: none"> • The existence of a regional distributed education strategy underpins and supports the short term and long-term success of all LHIN system integration initiatives in Northwestern Ontario. • Having a well educated health care workforce and a population that knows how to use the health care system appropriately will contribute to building healthy communities, strengthening community based service delivery, and creating sustainable health care systems in Northwestern Ontario. • Implementing a Regional Education Strategy is integral to the success of the Health Human Resource Strategy. <p>Existing problems include:</p> <ul style="list-style-type: none"> • The general population lacks knowledge about the number and nature of our health care resources, and how to access services, community-based models of service delivery, and the roles of traditional and non-traditional providers. • There is a shortage of qualified Human Resources in all health disciplines in Northwestern Ontario. • The Health Human Resources shortage is expected to grow in the next 5 years due to retirements and relocations of the existing workforce. This workforce needs to be replaced. • Citizens interested in working in the health care professions and related human service fields lack access to education in their home communities that will prepare them for this work. • Health care providers lack access to education to upgrade their qualifications, for example, undergraduate and graduate degrees, certificates, diplomas and professional certifications. • Health care providers lack access to a full range of educational opportunities for continuing professional development. Education is needed to maintain professional certification and to ensure providers have up to date knowledge of best practices in their field. Access is particularly difficult for providers working in isolated communities. Both interprofessional and discipline specific education is needed. • There is a lack of coordination and articulation between educational programs currently provided through Lakehead University and Confederation College. • There is lack of coordination between the Ministry of Health and Long-Term Care and other funders for health education initiatives. • No one has responsibility and is accountable to develop and implement a comprehensive and coordinated regional strategy to provide interprofessional Health Human Resources education in Northwestern Ontario. 			

High Level Action Plan:

To form a partnership/consortium of stakeholders to develop and implement a comprehensive and coordinated regional educational strategy to provide education that meets the needs of current and future health care providers, and the public in Northwestern Ontario. Lakehead University, through the Faculty of Professional Schools and the Office of the Dean, is willing to take leadership and responsibility for facilitating this process. Senior administrators, on behalf of the following organizations that have an education mandate, have stated support for the Regional Education strategy: Lakehead University; Confederation College; Northern Ontario School of Medicine; Thunder Bay Regional Health Sciences Centre and St. Joseph's Care Group. Education providers will work with health care organizations, providers and the LHIN Board in providing education that is distributed across the region (see list of partners).

A regional education evaluation needs to be conducted that includes:

- An environmental scan to identify what education is currently being offered, where, by whom and using what modalities (e.g. web, face to face).
- A review of relevant existing studies and needs assessments to see what is known already.
- An educational needs assessment to identify needs for and delivery methods in preservice education, (undergraduate), postgraduate education and continuing professional education.

An ongoing regional education plan (e.g. 5 yr, 10 yr, 15 yr, etc.) needs to be developed, including plans for funding and ensuring that resources are available over the period of the plan. The goals of the plan will be:

- To prepare people for their first professional degree or certificate in the health disciplines or related work (nursing, social work, psychology, lab technicians, PT, OT, nutrition, etc.).
- To prepare people with advanced, postgraduate or specialist degrees in the health professions (nursing, social work, psychology, public health, MD residency).
- To provide interprofessional and discipline specific continuing education (broad range of courses, topics and modalities). One example is the proposal to develop a Northwestern Ontario Regional Bioethics Program.
- To provide public education (clients, families and communities) on the nature of the health care system, the role of providers and services. Use this to also recruit young people into the health professions.

The educational needs identified throughout the other LHIN integration initiatives should be considered PRIORITY AREAS when planning the education strategy.

The LHIN board and Ministry of Health and Long-Term Care need to work with other Ministries and levels of Government (e.g. Ministry of Northern Development and Mines, Ministry of Colleges and Universities, Ministry of Community and Social Services, FedNor, Health Canada, HRDC) to devise strategies for sufficient and sustainable funding for health education in Northwestern Ontario.

It is anticipated that education will need to be subsidized because the low numbers of students, the great diversity of needs and the geographical challenges of distributed education will not make delivery of the education cost effective for the educational institutions.

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

What is the current status?

Resources in Place:

- Existing educational offerings of Lakehead University, Confederation College, the Northern Ontario School of Medicine (including HSN), Regional Health Care Facilities and organizations and distance education capacities.
- Existing technology, e.g. NORTH Network (videoconferencing).

Resources Needed:

- LHIN funding for a coordinator to develop a plan for a regional education strategy.
- Funding to ensure sustainable delivery of education on a long-term basis.

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

- A strong consensus among all the Health Care organizations and providers throughout the districts of the need for an education plan to address quality service delivery and recruitment/retention of Health Human Resources.
- A strong willingness and commitment from education providers to co-operate in developing a regional education plan (written support has been obtained from Lakehead University, Confederation College, Northern Ontario School of Medicine, St. Joseph's Care Group and Thunder Bay Regional Health Sciences Centre).
- Lakehead University willing to facilitate the development of a plan.

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B/C-4. Description of Administrative Support Services Integration Initiative

Title of administrative support service initiative: Keeping LHIN 14 (Northwest) local and accountable to its residents.		Type of integration (more than one box can be checked) <input checked="" type="checkbox"/> Horizontal <input checked="" type="checkbox"/> Vertical <input checked="" type="checkbox"/> Intersectoral <input checked="" type="checkbox"/> Other, describe: Needs Manitoba, Quebec, Ontario, Canada and Aboriginal negotiation to establish appropriate funding for adequate services
Existing or new initiative? <input type="checkbox"/> Initiated/existing integration activity* <input checked="" type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	List of partners involved: CCACs LTC Centres Physicians Community Health Organizations Public Health Ministry of Health & Long-Term Care Hospitals FHNs & FHGs EMS Community Support Services Mental Health Private Facilities CHCs Aboriginal health organizations First Nations services Federal nursing stations Individuals seeking services	
Please briefly describe the initiative: Key Components: Regional inequities exist within health care service delivery in Northwestern Ontario with one large urban centre, several small towns, rural hamlets and 28 Aboriginal fly-in communities. For these 28 fly-in communities, the nearest hospital, accessible by air only, has emergency flight turnaround times of 3-8 hours to fly the 300-600 km distance. Some small rural centres (e.g. Armstrong) and First Nations communities do not have 24 hour medical or nursing service. Weather and geographical isolation/distance create diverse needs in public transportation; accessibility, affordability, and acceptability of health services; income and social status; education; employment; and physical and mental health. Meanwhile the cost of living, distance to travel, and difficulties in communication increase. Facilities and providers delivering curative, preventive and rehabilitative services suffer recruitment and retention issues that affect quality of care. LHIN mechanisms must be local to address the realities of the Northwest, especially the poor health status of Aboriginal Peoples and the health needs over this vast geographic area. Accountability to the residents is required by having: <ul style="list-style-type: none"> • A population-health needs model for funding allocation and service provision • Integrating physicians, drug plans, and other Ministerial departments (e.g. Ministry of Community and Family Services, Education, etc.) to provide seamless service. • Integration of Aboriginal people into the LHIN will be facilitated by addressing culturally appropriate protocols since the methods used to date are not considered by Aboriginal peoples as constituting consultations. • Board membership that reflects the diverse population of the Northwest including geographic dispersion, Aboriginal diversity and numbers, and population-health needs. • An independent third party evaluate the Board using population health outcomes, determined by the residents within a population-health model, and communicate the results to the LHIN 14 residents annually. • A mechanism devised to help residents navigate the LHIN processes • The needs of smaller rural centres recognized for providing quality services in multiple diverse cultural areas (i.e. avoid “one size fits all” approach) • Opportunities for meaningful engagement of all residents, including Aboriginal people, in planning and funding mechanisms. 		
High Level Action Plan: Government requirements: Collaborate with Ministry of Health and Long-Term Care, First Nations, Statistics Canada, First Nations and Inuit		

Health Branch, Indian and Northern Affairs Canada to improve demographic data for on- and off-reserve Status and non-Status Indians as well as other reserve residents.

Collaborate with the Ministry of Health and Long-Term Care, Manitoba Health and the Canadian Institute for Health Information to improve the health of LHIN 14 residents by providing health information for individuals routinely traveling to Manitoba for primary and tertiary care.

Set province-wide standards for service delivery with appropriate funding:

- All Ontarians can access physicians and hospital services for emergency primary health care within 120 minutes (British Columbia set 90 minutes).
- Time limits for access for emergency, urgent and non-urgent primary, secondary and tertiary care need to be established for the entire province.
- Person-centred care allows the individual to select the provider (ring of rings) – Appendix B/C-4.1. Appendix B/C-4.2 shows the local health care system as it plays out in personal action regarding health.
- Designate the number of physicians needed in each LHIN, beginning with the LHINs which have the highest number of people with poor health status and greatest need: NW and NE. Ensure physician relocation to areas of highest need by providing physician funding directly to the LHIN; doctors wishing to bill OHIP for their services must work within that LHIN. Limit the number of MD licenses available within major centres, much as BC has done.
- Measure the success of local integration through community-based health outcome measures and indicators designed in the local areas.
- Combine central (hospital) and community-based processes of service delivery, governance and priorities by utilizing the Community Health Centres model of health services; these already integrate multiple salaried partnerships within governance. Expand these to include other cultural-specific providers.
- Individuals must be able to go from home to facilities and return home in a seamless system; this requires individuals have access to affordable choices and be in-charge of selecting the options.
- Funding for LHINs be based on access to services (e.g. travel costs, distance, and weather).

Local requirements:

- Invite Minister Smitherman to visit and stay in several towns, villages and remote First Nations communities.
- Create and/or get buy-in from sub-networks, by using service catchment areas, communities and advisory committees, to feed direction to the LHIN and seek an accountability loop.
- Communications including consultation, feedback, information, updates and community forums to be held with the public about LHINs, in facilities and settings, and through regular news items in newspapers, on radio and TV, websites.
- Interpreters and medical translation available 24/7 in all facilities for non-English speakers
- Rotate Board meetings between the large urban setting, smaller towns, rural and remote communities.
- Have the LHIN Board office decentralized and use phone, fax, e-mail to promote accessibility to residents of the LHIN.
- Form sub-regional networks based on natural referral patterns and relationships to provide input to LHINs Board (e.g. Red Lake, Sioux Lookout, Dryden, Fort Frances, Geraldton, Thunder Bay, Big Trout Lake for 8-10 surrounding communities, etc.).
- Provide mobile services to catchment areas such as Red Lake, Sioux Lookout, Dryden, Fort Frances, Geraldton, Thunder Bay, Big Trout Lake for surrounding 8-10 surrounding communities.
- Provide more services at home where possible (e.g. dialysis, long-term care).
- Utilize and support technology (e.g. telehealth) for isolated areas, as an adjunct to provision of basic health care services delivered by physicians in communities.
- Honour natural referral patterns of people to use their nearest or most convenient service centre.

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

What is the current status?

N/A

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

Keeping LHIN 14 local and accountable is a major challenge for all Northwestern Ontario residents. This needs to be contextually considered with templates A/C-6 First Nations/Aboriginal Health – LHIN 14 and B/C-6 First Nations/Aboriginal needs-based funding.

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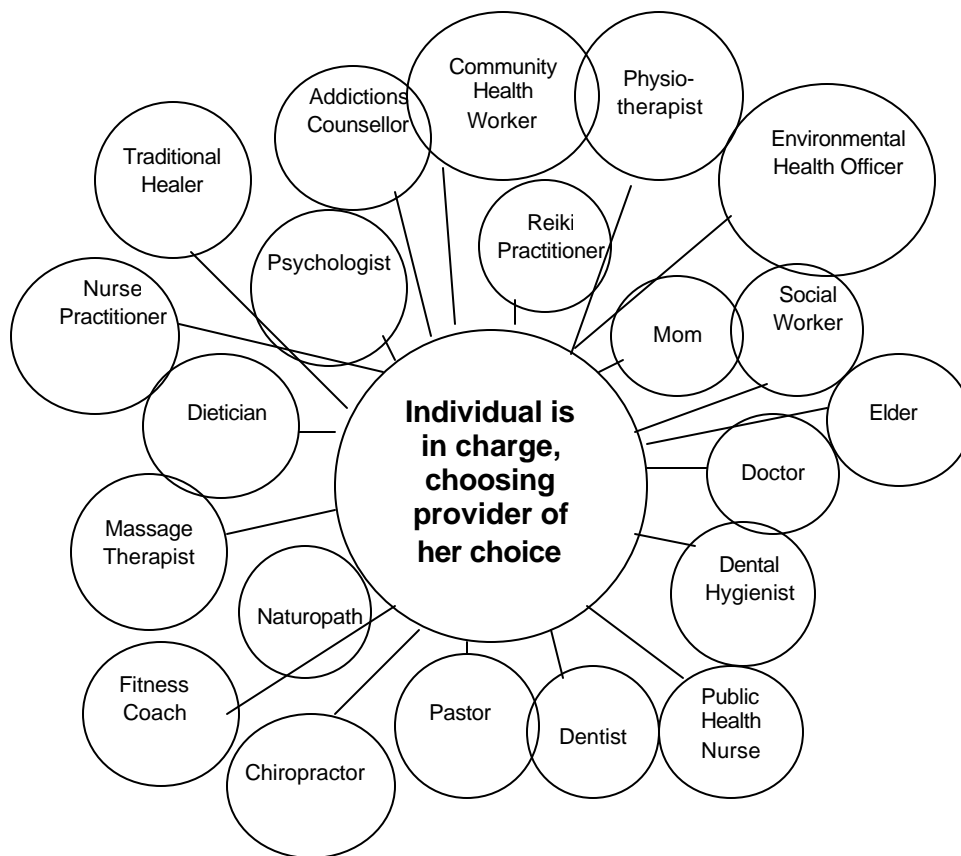
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Organization: Matawa Tribal Council
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Appendix B/C-4.1: Keeping LHIN 14 local and accountable to its residents

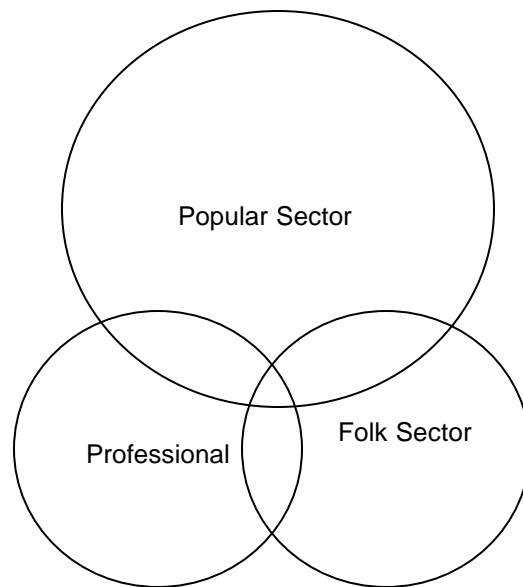
Ring of Rings Model



If all formal health care providers (HCP) are independent practitioners under law, working within their scope of practice, and all HCP are equally accessible, the individual can make a choice. Family and community play a significant role in determining what is managed at home and what requires professional assistance. The individual chooses HCP based on whom she would rather approach for examination, treatment, referral, consultation, discussion, etc.. Individuals ask the HCP for their input instead of provider-directed case-conferences. This model truly puts health back into the hands of individuals, creating self-reliance instead of dependency on HCPs and a system. This will need a transition period for development and implementation since dependency has been encouraged and expected under the current regime.

Appendix B/C-4.2: Local Health Care System: Internal Structure

Kleinman, 1980



This anthropological view of health is seen in cross-cultural exploration. The popular sector forms the largest portion of health care. In this area, we see the shared meaning of illness. Families, friends and neighbors help to define illness, label it and treat it or normalize the experience to something which is not illness. In this sector, the most used sector of health care, we see the value of diet, herbs, rest and patent medicines as society deals with illness through its own resources. Throughout this definition of illness, the support and caring is provided by significant others. Depending upon the perception and subsequent success of normalization or labeling and treatment, further choices are provided to the individual: folk or professional services. The professional sector includes bio-science based health care personnel (e.g. physicians, psychologists, social workers, etc.) and the organizations in which these people work. The folk sector includes non-professional specialists (e.g. hypnotists, elders, traditional healers, herbalists). An individual's decision as to which service to use will vary depending upon the supports from within the popular sector (e.g. the sub-society in which she lives). In the areas of overlap you have health care providers such as massage therapists, chiropractors, naturopaths, and osteopaths who move (or are pushed by system recognition or de-recognition through system-funding) from one sector to another. In communities and families we see professionals such as nurses and occupational or physiotherapists fulfilling roles in the professional as well as the popular when their advice is sought to define problems and to manage these outside the costliness of physician-based services.

Title of administrative support service initiative:		Type of integration (more than one box can be checked)	
Integration and Coordination of Health Human Resources Planning.		<input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input checked="" type="checkbox"/> Other, describe: requires info from all parts of the system & provides info to all	
Existing or new initiative?	List of partners involved:		
<input type="checkbox"/> Initiated/existing integration activity* <input checked="" type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	<p>All of the individuals and organizations present at the initial workshop. More specific input was gathered within small group who volunteered at the workshop.</p> <p>Going forward, this initiative will require input from all sectors, all organizations and many stakeholders.</p>		
Please briefly describe the initiative:			
Key Components:			
<p>Without appropriate healthcare human resources, the region cannot provide the services and level of care required by the system (integrated or not).</p>			
<p>Current levels of resources and their allocation limit the services available, in some cases. Much planning is currently done by individual organizations and agencies trying to make themselves the 'employers of choice' but this often makes the problems of scarce resources even worse in such a competitive environment.</p>			
<p>This Integration and Coordination of Health Human Resources Planning is an opportunity to look at needs of the region regarding Human Resources and an opportunity to be better able to plan the utilization of current resources and more efficient/effective recruiting and training.</p>			
<ul style="list-style-type: none"> • Planning already done by individual organizations and DHC, but LHIN would need to understand all healthcare HR requirements of region, starting with severe shortages/bottlenecks of system. • Could be opportunity for regional recruitment activities. • Would be able to compare bottlenecks in the system to shortages in Human Resources (e.g. shortages in Diagnostic Imaging human resources). • Before making plans for integration/new programs, etc. need to understand current HR situation and what is needed. • Coordination is KEY – understanding how shortages impact various organizations and across the region. • Help promote health careers within the region, which is a very serious challenge in the North. • Can work with youth to encourage training for health careers. • Succession planning for all healthcare positions (those with specialized skills – e.g. technicians, lab, etc have great impact on whole system). • LHINs could then provide information to Ministry of Education regarding needs for training courses and numbers of spots etc.. • Mentorship programs could be developed across professions and across the region. • Increased integration may require more equity in wages for the same profession but different centres/organizations. • Need to ensure that funding continues for recruitment and retention efforts (e.g. UAP incentive grants, site visit funding) and perhaps new incentives, etc. be developed that are unique to the region. 			
High Level Action Plan:			
Assess Current Resources:			
<ul style="list-style-type: none"> • Begin by understanding the current situation – approach the various communities and agencies/organizations in each community and determine the critical shortages (any surpluses), status of current levels and any known future changes. This data needs to be collected and retained for future analysis etc.. • As part of understanding the current situation, ensure that a comprehensive survey of the Aboriginal health 			

- human resources is completed (including all aspects of whole life care).
- Special attention should be made to the quality of care available with current resources.
- LHIN 14 should develop a platform for networking and building relationships starting sector by sector and then moving to a system wide collaboration.

Build Capacity:

Collaboration:

- Individual organizations need to continue to improve working environments and recognize the needs of their employees BUT collaborative approaches are more likely to provide long-term, system-wide solutions.
- LHIN 14 needs to develop mechanisms to encourage providers to think collectively, and to encourage better use of scarce resources by more effective sharing, collaboration and regionalization of programs.
- LHIN 14 can also suggest possible collaborations based on the information they may have collected from various organizations and communities.
- LHIN 14 should ensure that any incentives etc are designed to reward innovation and collaboration.
- Work with region to make collaboration a competitive strategy.

Education:

- Coordinate the human resource needs with the education and training being provided within the region and within the province and work with the action plan for the education priority (B/C-3).
- Provide the Ministry of Education with information regarding needs for local training courses (those trained in region tend to stay in region to practice) and for appropriate numbers of spots for postsecondary training courses.
- Promote health careers within the region and work with youth to encourage training for health careers.

Licensing Bodies and Labour Organizations:

- In an effort to breakdown the barriers created by: collective agreements, turf wars amongst professions, and lack of understanding of the overlap in education between disciplines, LHIN 14 should facilitate collaboration among regulatory bodies and across sectors to explore scope of practice issues, and should work with unions representing employees.
- Standards for entry to practice and the scope of practice, developed largely by professional bodies, need to be reviewed as to the practical, effective and coherent application in the North. LHIN 14 should support a strong evidence-based needs assessment to be completed before action is initiated.
- Employment stability should remain a high priority when planning for LHIN 14 services and therefore, comprehensive, enforceable employment security agreements should be a part of the LHIN 14 planning initiatives. LHIN 14 should consult with the labour organizations that represent employees and other stakeholders.
- Work with various labour organizations to develop better wage equity across professions - currently different organizations have very different wages for the same profession. Similar wages across the system will help create an integrated health care system that emphasizes retention of the work force in the region. Attention should also be given to those caregivers in the system that perform duties similar to regulated healthcare workers.
- It is also felt one way of achieving better retention of employees in the region may be recommending to the Province that successor rights be restored.

MOHLTC:

- Work with the MOHLTC to develop policies, legislation and regulations that support innovative practices and remove barriers to health human resource deployment. (This can include Alternate payment arrangements, scope of practice, addressing policy barriers to sharing patient information, Billing codes etc.)

Plan for Future (including recruitment/retention planning):

- LHIN 14 needs to facilitate regional Health Human Resource planning.
- Develop the Magnet Hospital Concept (Centre of Excellence) across the entire health system as a major tool for recruitment and retention of staff.
- All planning should maintain the principle of a publicly funded, not-for-profit healthcare system.
- LHIN 14 should be responsible for doing more system-wide analysis, in order to anticipate and deal with the effect of different policies being implemented from government or licensing bodies.
- Encourage succession planning to address the aging workforce and technological changes (especially those with specialized skills – technicians, lab, x-ray – all of which have great impact on system).
- Develop mentorship programs across professions and across the region to encourage retention and job satisfaction.

- Ensure that funding continues for recruitment and retention efforts (e.g. UAP incentive grants, site visit funding etc.) and perhaps fund new incentives to be developed that are unique to the region of LHIN 14.
- LHIN 14 needs to encourage a community approach to recruitment, retention and deployment of resources – each community may require a specific policy to encourage local recruitment, but the region needs to work together to attract recruits to the region and work together in the system.

<p>If this is an initiated/existing activity... What is the current status?</p>	<p>What are the outcomes/lessons learned (if any)?</p> <p>It is hoped that on-going assessment, capacity building and planning should allow for greater quality of care and more collaboration and integration across LHIN 14.</p>
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<p>Name:</p> <p>Title:</p> <p>Telephone:</p>	<p>Ken McGeorge CEO 807-727-2231</p>	<p>Organization:</p> <p>Email address:</p>	<p>Red Lake Margaret Cochenour Memorial Hospital kmcgeorge@redlakehospital.ca</p>

Title of administrative support service initiative: First Nations/Aboriginal needs-based funding.		Type of integration (more than one box can be checked) <input checked="" type="checkbox"/> Horizontal <input checked="" type="checkbox"/> Vertical <input checked="" type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:
Existing or new initiative? <input type="checkbox"/> Initiated/existing integration activity* <input checked="" type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	List of partners involved: Aboriginal Health Access centres Thunder Bay Aboriginal Interagency Council Northern Ontario School of Medicine Nishnawbe Aski Tribal Council Treaty Three Tribal Areas Kenora Chiefs Council Robinson Superior Treaty area Ministry of Health and Long-Term Care First Nations and Inuit Health Branch Northwestern Ontario Hospitals Community Care Access Centres Northwestern Independent Living Services	
Please briefly describe the initiative: Key Components: <ul style="list-style-type: none"> • Equitable First Nation and Aboriginal health needs-based funding that recognizes demographic and geographic differences to develop an accessible, collaborative, integrated Aboriginal wholistic health system, that is community directed. • First Nation/Aboriginal people and communities diverse needs include cultures, traditional ways, languages, lifestyles, geographic locales and status. Flexible policies, programs and services are required to respect and address Aboriginal diversity. • To realize the goal of improving Aboriginal health, effective coordination of all health services is required. High Level Action Plan: <ul style="list-style-type: none"> • To improve access, enhance health outcomes and to effectively address inequitable health status of Northwestern Ontario First Nations and Aboriginal communities. • To facilitate a community capacity building process that will empower First Nation and urban Aboriginal people to plan, develop and support community participation and decision making in developing wholistic, integrated and community based driven solutions to community health problems. • To develop a comprehensive action plan that integrates traditions, values, culture, practices and language of Aboriginal peoples in Northwestern Ontario. A comprehensive action plan that supports and facilitates Aboriginal healing and practices in the continuum of care. • To develop a culturally specific continuum of care based on the World Health Organization model framework: health promotion; disease prevention; community needs-based screening; diagnosis; treatment; follow up/recovery/rehabilitation/long-term care; palliative care; training; infrastructure. • To ensure First Nation and urban Aboriginal peoples' meaningful participation in the design, development, implementation and evaluation of the LHIN 14 action plan. • To create a First Nation and urban Aboriginal structure within LHIN 14 which will be directly linked to the Provincial LHINs and includes linkages to the Federal guidelines for Aboriginal health. • LHIN 14 comprehensive action plan should support and facilitate Aboriginal control over the design, delivery, and implementation of a community based, community driven, health system that recognizes demographic and geographic differences. • Increased Aboriginal control over and participation in the design, delivery and implementation of programs and policy development and evaluation has led to improved socio-economic outcomes. The LHIN 14 Board should address the many gaps and barriers for Aboriginal individuals and communities seeking health care (attitudes, values, beliefs, structural, socio- economic, language and communication). 		

<p>If this is an initiated/existing activity...</p> <p>What is the current status?</p> <p>Review and update the New Directions Aboriginal Health Policy for Ontario.</p> <p>Recommendation: To provide resources for a manager and staff to ensure Aboriginal inclusion into the planning, process and implementation.</p>	<p>What are the outcomes/lessons learned (if any)?</p> <p>Protocols would improve integration.</p>
<p>Lead contact person:</p> <p>Name: Judy Morrison Title: Community Liaison Worker Telephone: 807-274-3201 Organization: Weechi-It-Te-Win Email address: jamorrison@yahoo.com</p>	

Capturing Unique Characteristics of LHIN 14

Template D

Capturing Unique Characteristics of LHIN 14

What role Academic Health Sciences Centres and Voluntary Networks play within each LHIN.

Northern Ontario School of Medicine (NOSM), a new medical school announced in 2003, is a joint venture between the province of Ontario, Laurentian and Lakehead Universities. While not an academic health sciences centre, the Universities have collaboration agreements with the Northwestern Ontario Medical Program (NOMP) and the Northeastern Ontario Medical Education Corporation (NOMECE). Medical school campuses are in Sudbury and Thunder Bay, however, other communities across Northern Ontario, both large and small, will also be sites for teaching and research.

The collaboration of these two Universities in medical education offers an unlimited range of possibilities for the Local Health Integration Networks 13 and 14. The NOSM's first undergraduate students will enroll in the fall of 2005. The curriculum has been designed to meet the needs of Northerners and reflect the realities of, and skills for northern, rural and remote lifestyles and medical practices. Students will be taught using the distributed model. They will learn in large and small hospitals, health services and community settings and in family practices throughout the North. The interdisciplinary focus on NOSM's approach to education provides opportunities for local support, planning and research with agencies in Northern Ontario.

Northwestern Ontario has a long history of working together in networks to address the challenges of the large geographic area, distances and small population bases. The Northwest Health Network, carried out collaborative work resulting in: the *Northwestern Ontario Health Human Resources Study* (2002), common credentialing for the Visiting Specialist Program, development of Telehealth and development of shared administration and service support for this service. Other integrative work includes the Kenora/Rainy River Regional Laboratory Program and North Shore District Laboratory Program who worked together to develop the Northwest Region Laboratory Service Plan. Additional networks and/or groups that have a history of working together in Northwestern Ontario include, but are not limited to the Northwestern Ontario Stroke program, the Dementia Networks of the Thunder Bay, Rainy River and Kenora Districts, the Northwestern Ontario Eating Disorders Outreach Network, and the Thunder Bay Mental Health Network.

The NORTH Network is Canada's busiest telemedicine program bringing together over 100 sites through technical and operational services. Telemedicine uses communications and information technologies to support the delivery of clinical care, professional education and health-related administrative services. Using live, two-way videoconferencing, NORTH Network clinicians apply the latest tele-diagnostic instruments - including digital stethoscopes, patient examination cameras, endoscopic equipment and digital imaging facilities - to examine and prescribe treatment so that a remote patient can "visit" an out-of-town specialist from their home community rather than having to travel. NORTH Network is a membership-based program of Sunnybrook and Women's College Health Sciences Centre (SWCHSC) in Toronto. Ontario members include academic health science centres, community hospitals, psychiatric hospitals, clinics, nursing stations, long-term care homes and educational facilities. Many residents and health professionals of Northwestern Ontario rely upon the NORTH Network for consultations and education.

In addition, Keewaytinook Okimakanak Telehealth (KO Telehealth) is a First Nations owned and operated service that coordinates delivery of telehealth services to the most isolated First Nations in Ontario. KO Telehealth began as a five site pilot project in 2001 and currently coordinates more than 100 telehealth sessions each month. KO Telehealth works in partnership with First Nations and Ontario telemedicine services to coordinate and support comprehensive clinical, educational and community-based health services, <http://telehealth.knet.ca>. KO Telehealth's connectivity service – K-Net – provides turnkey technology management and connectivity services. K-Net maintains a service level agreement with NORTH Network, manages the regional First Nations broadband network, provides HelpDesk services for all First Nations schools in Ontario and operates Industry Canada's National Satellite Initiative for Ontario and Quebec.

Working together has been a fundamental principle of Northwestern Ontario regionally-based organizations (e.g. Northwestern Ontario District Health Council; Northwestern Ontario Municipal Association; Integrated Services for Northern Children [ISNC]; Arthritis Society; Northern Ontario Medical Program). Distance and geography continues to be an on-going challenge in delivering quality programs.

A strong technology base and information technology (IT) infrastructure is currently being established across Northwestern Ontario. Some applications of this infrastructure include teleradiology, picture archiving and

communications system (PACS), and a common health information management system which is a foundation for an electronic health record.

The presence of post-secondary educational facilities such as Lakehead University and Confederation College are an asset in the Northwest, with teaching campuses located across the region. Recently, the addition of the Advanced Technology and Communications Centre (ATAC) represents a tremendous boost to distance education in the region and as a global linkage.

In addition to these few examples of networks, it is acknowledged that many others are operating in Northwestern Ontario and need to be identified once the Local Health Integration Networks are in place.

The Northern Ontario School of Medicine and the numerous supporting networks recognize the unique characteristics of the region which presents opportunities for collaboration in education, training and research. The strength of the networks can support the growth of the medical school. Overall, Northern Ontario organizations are mindful of the recruitment and retention of health care professionals, aware of the costs related to health care delivery in northern, rural and remote areas, understand the issues of Aboriginal people and support the objectives of the government to provide better, higher quality, cost effective, patient-focused and coordinated care in Northwestern Ontario.

Describe any unique characteristics/features of your LHIN that impact this process and/or future Integrated Health Services planning activity.

Northwestern Ontario is made up of three districts – Thunder Bay, Kenora and Rainy River. The proposed boundaries of Northwest Local Health Integrated Network (LHIN 14) are similar to the boundaries of the Northwestern and Thunder Bay District Health Units. In the absence of clear boundary definitions for LHIN 14, the demographic and health status characteristics of the population of Northwestern Ontario will be used to describe Northwest LHIN 14. It is assumed that information for Northwestern Ontario will mirror that of Northwest LHIN 14.

Geography

According to 2001 Census data, Northwestern Ontario covers an area of 526,355 square kilometres, which is approximately 60% of the landmass of the province of Ontario and almost the size of France. The population of Northwestern Ontario (234,770) is only 2.06% of the total population of Ontario and has a density of only 0.5 persons/sq km compared to 12.5 persons/sq km in Ontario. Northwestern Ontario has an undercounting of its population because many First Nations people did not participate in the enumeration process of the 2001 Census. Because of this undercounting, it is expected that the population of Northwestern Ontario would be larger.

Northwestern Ontario is comprised of numerous small towns and approximately 70 First Nation communities. Northwestern Ontario extends from White River in the east to the Manitoba border in the west, to James Bay and Hudson Bay in the North and to the United States border to the south. The distance between the eastern and western boundaries is slightly over 1,000 kilometres. In the Kenora and Rainy River Districts (west of Thunder Bay), the economies and health/social services are organized around the communities of Atikokan, Dryden, Fort Frances, Kenora, Red Lake and Sioux Lookout and their respective catchment areas. There is considerable affiliation and loyalty to this circumstance as evidenced by the natural referral patterns in each area. Northwestern Ontario has only one major highway – the two lane Trans Canada Highway.

The rural and remote areas of Northwestern Ontario represent an environment where the population has been vulnerable to the 'boom and bust' cycles of its primary industries. This environment has had an effect on health services in the region and, as a result, the state of health of its residents. The effect on health services is displayed by poorer health status of the population as evidenced by lower life expectancy and higher accident and injury rates compared to Ontario¹. The geographic isolation also creates numerous challenges in planning, delivering, and accessing health services. The recruitment and retention of staff in health fields remains a continuous challenge. In particular, there exists a severe shortage of family physicians in the city of Thunder Bay and throughout the region.

People in Northwestern Ontario are exposed to adverse health outcomes when they experience hazardous weather and road conditions, and traveling delays, when they are required to travel long distances to receive health care. Ground travel time from Kenora to Thunder Bay (the only tertiary centre) is 5½ hours, Red Lake to Thunder Bay 6½ hours and

¹ Pong R., Pitbladao JR., and A Irvine, A strategy for Developing Environmental Health Indicators for Rural Canada. *Canadian Journal of Public Health*, Vol. 93, Supplement 1, S52-S56, Sept-Oct 2002.

Manitouwadge to Thunder Bay 3½ hours. On the other hand, for residents living in Kenora, the travel time to Winnipeg is about 2 hours. The distances to Calgary and Toronto from Sioux Lookout are approximately the same. Many First Nations Communities are only accessible by air or winter roads which last only 3-6 weeks. Big Trout Lake, with an approximate population of 1,200 is only accessible by air (4½ hours flying time to Thunder Bay). A return airfare ticket to Thunder Bay is over \$1,000. A winter road trip from Big Trout Lake to Sioux Lookout is about 14 hours long (one way) with good weather and road conditions.

Efforts in providing and delivering health care services in small populated communities have led to an unequal distribution of services across the Northwest, creating unequal access. Our low population density contributes to the lack of services that are provided in urban centres. Many residents are required to access health services outside their home environments (at additional personal cost) or rely on the services of visiting physicians and specialists. Costs of doing business to deliver health services in rural and remote areas are generally higher than in urban areas.

While 52% of the region's population (121,390) reside in, or immediately around the Census Metropolitan Area of Thunder Bay, the other three largest cities in Northwestern Ontario are Kenora (population 16,000), Fort Frances (population 8,300) and Dryden (population 8,200).

The population size and health status of First Nations people in Northwestern Ontario is poorly documented. It is estimated that as many as 48,000 people in Northwestern Ontario are First Nations and living on or off reserve. The First Nations population is younger and growing. In Northwestern Ontario, in First Nations' population, 59% are under 30 years of age compared to 37% of the non-First Nations population in Northwestern Ontario. The health status of First Nations people is poorer than non-First Nations people. According to the Canadian Community Health Survey, 2003 and Health Canada, First Nations people have higher rates of smoking, arthritis, asthma, and high blood pressure. Diabetes is a major concern among First Nations people because of the 'early onset', greater severity at diagnosis, higher rates of complications, increasing prevalence of risk factors, and lack of accessible services. The only daily provision of primary health care is by Registered Nurses who work in remote fly-in communities. Physicians are flown in from time to time. The delivery of health services to First Nations people requires knowledge of the issues specific to First Nations people, as well as modes of delivery and services that are culturally appropriate. Any planning for First Nation health services must be in collaboration between First Nations, Provincial and Federal Governments.

Demographic Characteristics

According to 2001 Census data, in Northwestern Ontario:

- The population declined by 3.8% compared to 6.1% increase for the province.
- 13.2% of the population is over the age of 65 years compared to 12.9% for the province. In some communities, the percent of the population over 65 years varies from a low of 5.3% (Marathon) to a high of 25.4% (Rainy River). Long Term Care Facilities in Northwestern Ontario already suffer from long waiting lists.
- Almost ¼, 21.7% of the population (26,305 persons) report North American Indian as their ethnic origin compared to 1.2% (80,065) for the province.
- More residents report less than grade nine educational attainment (11.3%) compared to Ontario (8.7%).
- 13.9% of individual income is from government transfer payments compared to 9.8% in Ontario.
- The average income of Census families (\$62,833) is lower than Ontario (\$73,849). The average income of all Census families increased in Northwestern Ontario between 1995 and 2000 by 12.5%, however, this increase is half of that experienced by Ontario (23.4%)
- 32.5% of the population 65 years of age and older live alone compared to 26.8% in Ontario.
- 3.7% of the population in Northwestern Ontario report 10 or more hours of unpaid care to seniors in the week prior to Census day compared to 1.4% in Ontario.

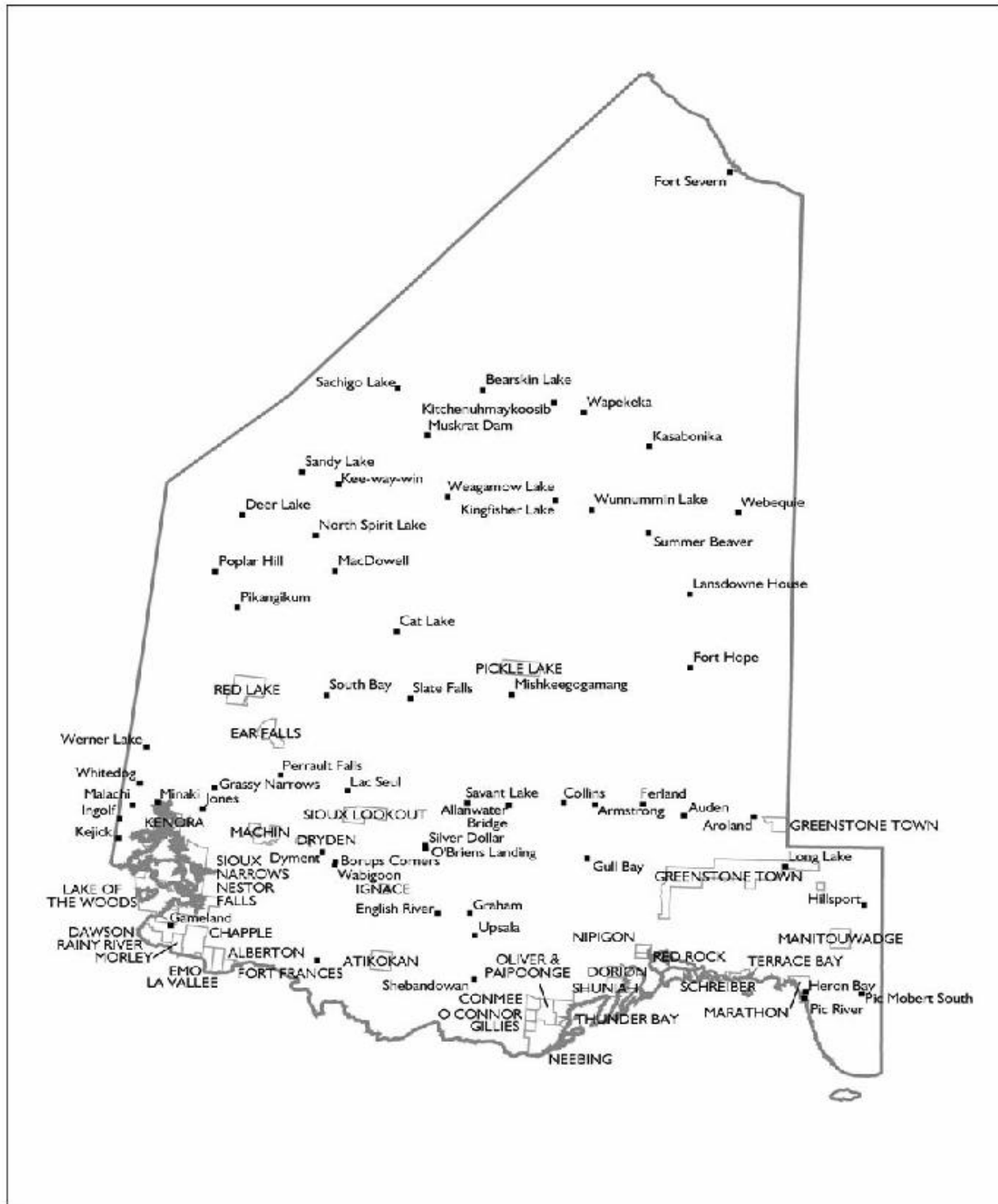
Health Status

- In 2000, mortality rates for cancer, circulatory disease, endocrine disease, mental disorders, nervous system, digestive system and injuries were higher and significantly different than Ontario.
- In 2001/02, hospitalization separation rates for diabetes, ischemic heart disease, bronchitis and emphysema, chronic obstructive pulmonary disease and circulatory disease were higher and significantly different from Ontario.
- In 2003/04, surgeries for hip and knee replacements were significantly higher than Ontario.
- In 2003/04, ambulatory care sensitive conditions (where hospitalization could have been prevented) were more than 2 times higher and significantly different from Ontario.
- Almost 8% of all hospital separations for residents of Northwestern Ontario take place in Manitoba. This historical referral pattern of communities west and north of Sioux Lookout is expected to continue. Almost 20% of all hospital separations in Manitoba are for obstetrics and gynaecology and 17% are for paediatricians. In addition to

hospital separations, a large number of residents from Kenora and Rainy River Districts receive health services (e.g. cataract surgery) in Manitoba as out patients or from Independent Health Facilities. The acquisition of health data for residents of Northwestern Ontario treated in Manitoba and the USA continues to be a challenge.

- According to the *Canadian Community Health Survey* (2003), the population 12 years and older in Northwestern Ontario reported significantly higher rates for high blood pressure, activity limitations, arthritis and rheumatism, diabetes, and daily smoking. A significantly lower rate was reported for self-rated health as “excellent and very good”.
- In 2001, the incidence rate for lung cancer was significantly higher than in Ontario.
- There is a continuous decline in the number of births in Northwestern Ontario. The teen pregnancy rate remains higher than that of the province. Most pregnant women living on remote First Nation communities are usually required to leave their families and homes months prior to the delivery which usually takes place in the urban centres of the Northwestern Ontario or in the province of Manitoba.

North West Health Integration Network
Réseau d'intégration des services de santé du Nord-ouest



11/22/2004

Transformational Thinking and the Process

Process and Approach

The initial consultation for Local Health Integration Network (LHIN) 14 priority setting took place on December 10, 2004 in Thunder Bay. Approximately 200 participants, representing the health sectors, provider agencies, and geographic regions of Northwestern Ontario, attended the consultation, hosted by the Ministry of Health and Long-Term Care.

Participants were asked to identify the top 10 priority integration opportunities (5 for patient care and 5 for administration) facing Northwestern Ontario. After priorities were identified (page 3), participants voted to select the most important integration priorities for LHIN 14. The priorities identified did not include a priority specifically addressing First Nation/Aboriginal health. The group unanimously supported the addition of a priority related to First Nation/Aboriginal health. With the addition of both a patient and administrative integration priority for this area, 12 priorities resulted and can be found on page 4 of this document.

A Steering Committee (consisting of 1-3 leads for each of the 12 priorities) was developed. Steering Committee members represented all districts of Northwestern Ontario. A total of three meetings were held in Thunder Bay. Teleconferencing technology was used to accommodate those members unable to attend the meetings in person. The initial Steering Committee meeting was January 6, 2005; Templates A and B were reviewed and a work plan was devised. It was also decided at this time to consolidate Template C with Templates A and B.

The Steering Committee members were responsible for consulting stakeholders involved in their topic area and using the information collected to complete the Template associated with their topic (in the patient care or administration category). Hundreds of individuals were engaged in the setting of the LHIN 14 integration priorities. Individuals were contacted via telephone, email, and in-person by Steering Committee members, and were then encouraged to seek input from their colleagues and contacts, by viewing the draft templates posted on the Northwestern Ontario District Health Council (NWODHC) website.

The NWODHC website was used as a central location for LHIN 14 information. Access to the Steering Committee members' contact information, the Steering Committee work plan, drafts of Templates A/C and B/C, and background information on the December 10, 2004 process and attendees was posted. By having access to the information via the Internet, input on the priorities increased dramatically. Individuals who may not have been contacted directly to participate in the process were able to provide feedback to any or all of the leads for the 12 priorities.

Drafts of Templates A/C and B/C were reviewed and edited at a meeting of the Steering Committee on February 2, 2005. Template D was completed by NWODHC staff and was also reviewed at this time. Following this meeting, the leads for the 12 priorities made revisions and submitted their completed Templates to be formatted by the NWODHC staff.

At the final meeting of the LHIN 14 Steering Committee, February 16, 2005, Templates A/C, B/C, and D and the list of organizations involved in the process were finalized. A discussion on the transformational thinking and process used in developing the integration priorities occurred at the meeting. Additional feedback after the meeting was received via email by the co-chairs. The final document was collated by the NWODHC staff and the co-chairs.

Key Learnings Arising from the Process

A facilitated session was held with members of the LHIN 14 Steering Committee. The following key learnings were identified as arising from the process:

- Planning requires strong and integral leadership by individuals with specialized skills who are both able and willing to organize and implement an effective, efficient process for "getting the work done". The DHC provided this essential leadership for the LHIN 14 Steering Committee.
- Key stakeholders and system players must be actively involved to ensure successful planning and implementation of such initiatives. Their specialized knowledge and commitment to the process is a prerequisite for success. This commitment to task and "in-kind" contributions of agencies across the region reaffirmed the "can do" spirit of the Northwest.
- The characteristics of the Northwest Region create both opportunities and challenges in health care delivery. As a vast and isolated region where resources are widely dispersed and distance is measured in time, not kilometers, we have addressed these challenges through capitalizing on the inherent strengths of our communities and "closed" geographical distances through the use of innovative technologies. This process provided opportunities to develop new linkages beyond the health care sector and facilitated a broader vision of health care delivery. This vision would enhance community capacity, reflect the wisdom and experience of consumers and providers, include traditional Aboriginal healing practices, and support timely access to services and supports when and where they are needed.
- The Northwest Region is well versed in building and maintaining networks within and across service sectors. Extensive consultation was facilitated through existing networks, which represent invaluable resources that should be built upon and maintained. Throughout this process, the spirit of collaboration and shared value of client-centered care, allowed us to develop a collective vision which was articulated by a unified voice.
- The process of "consultation" must be inclusive with consideration and respect for cultural diversity. Tight timelines did not allow for extensive consultation. Open-space technology and the process for selection of priorities led to "lost" information regarding identified regional needs and other priorities which did not make the "Top Ten" list. Some key stakeholders were not adequately represented or "missing" in the process.
- The LHIN manual and associated tools, templates, provincial workshop and Ministerial support all contributed to the success of the process. It was of particular interest to learn of the commonality of issues across the entire province.
- While we recognize that this process is evolutionary, additional information would have been useful in both planning and processes. Concerns were expressed regarding future commitment of the LHIN Board to act on identified priorities and recommended high level action plans.
- Adequate resources at all levels of the health care system will be required for both planning and delivery of a coordinated/integrated service system. The process of integration requires dedicated resources to ensure successful outcomes. Population-based funding formulas must also consider population health within the context of the broader determinants of health and be responsive to identified regional needs.

List of Organizations/Stakeholders Consulted in Process

- Anishnawbe Mushkiki Aboriginal Health Access Centre (Bernice Dubec)
- Aboriginal Health Access Centres
- Alliance for Community Support Service Agencies - Thunder Bay
- Alzheimer's Society
- Brain Injury Services of Northern Ontario
- Caregiver Support Network of Thunder Bay
- Comcare Health Services
- Community Care Access Centre for the Kenora and Rainy River Districts
- Community Care Access Centre of the District of Thunder Bay
- Community Support Service Agencies – Kenora/Rainy River
- Confederation College
- Dawson Court Home for the Aged
- Dementia Network Thunder Bay District
- District "H" of Ontario Community Support Agencies
- First Nation and Inuit Health Branch
- Fort Frances Interagency Committee
- Grandview Lodge Home for the Aged
- Health Sciences North
- Hospice Northwest
- Ka:nen Our Children Our Future (Joyce Atcheson)
- Kenora Chiefs Council
- Kenora-Rainy River District Mental Health and Addictions Network
- Lakehead University
- LHIN 14 Workshop attendees
- Matawa Tribal Council (Paul Capon)
- Ministry of Health and Long-Term Care, North Region Branch
- Nishnawbe Aski Nation (Helen Cromarty)
- Nor West Community Health Centre
- Northern Ontario School of Medicine
- Northwest Health Network
- Northwest Local Health Integration Network (LHIN 14) Steering Committee
- Northwestern Independent Living Services
- Northwestern Ontario District Health Council
- Northwestern Ontario Regional Cancer Centre
- Public Health Units – Thunder Bay District Health Unit; Northwestern Health Unit
- Rainycrest Homes for the Aged
- Robinson Superior Treaty area
- Saint Elizabeth Health Care
- St. Joseph's Care Group
- Thunder Bay Aboriginal Interagency Council
- Thunder Bay Addiction Service System Planning Group
- Thunder Bay District Mental Health Directors Network
- Thunder Bay Housing and Homelessness Coalition
- Thunder Bay Regional Health Sciences Centre
- Versa-Care Centre
- Victorian Order of Nurses
- Weechi-It-Ti-Win (Judy Morrison, Kathy Jack)
- Wesway

Note: Although the list of organizations/stakeholders consulted is meant to be comprehensive, we recognize that it is a partial list. Many individuals represent several agencies or networks and much of the consultation process was conducted via networking, 'word-of-mouth' and the NWODHC website. A complete list of participants from the December 10, 2004 consultation session is located in the session minutes.

Summary

While developing the integration priorities for LHIN 14, it was reinforced that high energy and synergy exists in the networks, groups, and individuals involved in healthcare in Northwestern Ontario. This document was completed following consultation with over 400 individuals. We are confident that this document is one of many documents that can be used to inform the Health Results Team of the Ministry of Health and Long-Term Care, and the Chief Executive Officer and Board of LHIN 14. In the development of LHIN 14, it will be important to continue this momentum and to ensure meaningful community-wide engagement.

Appendices

Template A: Other Initiatives as Identified at December 10, 2004 Workshop

Appendix A-1. Description of Patient Care/ Services Integration Initiative

Title of patient care/service initiative: Role of extended class nurse in delivery of care within the LHIN.		Type of integration (more than one box can be checked) <input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:	
Existing or new initiative? <input checked="" type="checkbox"/> Initiated/existing integration activity* <input type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>		List of partners involved: Joan Reid Lake of the Woods District Hospital Kim Cross Atikokan General Hospital Paul Capon Matawa First Nations Susan Pilatzke Registered Nurses Association of Ontario	
Please briefly describe the initiative: Key Components: <ul style="list-style-type: none"> • Nurse practioners/RN's could be the entry point for access, to navigate the patient throughout the system, to coordinate care. • Other key roles: <ul style="list-style-type: none"> • To educate, provided health care in remote areas. Why is it a priority: <ul style="list-style-type: none"> • There is a shortage of medical practioners; nurses are a cost effective, comprehensive method to fill that gap. 			
If this is an initiated/existing activity... What is the current status?		What are the outcomes/lessons learned (if any)?	
Lead contact person: Name: Sonia Hill Title: Surgical Services Manager Telephone: 807-468-9861 Organization: Lake of the Woods District Hospital Email address: sjhill@lwdh.on.ca			

Title of patient care/service initiative: Provide a framework for LHIN members to come together around a plan for service delivery that continues to utilize provincial specialized services.		Type of integration (more than one box can be checked) <input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:	
Existing or new initiative? <input checked="" type="checkbox"/> Initiated/existing integration activity* <input type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>		List of partners involved: Not available	
Please briefly describe the initiative: Key Components: <ul style="list-style-type: none"> • There is an opportunity to preserve effective provincial networks that coordinate/provide specialized services to ensure that these services are maintained and remain accessible to clients within our LHINs's coordinated programs and/or structure(s), as well as across the province. Why is it a priority: <ul style="list-style-type: none"> • Ensure access to quality coordinated services within our LHIN. • Ensure a mechanism to support best practices and evidence-based care as there is a need for critical mass to build expertise. • Services can be provided in a cost-effective and efficient manner e.g. Northern Diabetes Health Network, Arthritis Society, Canadian National Institute for the Blind, Alliance for Community Support Service and Mental Health and Addictions. • Creates a mechanism for assigning accountability for the delivery of specialized services and for the outcomes. • Ensure rural and remote services. • Provide network for geriatrics. • Ensure family caregiver support. 			
If this is an initiated/existing activity... What is the current status?		What are the outcomes/lessons learned (if any)?	
Lead contact person: Name: Lynne Bisset Title: Chair Telephone: 807-548-2240 807-626-9788 Organization: Northern Diabetes Health Network Email address: alynbisset@kmts.ca			

Title of patient care/service initiative:		Type of integration (more than one box can be checked)	
Cross sector integration of services.		<input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:	
Existing or new initiative?		List of partners involved:	
<input type="checkbox"/> Initiated/existing integration activity* <input checked="" type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>		Alice Bellavance BISNO Bernie Travis OPTIONS Northwest Carol Neff Wesway Carolyn High Canadian Hearing Society Cassandra Moeller Kenora Health Coalition Colin Stewart PACE-LPH Dan MacMillan Wesway Gordon Allen Alpha Court Jill Colquhoun Rainycrest LTC Laurie Albertini PACE Lee Mesic LTC Homes for the Aged Nancy Chamberlain Family Services Thunder Bay Wendy Savoy ILRC	
Please briefly describe the initiative:			
Key Components: <ul style="list-style-type: none"> • Cross ministries, federal/provincial and LHINs 			
Why is it a priority: <ul style="list-style-type: none"> • Health goes beyond the services provided by health care. They include: <ul style="list-style-type: none"> • Education; • Housing; • Justice system; • Youth services; • Community supports; • Family support; and • Culturally specific needs/service. • New partners equates to synergy: greater outcomes through integrating services. • Common funding opportunities across silos can enhance trust and relationships of providers. • A change of how we do business means all share the responsibility for the people we serve: from “dumping” to sharing our resources for the individual. 			
If this is an initiated/existing activity... What is the current status?		What are the outcomes/lessons learned (if any)?	
Lead contact person:			
Name: Brian Thompson		Organization: Alpha Court Non Profit Housing	
Title: Executive Director		Email address: brithomp@tbaytel.net	
Telephone: 807-623-8200			

Title of patient care/service initiative:		Type of integration (more than one box can be checked)															
Linking and creating long-term care resources for First Nations population in rural and remote communities.		<input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:															
Existing or new initiative?	List of partners involved:																
<input type="checkbox"/> Initiated/existing integration activity* <input checked="" type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	<table border="0"> <tr> <td>Bernice Dubec</td> <td>Anishnawbe Mushkiki</td> </tr> <tr> <td>Cheryl Grant</td> <td>VCC</td> </tr> <tr> <td>Jeanette Rawana</td> <td>VCC</td> </tr> <tr> <td>Marja Rehkonen</td> <td>Pioneer Ridge</td> </tr> <tr> <td>Roger Walker</td> <td>Sioux Lookout Meno-Ya-Win Health Centre</td> </tr> <tr> <td>Tanya Shute</td> <td>Versa Care Centre</td> </tr> <tr> <td>Wendy Sarfi</td> <td>Birchwood Terrace LTC, Kenora</td> </tr> </table>			Bernice Dubec	Anishnawbe Mushkiki	Cheryl Grant	VCC	Jeanette Rawana	VCC	Marja Rehkonen	Pioneer Ridge	Roger Walker	Sioux Lookout Meno-Ya-Win Health Centre	Tanya Shute	Versa Care Centre	Wendy Sarfi	Birchwood Terrace LTC, Kenora
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Roger Walker	Sioux Lookout Meno-Ya-Win Health Centre																
Tanya Shute	Versa Care Centre																
Wendy Sarfi	Birchwood Terrace LTC, Kenora																
Please briefly describe the initiative:																	
<p>Key Components:</p> <ul style="list-style-type: none"> • There is an identified need for long-term care resources specifically for First Nations in rural/remote communities. • Increasing Home Support within the community is important to maintain individuals in their community. • Additionally, accessing First Nations individuals who can provide paraprofessional services, so that First Nations individuals are not having to relocate to LTC facilities in larger urban communities. <p>Why is it a priority:</p> <ul style="list-style-type: none"> • There are many older persons of First Nations descent whose needs are not being met. • Unable to provide quality care to our First Nations population with little to no available resources/funding. • Need to allocate resources to where the needs are (northern/rural/remote communities). <p>Communication/Interpreter Access</p> <ul style="list-style-type: none"> • Depending on circumstance, payment of interpreter services is currently up to the resident or LTC facility to pay, otherwise the resident receives most care/services in English. • Need for culturally embedded programming, food. <p>Education</p> <ul style="list-style-type: none"> • Need to provide staff education around cultural issues. • First Nations persons may require ongoing health education to ensure-informed decisions/consent are obtained. • Need to create/link positions of “Aboriginal navigators” (paraprofessionals) who can not only provide cross cultural training with staff...but can also navigate the system on behalf of family, client and senior. • Residents must currently choose between receiving treatment or no treatment (therefore, they must choose between moving into long-term care –out of their community for treatment (such as dialysis) or stay home (on their reserve, which may have been their place of residence all of their life, however, with the choice of staying home, consequently, the resident will likely die without this treatment). • Life support systems must be put into place to honour their specific health needs in order to have a choice of where to die (live their last days). <p>Accessibility</p> <ul style="list-style-type: none"> • Access to services such as cancer care services for Aboriginal persons –accessibility to services (transportation-flights, taxis etc.) as well as the number of people involved in communication, can sometimes result in problems. • People who are moved to LTC (ie-in Thunder Bay), may not have the family supports to assist with transportation to appointments, or mandatory medical escorts to hospital visits, as well as other health services which may incur additional costs. • While there are services such as NIHB, most of these residents can no longer access Aboriginal funding if they are not currently living on their reservation. 																	

- Resident's applying for LTC in the district, may eventually end up travelling from Bearskin Lake, Cat Lake, Big Trout, Webequie, Osnaburgh,all the way to Thunder Bay (with a promise from CCAC that they will remain on waitlists for the facilities closest to home; such as Sioux Lookout, which is nowhere close to most reserves).
- Most of these residents never get to make this move to a closer facility, as they either die in LTC in Thunder Bay, or go back to their reserve to die.
- We need some type of Priority List (such as the spousal reunification) to get these residents closer to home....quicker.
- The only problem with this, is that there are not enough beds to facilitate this, because as soon as a bed becomes available, it would likely be filled by an area hospital.
- Need more resources in rural/remote communities.

If this is an **initiated/existing** activity...
What is the current status?

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

Lead contact person:

Name: Angela Treadway
 Title: Resident Services/Volunteer Coordinator Organization: Birchwood Terrace
 Telephone: 807-468-9532 ext. 234 Email address: angelatreadway@cplodges.com

Title of patient care/service initiative:		Type of integration (more than one box can be checked)	
Integrated, client focused, network of holistic services from diagnosis through to bereavement support for families/caregivers in city and region.		<input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:	
Existing or new initiative?		List of partners involved:	
<input type="checkbox"/> Initiated/existing integration activity* <input type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>		Aldene Rankin CCAC for Kenora and Rainy River Districts Allen Poling MCSS Anne Bowd St. Joseph's Care Group – PH Bernard Travis OPTIONS Northwest Carol Neff Wesway Cassidy Moeller Kenora Health Coalition Dana MacMillan Wesway Darlene Harrison St. Joseph's Care Group – PH Ed Linkewich Falls Prevention Jane Davidson Community Support (Kenora/Rainy River District Volunteer Palliative Care Program) Janet Northam TBRHSC Joan Williams Hospice Northwest John Salamon Bayshore Home Health Lee Mesic LTC COTB Homes Linda Tolmonen Nipigon District Memorial Hospital Madeleine Platana Hospice Northwest Mary Jane Kurm Hospice Palliative Care Network Northwest Mary Lou Kelley CERAH (L.U.) Nadia Thatcher Bethammi SJCG Sheila Woodford Comcare Health Services Sonja Habjan CERAH – Lakehead University Susan Thom Ontario Community Support Association Terri Curney St. Joseph's Care Group	
Please briefly describe the initiative:			
Key Components: <ul style="list-style-type: none"> • Overriding Principles: respect individuals' right to dignity, privacy and choice among options. • Strive for better access to standardized services, homogeneous approach inappropriate. 			
Components of Integrated Strategy: <ul style="list-style-type: none"> • Forging partnerships with regional and local partners both formally and informally. • Clinical rounds with many experts needed, not specific to CA (cardiac, respiratory, renal). • Telehealth consultations to region upon request. • Coordinated integrated network that provides expert resources for holistic needs of person and family. • Communication tool (ie palliative care chart) for professional and non professionals. • Integration takes many forms- it is not a takeover of organizations that provide good service rather collaborate and collectively deal with issues. • Client focused: supports and education for coping: Family/friends, alternative providers, clinical providers (challenging issues). • Care provided in setting of choice. • Practical supports ie banking house repairs. • Transportation (to appointments, for caregivers) : not specific to disease, accessible. • Navigator role- to assist client/family to make choices. • Consider alternative settings of care- ie acute hospice beds in region, residential hospice for those without resources in home to provide care (family). • Care is not maintenance: highly complex, high resource. May consider expert consultation team, (spiritual, dietary, etc) that will interact in all settings (ambulatory, home, LTC). • Need process to care for adults with developmental/cognitive disabilities who are palliative. 			

- Must have system that is flexible and responsive to changing individual needs.
- Need resources for crisis intervention to prevent acute care admission.

Volunteers

- Present **system** highly dependent on volunteers (professional and non professional).
- Volunteers are needed to work in collaboration with formal caregivers.
- Have to make investment in volunteers.
- Incentive programs are needed to boost volunteer resources- health care employers incorporate incentive programs into HR practices.

Region/Rural/Remote/First Nations

- Any model has to be developed with input from region to meet their needs.
- Recognize geography- Kenora/Rainy River/Winnipeg connection.
- Non traditional approaches- police ambulance funeral homes to get on board.
- Recognize differences in rural cultural and urban settings- may not be desirable for care/support.
- Need connection between groups- infrastructure, ie contractual agreements.

Education/Best Practice/Research

- Recognized a lot of education has been done.
- Ongoing need for education, recognition of best practice and research.
- Education for patients families professional and non professionals.

End of Life Strategy

- We are pleased that in the Transformation Project (MOHLTC), End of Life Strategy is a priority.
- We feel with building of infrastructure and minimal enhancements will have a huge impact on client outcomes.

Why is it a priority:

- Dignity in dying process essential: currently there are gaps in system, inequities in access, inequities throughout region, care is now disease specific, location specific, clients do not have real choices in where they die, funding attached to disease, location community care is dependent on families and informal caregivers.
- Inadequate supports for caregivers result in caregiver burnout and crisis, forcing acute care admission for clients.
- Investment in sustained community care is required to support caregivers.
- In situations where clients lack caregiver supports, we need alternative community care options.
- Specialized bereavement support available only to survivors of CA.
- Community bereavement support programs are needed.

If this is an **initiated/existing** activity...
What is the current status?

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

Lead contact person:

Name: Madeleine Platana
 Title: Volunteer
 Telephone: 807-684-7320

Organization: Hospice Northwest
 Email address: mplatana@shaw.ca cc: williamj@tbh.net

Title of patient care/service initiative:		Type of integration (more than one box can be checked)	
Population/public health in rural and remote First Nations Communities.		<input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:	
Existing or new initiative?		List of partners involved:	
<input type="checkbox"/> Initiated/existing integration activity* <input checked="" type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>		Carolyn High CHS Gloria Casey -Clibbery NorWest CHC's Helen Cromarty NAN Joe Barnes Kenora Cheifs Advisory Judy Morrison Weechi-It-Te-Win Family Services Kathie Jack Weechi-It-Te-Win Family Services Nicolette Kaszor First Nations & Inuit Health Branch Paul Capon Matawa First Nations Roger Walker Sioux Lookout Meno-Ya-Win Health Centre Virginia Sutherland Nishnawbe-Aski Nation (NAN)	
Please briefly describe the initiative:			
<p>Why is it a priority:</p> <ul style="list-style-type: none"> Population/public health is lacking in remote and rural First Nations. Population and public health are special as needs require recognition and to be addressed as public health services are sporadic and/or non-existent in remote and rural First Nation Communities. <p>Population/Public Health Issues</p> <ul style="list-style-type: none"> Accepting and embedding First Nation culture in the provision of services. Can LHIN respond directly to the needs or should it work through (NAN, Treaty 3, PTO's, First Nation Communities, rural, remote and urban First Nation). Province of Ontario Signatories of NAN Treaty 9 – How is it addressing health issues and services for Ontario First Nations under Treaty 9 (NAN)? How do we create a policy context for LHIN to operate in. <p>Recommendations:</p> <ul style="list-style-type: none"> Develop/fund Northern Working Group to take the initiative to develop a strategic plan to address the issues. How to get consistent data we need a mechanism in body that will collect data. Data collection void. Mechanism to collect and centralize data (OCAP) Ownership, Control, Access, Possession, of First Nation data. Accepting and embedding traditional health as a critical pathway through the health care system with client choice. Health planning that incorporates and respects the Elder's, teachings and traditional medicine and practices. <p>Issues</p> <ul style="list-style-type: none"> Integration of federal and provincial health services and programs. Access to provincial program/services; -limited by the Health Canada health policy on Medical Transportation Recruitment and retention of doctors, nurses and other health professionals. Sustainability of health services permanent basis necessary. Lack of absence of public health services. Addressing the determinants of health; H2O, and housing, access to housing, education and employment. First Nation Communities housing does not meet the United Nation definition of housing homelessness, relative homelessness, etc. Federal/provincial governments need to be in bed together. LHIN not to impact, prejudice the current health care services/programs with the First Nation Communities/Tribal Council, agencies and organizations. 			

If this is an initiated/existing activity... What is the current status?	What are the outcomes/lessons learned (if any)?
Lead contact person:	
Name: Roger Walker Title: CEO Telephone: 807-737-3238	Organization: Sioux Lookout Meno-Ya-Win Health Centre Email address: rwalker@slmhc.on.ca

Title of patient care/service initiative:		Type of integration (more than one box can be checked)	
Timely access to services, both care and prevention.		<input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:	
Existing or new initiative?		List of partners involved:	
<input type="checkbox"/> Initiated/existing integration activity* <input type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>		Dennis Brown Rainycrest Bd.ot Management Lee-Ann Nalezty NWODHC Lynne Bisset NDHN Norma Elliott Riverside Health Care Facilities Inc. Sally Prystanski The Arthritis Society	
Please briefly describe the initiative:			
Key Components: <ul style="list-style-type: none"> • The Arthritis Society has services in Northwestern Ontario but very few people and/or medical professionals know about it. • Arthritis care depends upon prevention, proper treatment and timely access to it. • It requires a multi-disciplinary approach (M.D.'s/N.P.'s, P.T.'s, O.T.'s, support groups, public education, telehealth and so on.) • People can be taught to manage much of their arthritis by themselves but Inflammatory arthritis can be a medical emergency as much of the joint damage is initiated in the first two years of the disease. • Early diagnosis and treatment is crucial. • Knowledge of local, provincial and national resources need to be disseminated. • Continuing education of both the people with arthritis and health professionals about arthritis is critical if we are to successfully handle this emerging crisis. • Local initiatives for exercise groups, walking groups, Tai Chi for arthritis, arthritis self management programs and aquatic programs are to be encouraged. These can be linked to other programs e.g. osteoporosis, heart and stroke etc.. 			
Why is it a priority: <ul style="list-style-type: none"> ▪ The incidence of arthritis is much higher here than nationally: 1 in 5 rather than 1 in 7.(older population, harder physical work, less access to timely medical management). ▪ Arthritis is the number 1 reason for hip and knee replacement surgery. ▪ Baby boomers are now 55. ▪ In 20 years they will be 75! (a growing epidemic). ▪ Prevention is a much better use of money than surgical management. ▪ The Arthritis Society has a unique client services program that is based on "Best Practices Model" and needs to be supported and improved to best access all clients in Northwestern Ontario. 			
If this is an initiated/existing activity... What is the current status?		What are the outcomes/lessons learned (if any)?	
Lead contact person:			
Name: Sally Prystanski		Organization: The Arthritis Society	
Title: Pysiotherapist		Email address: tbcars@tbaytel.net	
Telephone: 807-344-1950			

Appendix A-8. Description of Patient Care/ Services Integration Initiative

Title of patient care/service initiative: Provide homecare and other health professional services (PT, OT, SLP) to remote communities using existing ehealth technologies (model already exists but needs to be expanded).		Type of integration (more than one box can be checked) <input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:	
Existing or new initiative? <input checked="" type="checkbox"/> Initiated/existing integration activity* <input type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>		List of partners involved: Kevin Holder CCAC for Kenora and Rainy River Districts Mark Balcan Lake of the Woods District Hospital	
Please briefly describe the initiative: Key Components: <ul style="list-style-type: none"> • We have difficulty recruiting therapy professionals to travel to remote communities to provide face to face health services. • Using existing telehealth infrastructure and videoconferencing, we can try to recruit professionals to physically travel to remote communities for initial assessments and then use existing technology to provide follow up visits, scheduling, referral etc.. • This will decrease travel cost. • This will assist with ability to recruit for these “travelling” positions which are difficult to fill. Why is it a priority: <ul style="list-style-type: none"> • Provide equitable access to service to all Ontarians. • Will reduce the need for residents to travel to distant centres to obtain those services. 			
If this is an initiated/existing activity... What is the current status?		What are the outcomes/lessons learned (if any)?	
Lead contact person: Name: Kevin Holder Title: Financial Manager Telephone: 807-467-4753 Organization: CCAC for Kenora and Rainy River Districts Email address: kevin.holder@kenora.ccac-ont.ca			

Title of patient care/service initiative: Rationalization of the Hospital Sector.		Type of integration (more than one box can be checked) <input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:	
Existing or new initiative? <input type="checkbox"/> Initiated/existing integration activity* <input checked="" type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>		List of partners involved: Doris Meredith OPSEU Section 18 Dave Gibbons OPSEU Local 715 Hospital Professionals of TBRHSC Iris Sullivan The Corporation of the Town of Marathon Maureen Judge MOHLTC NRB Phil Minty Manitouwadge General Hospital Scott Potts Thunder Bay Regional Health Sciences Centre	
Please briefly describe the initiative: Key Components: <ul style="list-style-type: none"> Organizing hospitals in the Northwest in such a way that roles/expectations are clear, redundancy reduced and patient care and administrative processes are standardized. In today's climate it is possible to create an environment in which hospitals, although geographically and organizationally separate, could operate "as if they were one". An essential ingredient of moving forward must involve finding some new, innovative ways of compensating physicians who practice in hospitals so that their means of compensation and the hospital operations are blended in some fashion. In the restructuring of health care services in other provinces, rural health care has suffered or has been seen to be suffering. Rationalizing the hospital system in Northwestern Ontario will go a long way to preserving essential services in rural areas for which service alternatives are at least a 3 hour drive away. Why is it a priority: <ul style="list-style-type: none"> Amongst the 13 hospitals in the Northwest there is redundancy and duplication in administrative processes and procedures; there is no means of standardizing clinical processes; some of the smaller hospitals face issues of program and/or corporate viability. The Regional Lab Program stands as a wonderful model of how services could be coordinated. Small facilities need partnership arrangements with larger organizations in order to provide essential services. There are major issues of access to the regional centre (secondary and tertiary services) and the intentional development of sub-regional programs (e.g. Surgicentre; Diagnostic Centre), closer to home, could go a long way to relieving the access issues and make the sub-regional areas more self-sufficient. The rural communities of Northwestern Ontario need strong, high quality health care services to be maintained due to the extraordinary long travel distances over highways that are less than excellent! 			
If this is an initiated/existing activity... What is the current status?		What are the outcomes/lessons learned (if any)?	
Lead contact person: Name: Ken McGeorge Title: CEO Telephone: 807-727-2231 Organization: Red Lake Margaret Cochenour Memorial Hospital Email address: kmcgeorge@redlakehospital.ca			

Title of patient care/service initiative: Ensuring that consumers and clients are involved in the LHIN process.		Type of integration (more than one box can be checked) <input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:	
Existing or new initiative? <input type="checkbox"/> Initiated/existing integration activity* <input type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>		List of partners involved: Colin Stewart PACE – LPH Laurie Albertini PACE Mary Ann Mountain SJCG – LPH – CMHS	
Please briefly describe the initiative: Key Components: <ul style="list-style-type: none"> When looking at service integration, “client centered care” needs to involve clients in the process. Why is it a priority: <ul style="list-style-type: none"> If LHINs are going to establish and make meaning change to provide integrated care at a community level, it is imperative that the voices of clients and consumers be heard in a meaningful way. This includes involving clients at all levels (program planning, treatment). In addition, clients need to be involved at the Community Board level, however, client involvement needs to be facilitated in a meaningful way which addresses potential barriers which may hinder involvement. Organizations also need to be held accountable with regards to making “client centred care” a reality. This may require individuals within organizations to examine beliefs, attitudes and values about involving clients. 			
If this is an initiated/existing activity... What is the current status?		What are the outcomes/lessons learned (if any)?	
Lead contact person: Name: Juanita Lawson Title: Psychiatric Patient Advocate Telephone: 807-343-4300 Organization: St. Joseph's Care Group Email address: juanita.lawson.gov.on.ca			

Title of patient care/service initiative: Volunteers - Making sure they are part of the process.		Type of integration (more than one box can be checked) <input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:	
Existing or new initiative? <input type="checkbox"/> Initiated/existing integration activity* <input checked="" type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>		List of partners involved: Angela Treadway Birchwood Terrace Jane Davidson Community Support Kenora District Lynne Bisset NDHN	
Please briefly describe the initiative: Key Components: <ul style="list-style-type: none"> Resources to coordinate volunteers. Why is it a priority: <ul style="list-style-type: none"> Statistical information reported and recognized in the system e.g. volunteer hours and time. Integrated volunteer pool e.g. volunteer centres. Volunteer budget – volunteers should not be out of pocket for expenses. 			
If this is an initiated/existing activity... What is the current status?		What are the outcomes/lessons learned (if any)?	
Lead contact person: Name: Jane Davidson Title: Director Telephone: 807-468-4562 Organization: Community Support Kenora District Email address: css.kenora@kenoradistricthomes.ca			

Title of patient care/service initiative: Immediate cross Ministry integration project. Cooperative funding between health and social services in meeting the long-term care needs of adults and children with intellectual disabilities.		Type of integration (more than one box can be checked) <input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:																														
Existing or new initiative? <input checked="" type="checkbox"/> Initiated/existing integration activity* <input type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	List of partners involved: <table border="0"> <tr> <td>Allen Poling</td> <td>MCSS</td> </tr> <tr> <td>Bernard M. Travis</td> <td>OPTIONS Northwest</td> </tr> <tr> <td>Brian Thompson</td> <td>Alpha Court</td> </tr> <tr> <td>Carol Neff</td> <td>Wesway</td> </tr> <tr> <td>Cassidy Moeller</td> <td>Kenora Health Coalition</td> </tr> <tr> <td>Danna MacMillan</td> <td>Wesway</td> </tr> <tr> <td>George Milne</td> <td>BISNO</td> </tr> <tr> <td>Heather Gray</td> <td>St. Joseph's Care Group</td> </tr> <tr> <td>Jeanette Rawana</td> <td>Versa Care Centre</td> </tr> <tr> <td>Kristan Miclash</td> <td>NILS</td> </tr> <tr> <td>Lee Mesic</td> <td>LTC COTB Homes</td> </tr> <tr> <td>Mary Jane Kuan</td> <td>OPTIONS Northwest</td> </tr> <tr> <td>Norma Elliott</td> <td>Riverside Health Care Facilities Inc.</td> </tr> <tr> <td>Paul Capon</td> <td>Matawa First Nations</td> </tr> <tr> <td>Rob Ritchat</td> <td>Atikokan General Hospital</td> </tr> </table>		Allen Poling	MCSS	Bernard M. Travis	OPTIONS Northwest	Brian Thompson	Alpha Court	Carol Neff	Wesway	Cassidy Moeller	Kenora Health Coalition	Danna MacMillan	Wesway	George Milne	BISNO	Heather Gray	St. Joseph's Care Group	Jeanette Rawana	Versa Care Centre	Kristan Miclash	NILS	Lee Mesic	LTC COTB Homes	Mary Jane Kuan	OPTIONS Northwest	Norma Elliott	Riverside Health Care Facilities Inc.	Paul Capon	Matawa First Nations	Rob Ritchat	Atikokan General Hospital
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Norma Elliott	Riverside Health Care Facilities Inc.																															
Paul Capon	Matawa First Nations																															
Rob Ritchat	Atikokan General Hospital																															
Please briefly describe the initiative: Key Components: <ul style="list-style-type: none"> Local development of community based (group living) opportunities for individuals, adults or children, to receive long term care supports and developmental services within a single program through blended funding from both Ministries, thus allowing for aging in place with continued opportunity to experience quality of life within their home and community. Why is it a priority: <ul style="list-style-type: none"> This is an area where we as a community can make a meaningful change in the very short term without waiting for "systems change" to occur. People with developmental disabilities are more likely to experience increased need for long-term care services at earlier stages in life. The lack of adequate funding in either Ministry makes delivery of services more and more difficult, and has the potential for increased pressure on ALC services; early loss of independence; and increased cost. 																																
If this is an initiated/existing activity... What is the current status?	What are the outcomes/lessons learned (if any)?																															
Lead contact person: Name: Bernard Travis Title: Executive Director Telephone: 807-344-4994 Organization: OPTIONS Northwest Email address: bernie@optionsnw.co.ca																																

Title of patient care/service initiative: Integration of services/care of children and youth.		Type of integration (more than one box can be checked) <input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:	
Existing or new initiative? <input type="checkbox"/> Initiated/existing integration activity* <input checked="" type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>		List of partners involved: Carol Neff Wesway Tricia Jordan Health Sciences North	
Please briefly describe the initiative: Key Components: <ul style="list-style-type: none"> • Services to this group often cross many organizations. • Similar to care of the elderly, needs of this client group require many different types/levels of care. • Support for parents, respite and flexible range of service options. Why is it a priority: <ul style="list-style-type: none"> • To ensure highest level of care – integration is required. • Some services required are outside the region and coordination in the region would ensure smoother transition. 			
If this is an initiated/existing activity... What is the current status?		What are the outcomes/lessons learned (if any)?	
Lead contact person: Name: Tricia Jordan Title: Community and Professional Education Organization: Health Sciences North Development Coordinator Telephone: 807-343-2100 Email address: tjordan@hscn.ca			

Title of patient care/service initiative:		Type of integration (more than one box can be checked)	
Access to basic physician/medical services by rural/remote communities.		<input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:	
Existing or new initiative?	List of partners involved:		
<input checked="" type="checkbox"/> Initiated/existing integration activity* <input type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	Bruce Sutton Nipigon District Memorial Hospital Charlie Viddal NWODHC Dennis Brown Rainycrest Gilda Pang Allard CNIB Helen Tucker Schizophrenia Society of Ontario - Thunder Bay Chapter Joyce Atcheson Ka:nen Our Children Our Future Juliana Jackson		
Please briefly describe the initiative:			
<p>Key Components:</p> <ul style="list-style-type: none"> • Shift OHIP dollars for doctors from the government to the LHINs, then shift it to individuals so that doctors must follow the money in order to get paid. • Cap the number of dollars accessible in major centres and provide more to rural/remote areas. • Funding for LHINs must include money for travel costs associated with accessing basic services, tests, etc. since northern travel is exorbitantly expensive. • The concept of northern group funding plans are used in some communities (salaried doctors work a limit of 20 hours a week in a group of 7 with a nurse practitioner) but this model does not make physicians and the nurse accountable to the individuals they serve. • Accountability will always be to the ones with money so we must shift the money to the people and get it out of government silos devoted to healthcare practitioners. • Bring services to the people by providing: <ul style="list-style-type: none"> • Transportation (e.g. volunteer drivers take people to appointments for a fee of \$100 but this example needs a centralized phone access). • Mobile MRI and staff to service it • Mobile primary health care service bus (like CNIB eye van which provides surgery, treatments and exams). • Home dialysis. • Telehealth as long as that doesn't become the only doctor people from the north see. • Early diagnosis needed for mental health issues. • Training the trainer and providing on-going support. • Provide "centralized services to one small area to serve a number of smaller communities in the immediate area. • Regional centres cannot close services to the region because people need constancy and consistency in service delivery. • Standards for "reasonable access": <ul style="list-style-type: none"> • Access to PHC, secondary and tertiary. • Access to include definition of geography, costs and what is unique to Northwestern Ontario. • Access times to doctors and wait times. <p>Why is it a priority:</p> <ul style="list-style-type: none"> • Inequality and inequity exists: some people have access to finite treatments such as in vitro fertilization while others do not have regular daily access to qualified physician services. 			

Title of patient care/service initiative:		Type of integration (more than one box can be checked)	
Access to rehabilitation services (OT/PT/SLP/Chiro/RMT).		<input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:	
Existing or new initiative?		List of partners involved:	
<input type="checkbox"/> Initiated/existing integration activity* <input checked="" type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>		Claudette Gleeson l'Accueil Francophone Donna Opie Victorian Order of Nurses Heather Gray St. Joseph's Care Group Sheila Woodford Comcare Health Services Stephen Mangoff Ontario Physiotherapy Association Susan Pilatzke RNAO Terri Gurney St. Joseph's Care Group	
Please briefly describe the initiative:			
Key Components: <ul style="list-style-type: none"> Improving timely access to rehab professionals. Use of technology to improve access. Timeliness of access. Integration of players in clinical care path. Long term sustainable funding for CCAC's and their provider agencies (increase length of time between RFP's). Expand scope of practice to allow other professionals to work under the guidance of a registered health professional. Retention/recruitment – educate rehab professionals in the northwest. How can the regional rehab centre provide leadership and support to rehab professionals in smaller communities. Maintenance of funding to keep rehab networks running. Re-investment of health care dollars taken from chiropractic and physiotherapy. Preventative healthcare and health promotion – including PREHAB and Do we provide care in the hospital or in the community- what do the clients want/need – is it client centered? Educate doctors re role of rehab professionals. Primary access to hospital rehab – take doctor out of the access path. 			
Why is it a priority: <ul style="list-style-type: none"> Timely access to rehab services can prevent need of other services that are more costly and difficult to access. Investment in rehab can decrease access to acute care facilities and family doctor visits. 			
If this is an initiated/existing activity... What is the current status?		What are the outcomes/lessons learned (if any)?	
Lead contact person:			
Name: Stephen Mangoff Title: Physiotherapist Telephone: 807-887-3026 ext. 252		Organization: Ontario Physiotherapy Association Email address: smangoff@ndmh.ca	

Title of patient care/service initiative: Wellness and disease prevention model of health care for the Northern LHIN.		Type of integration (more than one box can be checked) <input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:	
Existing or new initiative? <input type="checkbox"/> Initiated/existing integration activity* <input checked="" type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>		List of partners involved: Andrew Skene DRHC Anita Jean Norwest Community Health Centre Debbie Larson Red Lake Margaret Cochenour Memorial Hospital Janet Sillman Norwest Community Health Centres Kim Morgan Alzheimer Society Nadia Thatcher Bethammi SJCG Sheila Woodford Comcare Health Services Wendy Savoy ILRC Wendy Talbot Norwest Community Health Centres	
Please briefly describe the initiative: Key Components: <ul style="list-style-type: none"> • This is a model that encompasses pre-birth to end of life (a circle of life and health). • Various components include: <ul style="list-style-type: none"> • Screening and early diagnosis; • Education; • Triage; • Caregiver supports; • Single point of access; • Lifestyle (eg nutrition and exercise); • Research; • Electronic health cards; and • Wellness clinics. • Health check ups include: <ul style="list-style-type: none"> • Dentistry; • Optometry; • Physiotherapy; and • Chiropracty etc.. • In-home supports. • Psycho-social-recreational and interactive activities and communication. • Alternatives to in-patient care. • Less emphasis on use of medications. • Appropriate use of health care professionals skills. 			
Why is it a priority: <ul style="list-style-type: none"> • This is a priority as the system itself needs to be changed – this is not just an issue of integration but a total model change for that new system of care. 			
If this is an initiated/existing activity... What is the current status?		What are the outcomes/lessons learned (if any)?	
Lead contact person: Name: Kim Morgan Title: Executive Director Telephone: 807-345-9556 Organization: Alzheimer Society Email address: kimmorgan@alzheimerthunderbay.ca			

Title of patient care/service initiative:		Type of integration (more than one box can be checked)			
Opportunities for collaboration at the federal, provincial, local and First Nations levels.		<input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:			
Existing or new initiative?	List of partners involved:				
<input checked="" type="checkbox"/> Initiated/existing integration activity* <input checked="" type="checkbox"/> New integration opportunity	<table border="0"> <tr> <td style="vertical-align: top;"> Aldene Rankin Bernice Dubec Dick O'Donnell Helen Cromarty Joe Barnes Kathy Mastragelo Margaret Wanlin Maureen Judge Susan Thom </td> <td style="vertical-align: top;"> CCAC for Kenora and Rainy River Districts Anishnawbe Mushkiki St. Joseph's Care Group Nishnawbe Aski Nation Kenora Chiefs Comcare Health Services Mayor's Health Task Force MOHLTC Ontario Community Support Association </td> </tr> </table>			Aldene Rankin Bernice Dubec Dick O'Donnell Helen Cromarty Joe Barnes Kathy Mastragelo Margaret Wanlin Maureen Judge Susan Thom	CCAC for Kenora and Rainy River Districts Anishnawbe Mushkiki St. Joseph's Care Group Nishnawbe Aski Nation Kenora Chiefs Comcare Health Services Mayor's Health Task Force MOHLTC Ontario Community Support Association
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<i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>					
Please briefly describe the initiative:					
Key Components:					
<ul style="list-style-type: none"> Aboriginal/First Nations health services and health care is highly problematic. Existing policy, funding, program and service delivery agencies at all 4 levels are often redundant and overlapping and consequently significantly less effective than could/should be the case. Patients/clients, the public and providers all receive sub-optimal results. 					
Why is it a priority:					
<ul style="list-style-type: none"> The illness burden and health status problems of this population are at the extreme end of national and provincial, and in some cases, world-wide measures. Access is a major issue relative to the rest of the province because of remoteness, geographic or cultural isolation. Suggestions include: <ul style="list-style-type: none"> Understanding the context created by and ensuring (re)commitment to pre-existing agreements: eg. Treaty 9, Sioux Lookout Four Party Hospital Services Agreement, etc. which were signed by Canada and Ontario, plus other historical treaty and "local" agreements. The "unilateral" policy move to transform healthcare cannot supplant existing commitments without serious political implications. Convene a high level summit (Health Canada and other federal agencies, MOHLTC and other provincial agencies such as AHWS and AHO, LHIN, local bodies (which ones?), and Aboriginal/First Nation bodies (which ones?) to: <ul style="list-style-type: none"> Revisit roles. Set an agenda. Set action plans and outcome targets. Look for opportunities to pool resources (people - dollars - technology, etc.). One goal should be to ensure access to Aboriginal-specific health care services. Build from the community-level up. Flow dollars and other resources to the community level. Recognize that Aboriginal populations are diverse (First Nations, Metis, etc.). Policies, funding, programs and services to be based on NEEDS not population numbers. Develop Community Wellness Plan: <ul style="list-style-type: none"> That addresses determinants of health. Provides actions and resources in direct response and proportion to the illness burden. Addresses the problems of logistics of access. Meets cultural needs - an equal place for traditional healing and medicines – for traditional ways. A consistent, accurate data base. Set priorities. Learn from successful models in other parts of Ontario, other sectors than health, other provinces, other 					

- countries.
- Jointly organize resources around priority targets

If this is an **initiated/existing** activity...
What is the current status?

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

Lead contact person:

Name: Roger Walker, Joe Brassard
 Title: CEO
 Telephone: 807-737-3238

Organization: Sioux Lookout Meno-Ya-Win Health Centre
 Email address: rwalker@slmhc.on.ca

Title of patient care/service initiative: Aboriginal issues: 1) Recognition is a priority. 2) Interpretation of integration. 3) Separate sector.		Type of integration (more than one box can be checked) <input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:
Existing or new initiative? <input checked="" type="checkbox"/> Initiated/existing integration activity* <input type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	List of partners involved: Angela Treadway Birchwood Terrace Bruno Carella HAGI Cassidy Moeller Kenora Health Coalition Helen Cromarty NAN Jeanette Rawana Versa Care Centre John Albanese NWHV Judy Morrison Weechi-It-Te-Win Karen Ingebrigtsen CCAC for Kenora and Rainy River Districts Kathie Jack Weechi-It-Te-Win Marc Bouchard MOHLTC Nicollette Kazor First Nations and Inuit Health Branch Paul Capon Matawa First Nations Sonia Hill Lake of the Woods District Hospital Wendy Sarfi Birchwood Terrace LTC, Kenora	
Please briefly describe the initiative: Key Components: <ul style="list-style-type: none"> • Education. • Public sector unit. Why is it a priority: <ul style="list-style-type: none"> • Clinical/traditional approaches (services). • Bi-cultural training. • Advocate/navigator between client and service provider. • Coordination of provincial/federal/municipal services. • Integrated service delivery. • Preventative to socio-economic issues. • Recognition as a citizen of Ontario. • Determinants of health: example, water, housing, employment. • Social support networks. • Supports for long-term patient (ie dialysis, cancer – housing, etc.). • WHO (World Health Organization) – address the high rate of suicides in Ontario. • For on-going short-term rehabilitation – on reserve, community based – capacity building initiatives. • Approach based on need, not on population. • Language, interpretation, translation. • Education for workers and community. • Culture shock. 		
If this is an initiated/existing activity... What is the current status?	What are the outcomes/lessons learned (if any)?	
Lead contact person: Name: Kathie Jack, Judy Morrison Title: Manager, Community Liason Worker Organization: Weechi-It-Te-Win Telephone: 807-274-4571, 807-274-3201 Email address: tlc1@jam21.net, j.a.morrison@cas.gov.on.ca		

Title of patient care/service initiative: Stakeholder accessibility to health care services which are publicly funded.		Type of integration (more than one box can be checked) <input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:
Existing or new initiative? <input type="checkbox"/> Initiated/existing integration activity* <input checked="" type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	List of partners involved: Carolyn High Canadian Hearing Society Cassidy Moeller Kenora Health Coalition Nancy Frost Canadian Hearing Society	
Please briefly describe the initiative: Key Components: <ul style="list-style-type: none"> Involving and addressing the needs of health care consumers in an equitable and publicly funded process. Why is it a priority: <ul style="list-style-type: none"> Communication needs are met in a publicly funded system. Create a level playing field to all persons requiring services. Create policies and guidelines prior to any major steps being taken to avoid mistakes which may not be able to be turned around. Reduce competition via guidelines, education, training;, funding (public not private). Silos include community service providers. Inclusion should be in a meaningful way by being adequately funded and involved in the decision making process. Funding needs to be stable to prevent gaps in service. On-going education of all health care providers. Access definition broadened to include availability, geographic, disabilities, rural/urban, age etc.. Equitable skills, funding;services between LHINs. Physicans need to be an integral part of the process (Physicians are the gatekeepers). Develop understanding of the duty to accommodate. Funding support to individuals in their homes (e.g. home Care, technology, home renovations etc.). 		
If this is an initiated/existing activity... What is the current status?	What are the outcomes/lessons learned (if any)?	
Lead contact person: Name: Carolyn High Title: Volunteer Telephone:		
Organization: Canadian Hearing Society Email address: cghigh@shaw.ca		

Template B: Other Initiatives as Identified at December 10, 2004 Workshop

Appendix B-1. Description of Administrative Support Services Integration Initiative

Title of administrative support service initiative: Accès aux services de santé en français. Access to French language services		Type of integration (more than one box can be checked) <input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:
Existing or new initiative? <input type="checkbox"/> Initiated/existing integration activity* <input type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>	List of partners involved: Angele Brunelle l'Accueil Francophone de Thunder Bay Anita Jean Norwest Community Health Centres Claudette Gleeson l'Accueil Francophone de Thunder Bay Denyse Culligan Conseil consultatif de la ministre de leguie aux affaires francophone Madeline Neilbur Diane Breton Services en Français Jocelyn Blais Reseau francophone de sante du Nord de l'Ontario	
Please briefly describe the initiative: Key Components: <ul style="list-style-type: none"> • Que le ministère reconnaisse le droit de la gouvernance par et pour les francophones dans les services de santé et que le financement soit associé à cette gouvernance. • That the ministry recognize the right to self-governance by and for francophones in the matter of French language health services and that adequate financing be provided to support this self-governance. Why is it a priority: <ul style="list-style-type: none"> ▪ D'après, le profil socio-économique de l'AFNOO, (association des francophones du nord-ouest de l'Ontario.) l'état de la santé des francophones du nord-ouest est inférieur à celle de majorité. ▪ L'accès aux services de santé en français est quasi inexistant dans le nord-ouest. ▪ La langue est un facteur déterminant dans la qualité du service. ▪ Nos droits constitutionnels et législatifs doivent être respectés. ▪ According to the socio-economic profile of the association des francophones du nord-ouest de l'Ontario the health condition of the northwestern Ontario francophone population is inferior to that of the majority. ▪ Access to French language health services is almost non-existent in the northwest. ▪ Language is a determining factor in the quality of services. ▪ Our constitutional and legal rights must be respected. 		
If this is an initiated/existing activity... What is the current status?	What are the outcomes/lessons learned (if any)?	
Lead contact person: Name: Claudette Gleeson Title: President Telephone: 807-684-1940 Organization: l'Accueil Francophone de Thunder Bay Email address: accueil@tbaytel.net		

Title of administrative support service initiative: Provide back office functions to smaller organizations that do not have the capacity or funding to do.		Type of integration (more than one box can be checked) <input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:	
Existing or new initiative? <input type="checkbox"/> Initiated/existing integration activity* <input type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>		List of partners involved: Colin Stewart PACE/LPH Kevin Holder CCAC for Kenora and Rainy River Districts	
Please briefly describe the initiative: Key Components: <ul style="list-style-type: none"> All MOH or LHIN funded agencies/TPAs are so will so be required to be MIS compliant and smaller organizations may not have the human/financial capacities to be compliant with those requirements. Existing organizations that have the expertise and can provide training, support or direct admin service can help. Many smaller organizations do not receive sufficient funding to have adequate admin support services so many directors end up doing their own administration. Sharing human resources (support staff, finance, IT, HR, etc.) can free up directors to carry out the work mandated by the program and assist more clients/patients etc.. Why is it a priority: <ul style="list-style-type: none"> In today's discussions surrounding LHIN integration opportunities, providing back office functions, utilizing people with the expertise can create efficiencies in administration allowing those that are the experts in client services to continue to focus on the client and program development. 			
If this is an initiated/existing activity... What is the current status?		What are the outcomes/lessons learned (if any)?	
Lead contact person: Name: Kevin Holder Title: Financial Manager Telephone: 807-467-4753 Organization: CCAC for Kenora and Rainy River Districts Email address: kevin.holder@kenora.ccac-ont.ca			

Title of administrative support service initiative: Sharing of Services for hospitals and long-term care.		Type of integration (more than one box can be checked) <input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:	
Existing or new initiative? <input type="checkbox"/> Initiated/existing integration activity* <input checked="" type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>		List of partners involved: Dave Gibbons OPSEU Local 715 (Hospital Professionals) Dennis Brown Rainycrest Doris Meredith OPSEU Sector 18 Jill Colquhoun District of Rainy River Home for the Aged Joan Reid Kenora P.C. John Whitfield NWODHC Ken McGeorge Red Lake Magaret Cochenour Memorial Hospital Maureen Judge MOHLTC - NRB Paulina Chow NWODHC	
Please briefly describe the initiative: Key Components: <ul style="list-style-type: none"> • Integration opportunity for Acute Care facilities and Long-Term Care. • Hospital costs generally higher- - global budget as opposed to a per diem. • Need to have integration of OHIP and LHIN in order to achieve true quality of care and to eliminate silos. • Need to meet the criteria of the Canada Health Act and hopefully the recommendations in the Romanow Report. • More emphasis of better coordination of acute care beds with Long-Term Care beds. • Needs an area solution, could be district not necessarily regional ie Northern Ontario. • Solution is best decided by the districts. Why is it a priority: <ul style="list-style-type: none"> • Meet the new initiative of the government. • Assist in the continuum of care for the patient/client. • Consolidate services, streamline costs, provide new opportunities within existing budgets. 			
If this is an initiated/existing activity... What is the current status?		What are the outcomes/lessons learned (if any)?	
Lead contact person: Name: Dennis Brown Title: Chair Telephone: 807-274-9858 Organization: Rainycrest Email address: admin@rainycrest.com			

Title of administrative support service initiative:		Type of integration (more than one box can be checked)	
Opting out.....		<input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:	
Existing or new initiative?		List of partners involved:	
<input type="checkbox"/> Initiated/existing integration activity* <input checked="" type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>		Brian Thompson Alpha Court Gord Allen Alpha Court Kathryn Campbell Mary Bergland Ignace Kim Morgan Alzheimer Society Rodger Dufault Mary Bergland Ignace Vick Topozini 3 Cs Wendy Talbot Northwest CHC's	
Please briefly describe the initiative:			
Key Components: <ul style="list-style-type: none"> • Where is the vision? • Need for greater system change to occur before the creation of LHIN's. • Is this better or ...same model/same components. • Health care is a puzzle... • Change from illness/disease based model to a wellness,health prevention model.... • Funding needs to reflect this.... • Greater distribution of the power base to ensure a truly multi-disciplinary approach.... • Prevention is long-term... • Need to change the fundamental way we provide healthcare before the LHIN's are created. • Change priorities within health care....prevent the problem before it becomes an expensive surgical procedure..... • Make health and the individual the priority not illness and the treatment the priority....long-term (change and benefits) vs. band aid (current system). • Is LHIN the answer?? • Who has asked the question? 			
Why is it a priority: <ul style="list-style-type: none"> • We don't want to go down this road if we don't know where we are going....this could adversely affect organizations who need to continue to exist to provide care to those who have a small voice or no voice. • How are we to change our system if we do not have the opportunity to address the hard questions? 			
If this is an initiated/existing activity... What is the current status?		What are the outcomes/lessons learned (if any)?	
Lead contact person:			
Name: Wendy Talbot Title: Executive Director Telephone: 807-622-8235 ext. 233		Organization: Northwest CHC's Email address: wtalbot@norwestchc.org	

Title of administrative support service initiative:		Type of integration (more than one box can be checked)	
Reducing distance (realities of Northwestern Ontario) using innovation, technology focus on client, family, caregiver and professional.		<input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:	
Existing or new initiative?		List of partners involved:	
<input checked="" type="checkbox"/> Initiated/existing integration activity* <input type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>		Debbie Larson Red Lake Margaret Cochenour Memorial Hospital Janet Northham TBRHSC Karen Ingebrigtsen CCAC for Kenora and Rainy River Districts Marc Bouchard MOHLTC Marcia Scarrow CCAC for Kenora and Rainy River Districts Roger Dufault Mary Bergland Health Centre Ignace Susan Pilatzke RNAO Tuija Puiras CCAC of the District of Thunder Bay	
Please briefly describe the initiative:			
Key Components: <ul style="list-style-type: none"> • Telehome health for client and family support. • Telehome health for caregiver support. • Provides demographic information for funding agencies. • Creating a workgroup to identify opportunities within specific communities and within the Northwestern Ontario LHIN. • Build on existing innovative resources that can be adapted, to meet specific needs. • Analyze demographic and identify top 5 strategies to maximize outcomes. • Prioritize top 5 strategies and develop business plan. • Build partnerships to offset cost and foster intersectoral collaboration. • Seek community involvement and commitment. • Develop implementation plan including outcome evaluation. Examples include: <ul style="list-style-type: none"> • Catalogue of clinical education. • Common skills training. • Telehome health to support clients and families in their home environment. • Maximize professional resource support utilizing interactive workgroups and one-one client specific communication. 			
Why is it a priority: <ul style="list-style-type: none"> • Distance is a reality. • Cost of maintaining and supporting professional competence and providing specialized client services in remote locations is prohibitive. • Local capacity must be developed. • Cost of providing services in sparse populations is challenging and costly. • Innovation will look at different ways of supporting providers and clients in their home and funding agencies to maximize resources. 			
If this is an initiated/existing activity... What is the current status?		What are the outcomes/lessons learned (if any)?	
Lead contact person:			
Name: Mary Anne Fish Title: Branch Manager Telephone: 807-344-2002		Organization: Saint Elizabeth's Health Care Email address: mafish@saintelizabeth.com	

Title of administrative support service initiative: Communications: One common clinical tool for all levels of care.		Type of integration (more than one box can be checked) <input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Intersectoral <input type="checkbox"/> Other, describe:	
Existing or new initiative? <input type="checkbox"/> Initiated/existing integration activity* <input checked="" type="checkbox"/> New integration opportunity <i>*Note: initiated/existing activities do not need to be confined within LHIN boundaries</i>		List of partners involved: Brian Thompson Alpha Court Bruce Sutton Nipigon District Memorial Hospital Darlene Harrison St. Joseph's Care Group David Bell The Corporation of the Town of Marathon Ed Linkewich Falls Prevention Harriet Ladaudio Victorian Order of Nurses Neil MacOdrum Corporation of the Municipality of Greenstone	
Please briefly describe the initiative: Key Components: <ul style="list-style-type: none"> • Having one common clinical tool for all healthcare services and available electronically to all, as needed, can improve services and shorten delivery time. • Essential client information on common page(s) accessible to all providers. • Each provider discipline has assigned specific pages of tool. • Common tool accessible with proper key to specific information to specific providers. • To be used by all levels of service from public health, CCAC, community health, clinics, doctors, pharmacies, LTC, emergency, chronic, acute care hospitals etc.. • Common language and electronically accessible across the province: <ul style="list-style-type: none"> • Privacy Act sensitive • Sign-in by each provider for each time accessed for accountability. • Provincial focus to avoid regional or local silos. Why is it a priority: <ul style="list-style-type: none"> • The common tool with a common language (terms) avoids misunderstandings, ensures accuracy, streamlines service delivery and provides necessary information in a timely fashion to those service providers who require it. 			
If this is an initiated/existing activity... What is the current status?		What are the outcomes/lessons learned (if any)?	
Lead contact person: Name: Ed Linkewich Title: Coordinator Telephone: 807-343-8063 Organization: Falls Prevention Email address: fpc@lakeheadu.ca			

LHIN 14 Steering Committee

Name	Organization
Laurie Albertini	People Advocating for Change Through Empowerment
Joyce Atcheson	Ka:nen Our Children Our Future
Alice Bellavance	BISNO
Nancy Black	St. Joseph's Care Group
Paul Capon	Matawa First Nations
Helen Cromarty	Nishnawbe Aski Nation
Corey Dmitriew	St. Elizabeth Health Care
Bernice Dubec	Anishnawbe Mushkiki
Gwen DuBois-Wing	Northwestern Ontario District Health Council
Maurice Fortin	Canadian Mental Health Association
Darlene Furlong	Dryden Regional Health Centre
Darlene Harrison	St. Joseph's Care Group
Sonia Hill	Lake of the Woods District Hospital
Karen Ingebrigtsen	CCAC for Kenora and Rainy River Districts
Kathie Jack	Training and Learning Centre
Tricia Jordan	Health Sciences North
Mary Lou Kelley	Centre for Education and Research on Aging and Health (CERAH)
Ken McGeorge	Red Lake Margaret Cochenour Memorial Hospital
Judy Morrison	Weechi-It-Te-Win
Leona Murphy	Centre for Addiction and Mental Health
Carol Neff	Wesway
Barry Potter	St. Joseph's Care Group
Tuija Puiras	CCAC of the District of Thunder Bay
Aldene Rankin	CCAC for Kenora and Rainy River Districts
Bruce Sutton	Nipigon District Memorial Hospital
Jon Thompson	Riverside Community Counselling Services

Northwestern Ontario District Health Council Support to Steering Committee

Susan Costigan
Katie Heikkinen
Lee-Ann Nalezty
Kristin Shields

Sincere appreciation is extended to Keli Kornylo for her technical expertise and formatting skills.