LOCAL HEALTH INTEGRATION NETWORKS
AND
CONSISTENCY WORKSHOP

MARCH 30-31, 2009

WORKSHOP PROCEEDINGS

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INTRODUCTION

BACKGROUND

The Ministry of Health and Long-Term Care (Ministry) established the 14 Local Health Integration Networks (LHINs) to bring about an integrated health system that allows local communities to make decisions that respond to unique local health care needs. At the same time, the work of the LHINs is to be guided and directed by an overall provincial plan and initiatives. In 2008, a review evaluated the effectiveness of the transition and devolution of authority from the Ministry to the LHINs.[1] Although the review concluded that the devolution of authority had been effective and successful, it raised the issues of consistent processes and programs that require innovative thinking and a provincial perspective, and consistent communications between the LHINs, the Ministry and health service providers.

On March 30-31, 2009, the Chairs of the Boards and the CEOs of the 14 LHINs, provincial thought leaders, and representatives of health service organisations and the Ministry participated in a workshop on LHINs and consistency. Prior to the workshop, a short survey was administered to obtain preliminary thoughts on consistency from workshop participants and other selected thought leaders.

The objectives of the workshop were to:

- Assess the results of the survey on LHINs and consistency completed by 63 workshop participants and thought leaders.
- Identify the top areas for LHIN consistency and any areas where variability may be preferred. Identify the risks and mitigating strategies associated with these choices.
- Identify the structures and supports needed for LHINs to successfully implement consistency.

The workshop agenda and list of participants are presented in Appendices A and B, respectively.

PROCEEDINGS

INTRODUCTIONS

Bill MacLeod (CEO, Mississauga Halton LHIN) and Ken Deane (Assistant Deputy Minister, Health System Accountability and Performance Division) welcomed everyone to the workshop and thanked them for attending. Both speakers stressed the need for greater consistency and coordination across the 14 LHINs. Bill and Ken noted that LHINs and stakeholders who are impacted by this issue need to have an explicit

[1] Ministry of Health and Long-Term Care. 2008 (September 30). *MOHLTC-LHIN Effectiveness Review Final Report. Review conducted by KPMG.*

discussion and identify solutions as the LHIN model continues to evolve. These discussions also need to recognise the Ministry's responsibility for safeguarding a provincial system of services and for providing strategic guidance and appropriate operating parameters. Ken highlighted the fact that everyone in the healthcare system shares the same aspirations: to provide safe, quality care in a timely manner.

RESULTS OF THE LHIN CONSISTENCY SURVEY

In early March 2009, the Chairs of the Boards and the CEOs of the 14 LHINs, provincial thought leaders, and representatives of health service organisations and the Ministry were asked to complete an on-line survey on LHINs and consistency. Of 80 people who were given the opportunity to submit their views, 63 completed the survey (79% response). The survey results were presented at the workshop.

Recognising that many respondents play multiple roles, respondents were provided with a list of roles and were asked to select the one that best described their role (Table 1).

Table 1: Survey Respondents by Role

Chair or Member of a LHIN Board of Directors	14
Chief Executive Officer of a LHIN	8
Senior Executive of a Community Care Access Centre, Community Health Centre or Hospital	17
Employee of the Ministry of Health and Long-Term Care or other Government Ministry	3
Senior Executive or Board Member of a Provincial Association or Agency, Provincial Lead or Expert Panel Chair	13
Researcher and/or Academic	1
No response	7
Number of Survey Respondents	**63 (79%)**
Number of Individuals Asked to Participate	80

*Six individuals provided additional comments on their role.

The survey asked for opinions on LHINs and consistency in four sections.

Survey Section 1: The Importance of Consistency in Selected Areas. Ten statements were presented. Respondents were asked to rate the importance of a consistent approach in each of the 10 areas using a Likert scale: not at all important; not very important; somewhat important; very important; critically important. A "don't know" response was also provided. Respondents were able to suggest other areas where a consistent LHIN approach is important.

Survey Section 2: Effectiveness and Areas for Improvement. Respondents were asked to identify the areas that are being addressed effectively and those that need greater attention.

Survey Section 3: Barriers to Achieving Consistency. Respondents were asked to comment on the barriers that need to be overcome to achieve appropriate levels of consistency.

Survey Section 4: Additional Comments. Respondents were invited to provide additional comments on LHINs and consistency.

SURVEY SECTION 1: THE IMPORTANCE OF CONSISTENCY IN SELECTED AREAS

Respondents were asked to rate the importance of a consistent approach in 10 areas:

1. The LHINs need to use consistent policies and processes to support a consistent range of programs across the province.
2. The LHINs need to use consistent policies and processes to support best practices across the province.
3. The LINS need to use a consistent approach to measure consumer satisfaction across the province.
4. The LHINs need to have a consistent approach for managing provincial programs (e.g., trauma, critical care, cardiac, cancer, transplantation)
5. The LHINs need to have a consistent approach for interacting with provincial associations and organisations.
6. The LHINs need to have a consistent approach for managing and interacting with health service providers that cross multiple LHIN boundaries.
7. The LHINs need to report a consistent set of information to the Ministry.
8. The LHINs need to share a consistent set of information with each other.
9. The LHINs need to support their staff with consistent professional development training.
10. The LHINs' local system priorities need to support the province's strategic priorities and directions.

Figure 1 indicates that at least 70% of all respondents agreed that a consistent approach is critically or very important in all areas except for one. Only 50% of respondents felt it was critically or very important for LHINs to support staff with consistent professional development training.

The top three areas that were viewed to be most critically important by respondents were:

- The LHINs need to have a consistent approach for managing provincial programs (71% critically important).
- The LHINs' local system priorities need to support the province's strategic priorities and directions (61% critically important).
- The LHINs need to report a consistent set of information to the Ministry (57% critically important).

Figure 1: The Importance of Consistency (All Respondents)

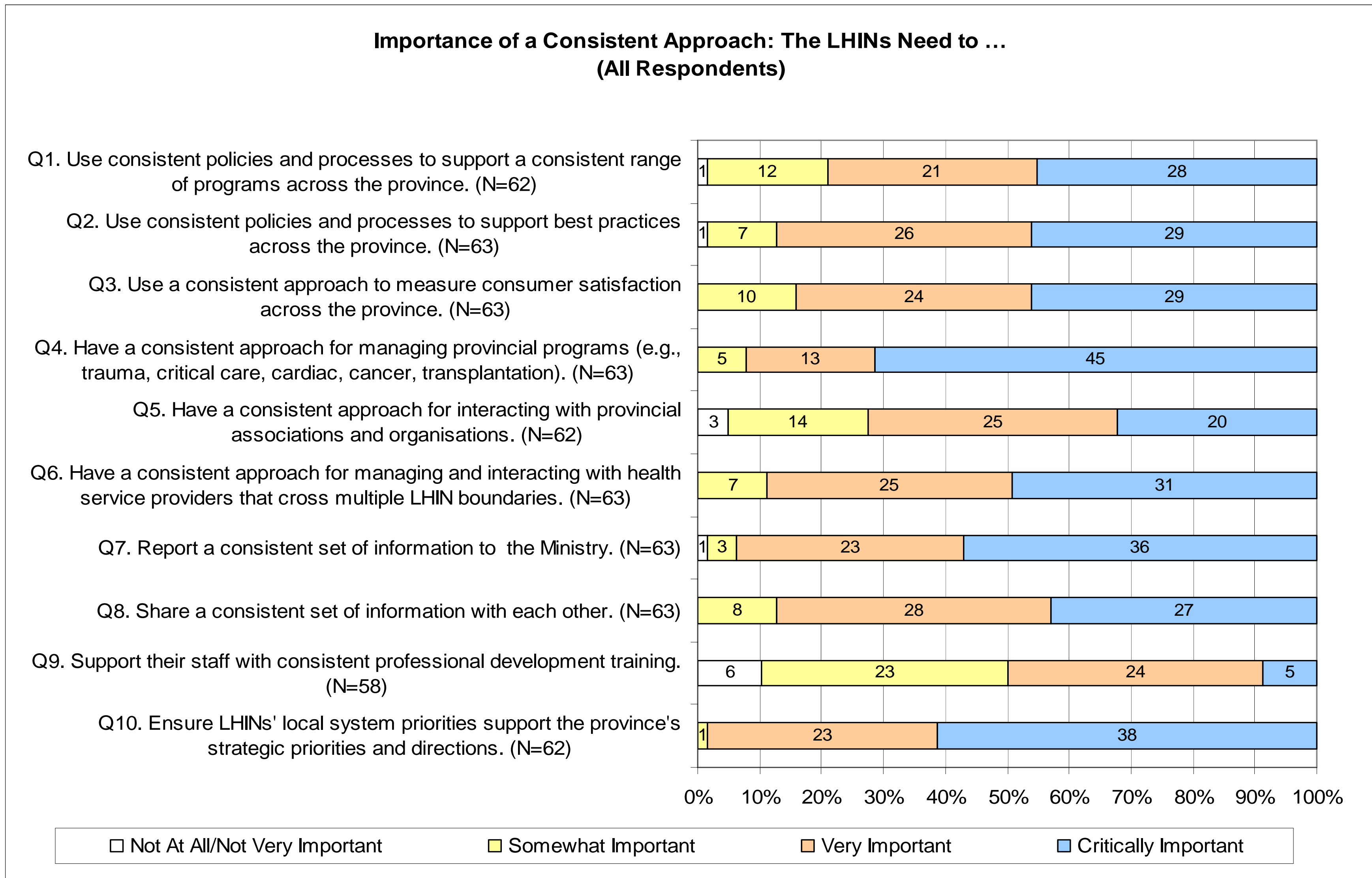
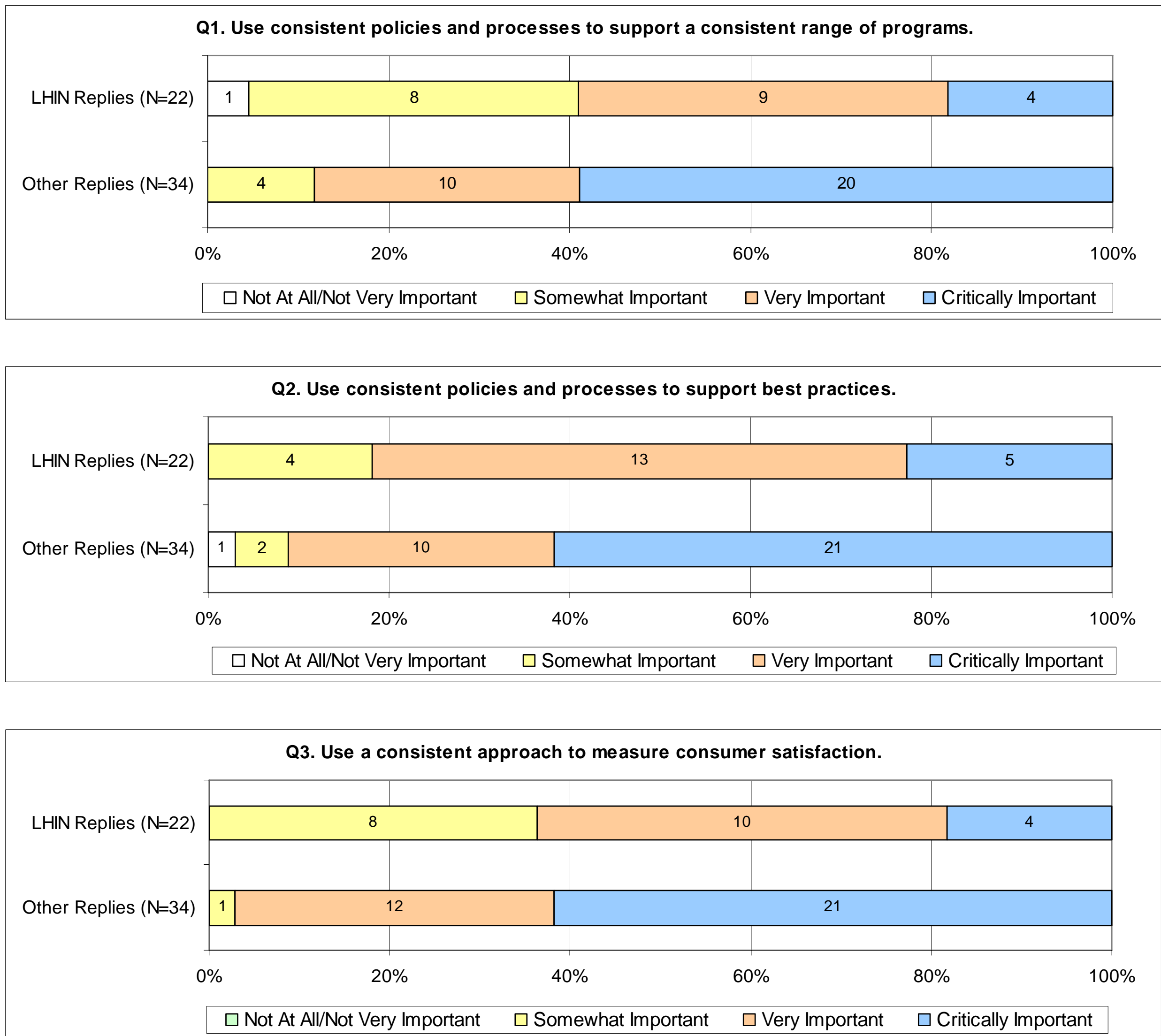
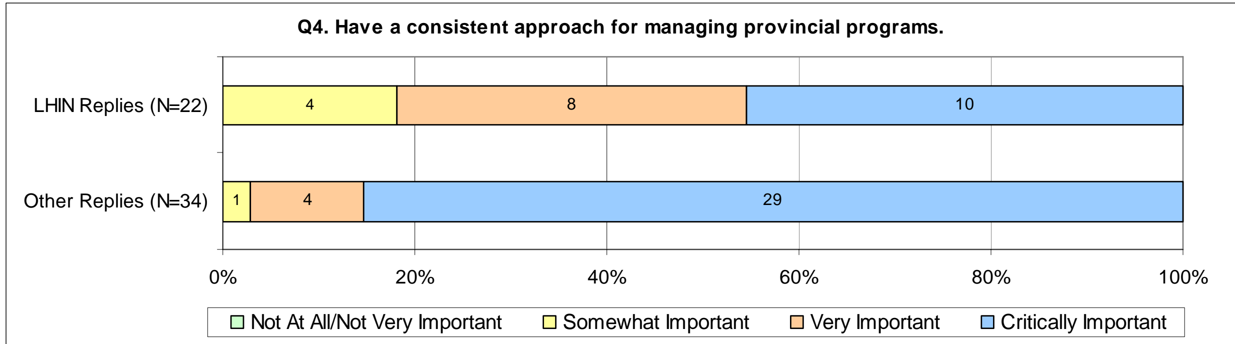


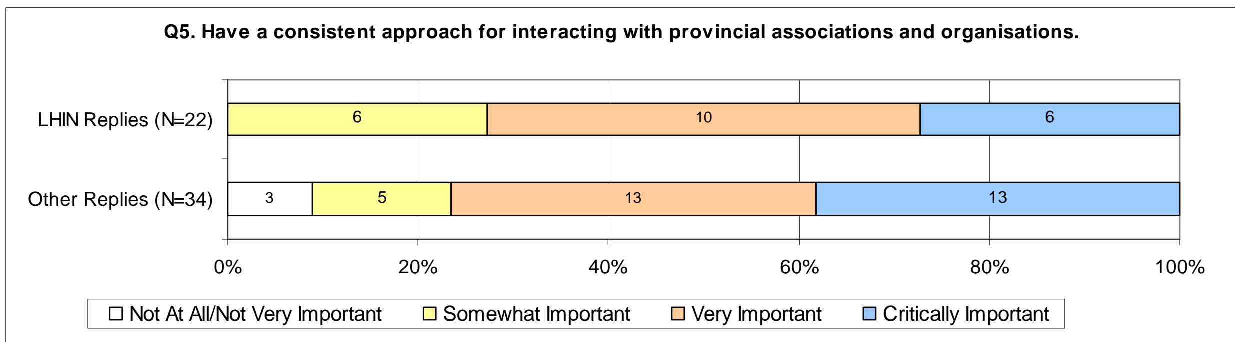
Figure 2 presents a series of graphs that analyse the importance of consistency in each of the 10 areas by type of respondent. In each graph, the LHIN respondents (22 surveys) are compared to all other respondents (34 surveys). Seven surveys could not be used in this analysis since these respondents did not identify their role.

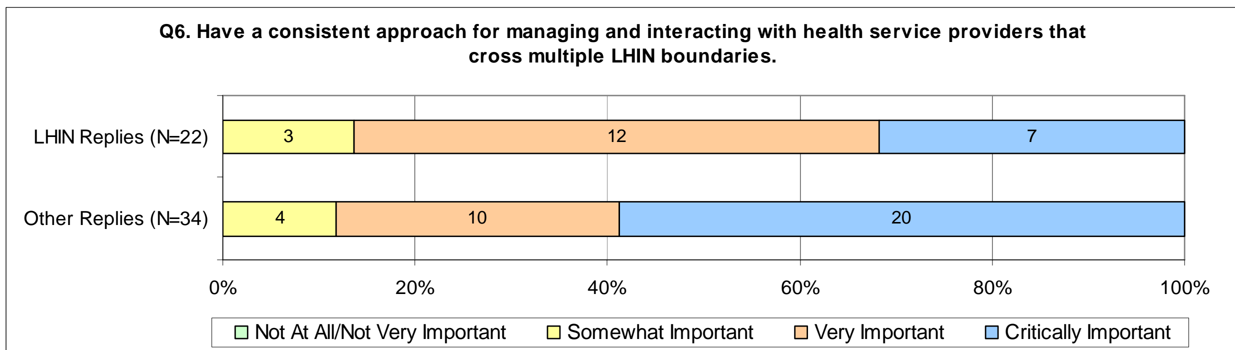
The 10 graphs clearly indicate that a larger proportion of other respondents rated each of the 10 areas of consistency as critically important compared to the LHIN respondents. In most areas, the difference in opinion was as large as 2:1. In some cases, the difference was as great as 3:1 (Q1: use consistent policies and processes to support a consistent range of programs; Q2: use consistent policies and processes to support best practices; Q3 use a consistent approach to measure consumer satisfaction).

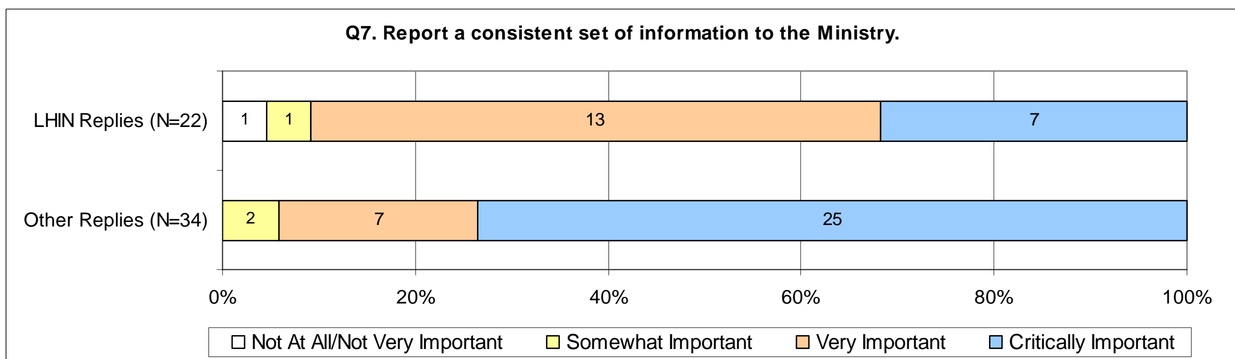
Figure 2 (Q1-Q10): The Importance of Consistency by Respondent Category
The LHINs Need to …

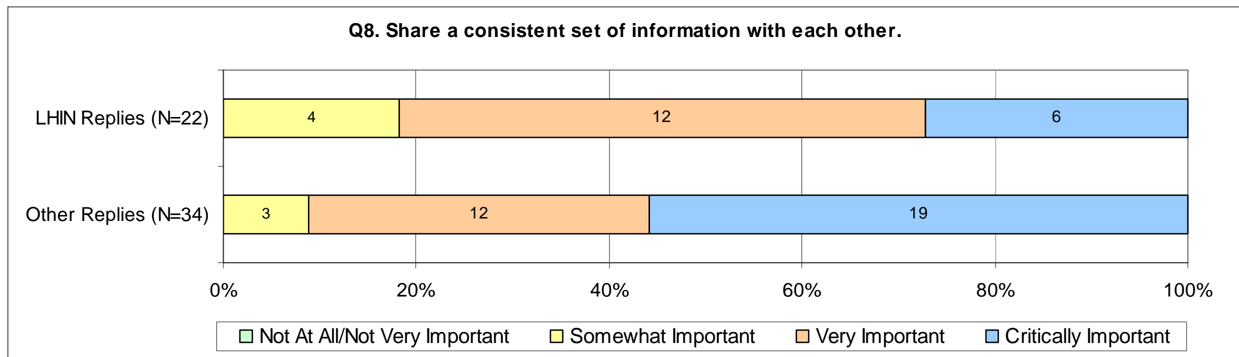


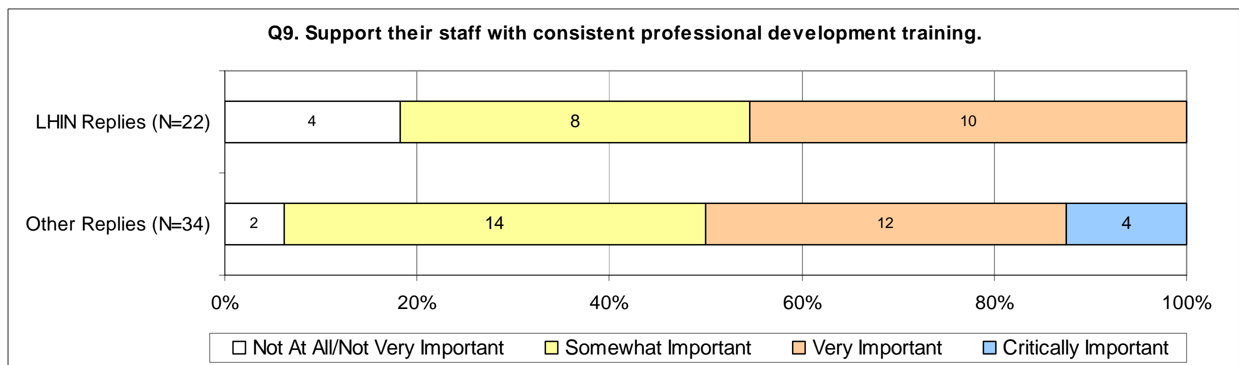

Q4. Have a consistent approach for managing provincial programs.
LHIN Replies (N=22)
Other Replies (N=34)
4
8
10
1
4
29
0%
20%
40%
60%
80%
100%
Not At All/Not Very Important
Somewhat Important
Very Important
Critically Important

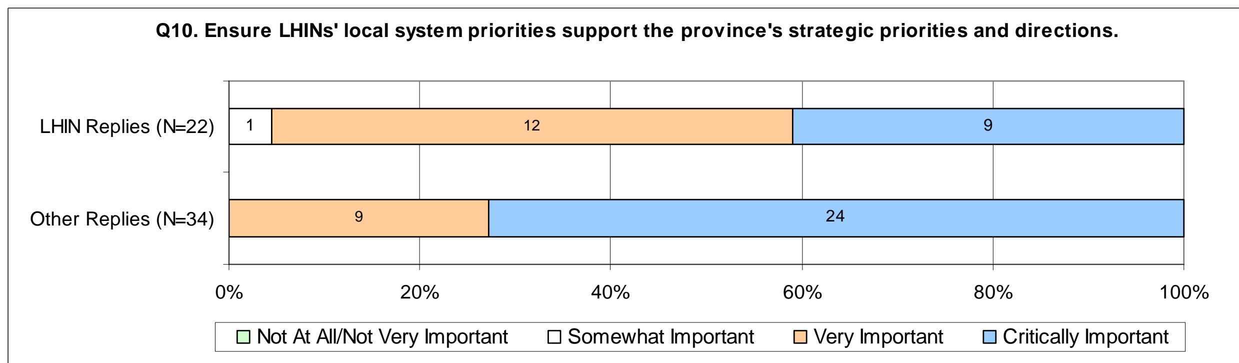

Q5. Have a consistent approach for interacting with provincial associations and organisations.
LHIN Replies (N=22)
Other Replies (N=34)
6
10
6
3
5
13
13
0%
20%
40%
60%
80%
100%
Not At All/Not Very Important
Somewhat Important
Very Important
Critically Important


Q6. Have a consistent approach for managing and interacting with health service providers that cross multiple LHIN boundaries.
LHIN Replies (N=22)
Other Replies (N=34)
3
12
7
4
10
20
0%
20%
40%
60%
80%
100%
Not At All/Not Very Important
Somewhat Important
Very Important
Critically Important


Q7. Report a consistent set of information to the Ministry.
LHIN Replies (N=22)
Other Replies (N=34)
1
1
13
7
2
7
25
0%
20%
40%
60%
80%
100%
Not At All/Not Very Important
Somewhat Important
Very Important
Critically Important







When asked to identify other areas where consistency was important, the major theme areas were:

- Funding methodology/allocation: across LHINs, providers organizations and services (suggested by other respondents only).
- Common understanding of everyone's role, responsibilities, authorities and operating principles: Ministry as stewards, LHINs, provider organizations (suggested equally by LHIN and other respondents).
- LHIN governance: principles and policies for Boards, professional development training, evaluation of effectiveness (suggested by LHIN respondents only).
- Communications to the public and providers (suggested by LHIN respondents only).

- Other: planning, human resource management, benchmarking and performance evaluation, CEO performance and compensation, community engagement, quality and safety (suggested equally by LHIN and other respondents).

SURVEY SECTION 2: EFFECTIVENESS AND AREAS FOR IMPROVEMENT

Survey respondents were asked to identify the areas that are being addressed effectively and those that need more attention.

As Table 2 indicates, respondents reported that the three areas being addressed most effectively are:

- Reporting information to the Ministry (20 out of 63 respondents or 32%);
- Ensuring local priorities support provincial priorities (17 out of 63 respondents or 27%); and
- Managing provincial programs (8 out of 63 respondents or 13%).

Table 2: Areas That Are Being Addressed Effectively

		All (63)	**LHIN (22)**	**Other (34)**	**Anon (7)**
1.	Policies/processes to support consistent range of programs	7	4	3	0
2.	Policies/processes to support best practices	2	2	0	0
3.	Measuring consumer satisfaction	7	3	2	2
4.	Managing provincial programs	8	4	4	0
5.	Interacting with provincial assoc/orgs	4	3	1	0
6.	Managing/interacting with health service providers across LHINs	3	3	0	0
7.	Reporting information to the Ministry	20	10	10	0
8.	Sharing information across LHINs	4	2	2	0
9.	Supporting staff with prof development training	4	2	1	1
10.	Ensuring local priorities support provincial priorities	17	7	8	2

Table 3 identifies the areas that need more attention. The top three areas are:

- Policies/ processes to support a consistent range of programs (42 out of 63 respondents or 67%);
- Policies/processes to support best practices (34 out of 63 respondents or 54%); and
- Managing/interacting with health service providers across LHINs (51%).

Table 3: Areas That Need More Attention

		All (63)	LHIN (22)	Other (34)	Anon (7)
1.	Policies/processes to support consistent range of programs	42	11	27	4
2.	Policies/processes to support best practices	34	16	16	2
3.	Measuring consumer satisfaction	31	15	16	0
4.	Managing provincial programs	28	11	15	2
5.	Interacting with provincial assoc/orgs	27	15	11	1
6.	Managing/interacting with health service providers across LHINs	32	15	15	2
7.	Reporting information to the Ministry	15	10	5	0
8.	Sharing information across LHINs	25	15	9	1
9.	Supporting staff with prof development training	20	12	8	0
10.	Ensuring local priorities support provincial priorities	22	12	10	0
11.	Other *	13	2	11	0

*Other areas included such things as funding methodology/allocation, Board governance and performance, communications, data quality, community engagement, demonstrating to the public value for money spent, etc.

SURVEY SECTION 3: BARRIERS TO ACHIEVING CONSISTENCY.

Respondents identified numerous barriers to achieving consistency. The barriers that were mentioned most often are noted below and are illustrated with quotations.

1. There is a lack of clear understanding and/or acceptance of everyone's roles, responsibilities and authorities.

Of those who identified this barrier, 18% were LHIN respondents and 82% were other respondents. Comments on this barrier included the following:

- "We need consistent messaging across all levels with appropriate attention given to those whose words or actions fall outside the consensus, including the Minister." (LHIN respondent)
- "The Ministry must establish clearly that it sets an overall agenda and priorities which the LHINs then implement. LHIN boards and CEOs must understand that the Ministry is ultimately in charge." (Other respondent)
- "We need clarity and understanding of what has been devolved to the LHINs completely, what are the boundaries of "stewardship" the Ministry still has with respect to these programs, and what program areas require central coordination or stronger stewardship by the Ministry." (Other respondent)
- "LHINs need to be perceived as the main conduit between the Ministry strategic /system development role and the local providers delivering services. As long as larger providers are seen/perceived as having direct access to the Ministry, LHINs will be challenged in trying to appear more consistent." (Other respondent)

- "The LHINs need to step back and view themselves as being local and not necessarily having to consult and establish 26 plus planning tables. This is a colossal barrier to achieving any kind of consistency provincially - when it is not even happening within a geographic area." (Other respondent)
- "The Ministry needs to be more directive with the expectations they have of the LHINs and understand that with 14 LHINs each going slightly their own way on key priority issues there is increasing fragmentation. Not every thing needs to be exactly the same, but some organized coordination of major issues would be helpful in these early days. The LHINs need to really work together and they need to value the input and insight of those of us who really do the work day in and day out and not see it as a threat or sign of resistance." (Other respondent)

2. LHINs operate as silos and lack a collaborative mindset.

Of those who identified this barrier, 63% were LHIN respondents and 37% were other respondents. Comments on this barrier included the following:

- "One of the key initiatives in the LHIN mandate is to create a true system of health care which is impossible when the very group that is suppose to do that – the LHINs – are silos onto themselves. This is how we are seen locally and provincially." (LHIN respondent)
- "There is a competitive nature in the LHINs … a sense of independence and arrogance … a lack of agreement as to what should be and needs to be shared … there is a need for more openness, transparency and trust among LHINs." (Consolidated comments from four LHIN respondents)
- "The thinking that the LHINs or their CEOs are competing against one another is a significant barrier … the 14 separate silos is becoming very challenging." (Consolidated comments from two Other respondents)

3. The level of knowledge and skills across the LHINs varies (Boards and senior staff).

Of those who identified this barrier, 27% were LHIN respondents and 73% were other respondents. Comments on this barrier included the following:

- "There is a need for a common orientation of Board members and senior staff … consistent knowledge and skill sets are needed across the LHINs … a greater understanding of business and government processes is needed." (Consolidated comments from three LHIN respondents)
- "I think there needs to an acknowledgement that leadership at the governance and senior team levels varies with some leaders more effective than others … we need to identify why and decide what kind of behaviours are acceptable ... what training, experience and personality are needed to have credibility and do the job." (Consolidated comments from three Other respondents)
- "There is enormous variability in the actual performance of the Boards. They use different models based on their experiences but many of these would never pass the

test of best practice. The governance leadership expectations of chairs/vice chairs and the actual performance of some of them needs to improve significantly. Too many governors are too involved in the operations and are not looking at the system. (Other respondent)

4. A provincial LHIN structure to support consistency does not exist.

Of those who identified this barrier, 89% were LHIN respondents and 11% were other respondents. Comments on this barrier included the following:

- "We need to dedicate a resource(s) to coordinate efforts across all 14 LHINs beyond what the Ministry does in its oversight function. All 14 of us tend to be locally-facing, and we are not thinking, living, breathing consistency. (LHIN respondent)
- "LHINs lack of a collaborative structure which will ensure the 14 LHINs can speak as a collective. (LHIN respondent)
- Suggested ideas for a provincial structure include: a secretariat and central data repository; a provincial association; a LHIN joint operational and strategy office; "we have never had a 15th LHIN and there is debate about whether we should. Perhaps the LHIN Liaison Branch should morph into the Ministry-LHIN Liaison Branch because so much work needs to be done in the Ministry with appropriate resources directed to the tasks at hand." (Consolidated comments from four LHIN respondents)
- "The LHINs need a central structure and resources to coordinate efforts." (Other respondent)

5. There is a lack of consistent and clear strategy, policies, standards and directions from the Ministry.

Of those who identified this barrier, 88% were other respondents and 12% were anonymous respondents. Comments on this barrier included the following:

- "These needs to be clarity from the Minister that LHIN Chairs are accountable to deliver the government's priorities first and foremost. (Other respondent)
- "Government should stop saying one thing, and doing another … it's very confusing. (Other respondent)
- "There is a lack of clear policy direction from the Ministry. (Anonymous respondent)

6. It is difficult to balance the need for local flexibility and provincial consistency.

Of those who identified this barrier, 57% were LHIN respondents, 29% were other respondents, and 14% were anonymous respondents. Comments on this barrier included the following:

- "In many cases, legitimate differences exist between LHINs in terms of how services are delivered and these need to be understood. It is difficult to balance the need for regional differences with the need for consistency. (LHIN respondent)

- "Our Boards tend to "pull" us in local directions. There is the need for consistency in the governance element along similar/same lines." (LHIN respondent)
- "Unfortunately, LHINs have misconstrued their need to reflect local differences in the needs of their communities with feeling that they could also do their own thing in establishing/interpreting policy frameworks and creating business and governance processes. A significant degree of process and governance standardization is based on true "best practice", setting out expectations, developing consistent scorecards and performance assessments on how LHINs themselves perform would enable serious improvements to occur." (Other respondent)
- "There is the lack of a shared understanding why consistency is important and whether the goal is consistency in outcomes, structures, processes or all three." (Anonymous respondent)

7. The Ministry micro manages.

Of those who identified this barrier, 80% were LHIN respondents and 20% were other respondents. Comments on this barrier included the following:

- "The Ministry has to stop micro-managing from head office and let the LHINs carry out the Ministry and Minister's priorities at the local level. (LHIN respondent)

8. The LHINs micro manage.

Of those who identified this barrier, 100% were other respondents. A comment on this barrier included the following:

- "Command and control thinking in the LHIN staff has led to a great deal of tension in the health system." (Other respondent)

9. Other Barriers.

Other barriers that were mentioned by one or a few respondents included:
- There is a lack of trust and collaboration between the Ministry and LHINs.
- Consistency needs to be clearly defined and the LHINs need to be willing to make it a priority.
- The Ministry needs to declare its commitment to and support the LHIN model.
- We have an unstable political environment.
- There is little focus on best practices, evidence and innovation.
- There is no clear consensus on why consistency is important.
- There is a lack of leadership commitment to consistency.
- There is financial inequity across the LHINs.
- LHINs are not dealing with poor performers.
- The LHINs have too many priorities.

SURVEY SECTION 4: ADDITIONAL COMMENTS

Respondents were invited to provide additional comments on LHINs and consistency. From the 28 additional comments that were made, a sample of comments are presented below.

- “Consistency is not always possible nor desirable. Using the same benchmarks for the northern LHINs as those for the southern LHINs disadvantages and can even destabilize the northern communities.” (LHIN Respondent)
- “As the system is transforming at both the provincial and the local level it will be important for a balance to be struck between the uniqueness of each of the LHIN geographical areas and the desire for "sameness" across the larger provincial geography. Local health systems, meeting the needs of residents at the local level implies that there will be differences in what, how, where and by whom services may be provided.” (LHIN Respondent)
- “My perception has been that the consistency “issue” is one that is largely driven by Associations who much prefer a central target on which to focus their advocacy agenda; it is much harder to produce results for their memberships when the effort must be split fourteen ways. Likewise, unions, lawyers, and province-wide advocacy groups have much greater difficulty achieving their interests in the LHIN environment and 'consistency' becomes the code word for a return to centralized Ministry control.” (LHIN Respondent)
- “I fear an Alberta model, which is really a failure of government and agencies to focus on outcomes/results within a provincial framework.” (Other Respondent)
- “Carpe diem! In the extremely tough times coming, lets get this straight, batten down the hatches, and support each other in a consistent fashion. This is not the time for brilliant new ideas- this is survival! Carpe diem, again.” (Other Respondent)
- “The question of the need for consistency probably could not be adequately addressed until now because of the lack of prior experience. Consistency, or the lack thereof, seems to me to have been at the centre of many of the issues and recommendation in the MLER. Congratulations to Ken Deane for taking this question/issue aside and giving it special priority and attention.” (LHIN Respondent)
- “This session on March 31st should be followed by a series of interactions with the Boards and CEOs. A one-off will not succeed.” (LHIN Respondent)
- “I am extremely happy to see that we are finally going to not only talk/look at consistency but do it.” (LHIN Respondent)

GUEST SPEAKER: DR. PENNY BALLEM

Dr. Penny Ballem was the workshop’s guest speaker. As the Chief Administrative Officer for the City of Vancouver, and former Deputy Minister of Health in British Columbia, Dr. Ballem shared her experiences and insights on healthcare. Dr. Ballem’s PowerPoint presentation is found in Appendix C.

TOP AREAS FOR LHIN CONSISTENCY: SMALL GROUP DISCUSSIONS

Workshop participants were placed into eight small groups and were asked to identify the top areas for LHIN consistency. Group discussions were wide-ranging. The top areas for consistency and the number of groups that highlighted these areas in their reports to the plenary session are noted below.

Top Areas for LHIN Consistency: Small Groups	Number of Groups
Standards, Best Practices and Clear Expectations for Performance and Outcomes • Clear and consistent standards and best practices need to be established, and expectations identified for LHIN performance and outcomes. It was suggested that these standards, best practices and expectations should support consistent programs, policies and processes that all LHINs should deliver, with LHINs determining *how* they would deliver these programs (e.g., Chronic Disease Management, CCAC service levels, etc.). It was further suggested that core services and programs should be available in all LHINs (either within the LHIN or through agreements between LHINs).	8
Clear and Consistent Accountabilities • Clear and consistent accountabilities must be identified for performance. Accountabilities should be set out in accountability agreements along with a process for escalation if deliverables are not met.	7
Data and Information • Consistent and reliable data should be collected and shared among the LHINs, Ministry and health service providers. These data should be used to support standards and best practices, and to measure outcomes. There should be a judicious collecting of data (i.e., quality rather than quantity).	5
Governance • Recognising that LHINs were established to meet the needs of different populations, LHIN boards need assistance to address issues consistently (e.g., tool kits, communication messages).	4
Ensure a Common Understanding of Roles • To support LHIN consistency, there needs to be a common understanding of the roles of the Ministry as stewards and the LHINs as local planners (e.g., roles in policy, priorities, processes).	4
Consistent Funding Methodology • A consistent and transparent funding methodology needs to be developed. It was suggested that the methodology recognise population needs, levels of care, and rewards for efficiencies.	4
Consistent Rules of Engagement and Communication Between LHINs, Between LHINs and the Ministry, and Between LHINs, the Ministry and Health Care Providers • Rules of engagement and communication will help ensure that issues are addressed more consistently and effectively.	3
Clear Provincial Priorities Supported by LHIN Local Priorities • The province's priorities need to be clearly articulated especially when they undergo change. In addition, the LHINs' local system priorities need to support the province's strategic priorities and directions.	3

Top Areas for LHIN Consistency: Small Groups	Number of Groups
Consistent Approach to Manage Provincial Programs • LHINs need a consistent approach to manage provincial programs that includes standards, deliverables and outcomes. LHIN/hospital accountability agreements must be consistent for the provincial programs.	3
Consumer Satisfaction • The LHINS need to use a consistent approach to measure consumer satisfaction. Different tools may be needed for different sectors.	2
Other Areas Mentioned by One Group Each • Create a LHIN Collaborative Structure to support consistent implementation. • Establish principles of equitable access. • Develop a consistent approach for interacting with provincial associations and organisations. • Develop a consistent framework for LHIN decision making. • Develop a consistent approach to community engagement. • Develop a consistent approach to programs that cross borders. • Establish a provincial body to coordinate all provincial programs. • Negotiate labour contracts consistently.	1

TOP ACTIONS TO SUPPORT LHIN CONSISTENCY THAT SHOULD BE INITIATED IMMEDIATELY: SMALL GROUP DISCUSSIONS

The small groups were asked to identify the top three actions to support LHIN consistency that should be initiated immediately. The items and the number of groups that highlighted these items in their reports to the plenary session are noted below.

Top Action Items: Small Groups	Number of Groups
Clarify the Ministry's Priorities and Expected Deliverables, and the Role of the LHINs in Meeting These Deliverables Specific actions that were suggested include: • Clarify the Ministry's priorities, deliverables and metrics, and consistent processes that LHINs need to use to meet these priorities. • Develop a focused and outcome-oriented description for what success looks like when these priorities are met. • Clarify whether Mental Health and Addictions is a Ministry priority. • Address the need to reallocate global budgets to support local priorities and deliverables.	8
Develop a Framework for How to Work Together Specific actions that were suggested include: • Establish rules for working together and communicating with each other. • Identify clear expectations of what we need from each other (Ministry, LHINs, providers). • Establish a resource table and conflict resolution forum. • Develop a decision-making framework.	5
Develop Valid and Reliable Data Specific actions that were suggested include: • Data should be usable to make decisions. • Good ALC data needs to be collected.	3

Top Action Items: Small Groups	Number of Groups
Address Funding Methodology Specific actions that were suggested include: • Funding should support pay-for-performance and provincial priorities. • Funding needs to be flexible and transparent. • Funding methodologies should address Ministry to LHINs, and LHINS to health service providers.	3
Other Areas Mentioned by One Group Each • Support the consistent implementation of transitional beds (e.g., consistent policy on the use of retirement beds, legislative and regulatory framework, standards). • Communicate to the field the structures, committees and processes that are in place or are being planned as announced by Ron Sapsford and others at the workshop (e.g., LHIN Collaborative, Ministry Strategic Table, etc.). • Establish the LHIN Collaborative (LHINC) and have it address standards, expectations and funding issues. • Clarify what the provincial programs are and what they do. • Develop tools and supports to encourage and, if necessary, enforce integration. • Develop leaders who will get everyone excited about coordination, collaboration and integration. • Develop a provincial strategic plan. • Develop a methodology to plan capacity. • Define what consistency means in terms of client outcomes • Discuss ways to embrace innovation at the local level	1

APPENDIX A: WORKSHOP AGENDA

LOCAL HEALTH INTEGRATION NETWORKS
AND CONSISTENCY WORKSHOP

Monday, March 30, 2009 (5:30 p.m. – 8:45 p.m.)
Tuesday, March 31, 2009 (8:00 a.m. – 12:30 p.m.)
Metropolitan Hotel – Toronto Ballroom
108 Chestnut Street, Toronto

WORKSHOP OBJECTIVES

Assess the results of the survey on LHINs and consistency completed by 63 workshop participants and thought leaders.

Identify the top areas for LHIN consistency and any areas where variability may be preferred. Identify the risks and mitigating strategies associated with these choices.

Identify the structures and supports needed for LHINs to successfully implement consistency.

AGENDA

MONDAY, MARCH 30, 2009 (5:30 p.m. – 8:45 p.m.)

Registration, Reception and Cash Bar **5:30-6:15 p.m.**

Welcome and Opening Remarks **6:15-6:30 p.m.**
Bill MacLeod, Chief Executive Officer, Mississauga Halton LHIN
Ken Deane, Assistant Deputy Minister, Health System Accountability and Performance Division, Ministry of Health and Long-Term Care

Dinner 6:30 p.m.

Workshop Overview and Results of the LHIN Consistency Survey **7:30-8:00 p.m.**
Joann Trypuc, Facilitator

Guest Speaker: Dr. Penny Ballem **8:00-8:40 p.m.**
Chief Administrative Officer, City of Vancouver
Former Deputy Minister of Health, British Columbia

Concluding Remarks **8:40-8:45 p.m.**
Bill MacLeod and Ken Deane

TUESDAY, MARCH 31, 2009 (8:00 a.m. – 12:30 p.m.)

Breakfast 8:00 a.m.- 8:30 a.m.

Objectives for the Morning, Recap of Key Survey Results and General Discussion **8:30-9:00 a.m.**

Top Areas for LHIN Consistency **9:00 a.m.-10:30 a.m.**
Areas Where Variability May be Preferred
Risks and Mitigating Strategies Associated With These Choices
Small Group Discussions, Report Back and Group Discussion

Break 10:30 a.m.-10:45 a.m.

Structures and Supports Needed for LHINs to Successfully Implement Consistency **10:45 a.m.-12:15 p.m.**
Small Group Discussions, Report Back and Group Discussion

Concluding Remarks **12:15 p.m.-12:30 p.m.**
Bill MacLeod and Ken Deane

Lunch

APPENDIX B: WORKSHOP PARTICIPANTS

LOCAL HEALTH INTEGRATION NETWORKS

Central LHIN
1. Ken Morrison, Chair
2. Hy Eliasoph, CEO

Central East LHIN
3. Foster Loucks, Chair
4. Deborah Hammons, CEO

Central West LHIN
5. Joe McReynolds, Chair
6. Mimi Lowi-Young, CEO

Champlain LHIN
7. Michael LeMay, Vice Chair
8. Dr. Robert Cushman, CEO

Erie St. Clair LHIN
9. Mina Grossman-Ianni, Chair
10. Gary Switzer, CEO

Hamilton Niagara Haldimand Brant LHIN
11. Jack Brewer, Vice Chair
12. Pat Mandy, CEO

Mississauga Halton LHIN
13. John Magill, Chair
14. Bill MacLeod, CEO

North East LHIN
15. Remy Beaudoin, CEO

North Simcoe Muskoka LHIN
16. Lynn Stevenson, Vice Chair
17. Bernie Blais, CEO

North West LHIN
18. Janice Beazley, Chair
19. Andy Gallardi, Senior Director

South East LHIN

20. Georgian Thompson, Chair
21. Paul Huras, CEO

South West LHIN

22. Norm Gamble, Chair
23. Michael Barrett, CEO

Toronto Central LHIN

24. Mohamed Dhanani, Chair
25. Matt Anderson, CEO

Waterloo Wellington LHIN

26. Kathy Durst, Chair
27. Sandra Hanmer, CEO

MINISTRY OF HEALTH AND LONG-TERM CARE

28. Ken Deane, Assistant Deputy Minister, Health System Accountability and Performance
29. Melissa Farrell, Manager, Implementation Branch, Health System Accountability and Performance
30. Susan Fitzpatrick, Executive Director, Negotiations and Accountability Management
31. Carrie Hayward, Director, LHIN Liaison, Health System Accountability and Performance
32. John McKinley, Assistant Deputy Minister, Health System Information Management and Investment
33. Ron Sapsford, Deputy Minister

ADDITIONAL THOUGHT LEADERS

34. Bonnie Adamson, President and CEO, North York General Hospital
35. Jean Bartkowiak, CEO, Bruyere Continuing Care
36. Janet Beed, President and CEO, Markham Stouffville Hospital
37. Sheila Braidek, Executive Director, Regent Park Community Health Centre
38. Dan Carriere, President and CEO, Southlake Regional Health Centre
39. Tom Closson, President and CEO, Ontario Hospital Association
40. Dr. Corin Greenberg, Executive Director, Paediatric Oncology Group of Ontario
41. Dr. Alan Hudson, Executive Lead, Access to Services and Wait Times; Chair, eHealth Ontario
42. David Kelly, Executive Director, Ontario Federation of Community Mental Health and Addiction Programs
43. John King, Executive Vice President and Chief Administrative Officer, St. Michael's Hospital
44. Dr. Bernard Lawless, Provincial Lead, Critical Care and Trauma (St. Michael's Hospital)

45. Brenda McNeill, Executive Director, Anne Johnston Health Station
46. Kevin Mercer, Director, Member Outreach Program and Public Affairs and Communications, Ontario Medical Association
47. Jane Moore, Executive Director, Senior Peoples' Resources in North Toronto Inc. (SPRINT)
48. Robert Morton, Board Chair, North Simcoe Hospital Alliance
49. Margaret Mottershead, CEO, Ontario Association of Community Care Access Centres
50. Stephen Picott, Senior Vice President, Long-Term Care Operations for Chartwell Seniors Housing REIT
51. Donna Rubin, CEO, Ontario Association of Non-Profit Homes and Services for Seniors
52. Rebecca Scott, Manager, Communications and Strategic Partnerships, Extendicare (Canada) Inc.
53. Shirlee Sharkey, President and CEO, St. Elizabeth Health Care
54. Michael Sherar, Vice President, Planning and Regional Programs, Cancer Care Ontario
55. Dr. Kevin Smith, Provincial Lead, Alternate Level of Care; St. Joseph's Healthcare Hamilton)
56. Dr. Thomas Stewart, Chair, LHIN Critical Care Leads (Mt. Sinai Hospital)
57. Terry Sullivan, President and CEO, Cancer Care Ontario
58. Cathy Szabo, Executive Director, Central CCAC
59. Dr. Jim Waddell, Chair, Orthopaedic Expert Panel (St. Michael's Hospital)

WORKSHOP SUPPORT

60. Dr. Penny Ballem, Chief Administrative Officer, City of Vancouver (Guest Speaker)
61. Barry Monaghan, Interim Lead, LHIN Collaborative
62. Dr. Joann Trypuc, Workshop Facilitator
63. Dr. Jan Walker, Associate, LHIN Collaborative

APPENDIX C: PRESENTATION BY GUEST SPEAKER, DR. PENNY BALLEM

LHINs
Optimizing the Balance:
Consistency and Coherence
versus
Autonomy and Local Responsiveness

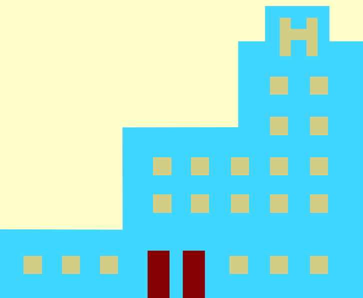
LHINs Consistency Workshop

March 30 2009

Penny Ballem MD FRCP

Chief Administrative Officer, City of Vancouver

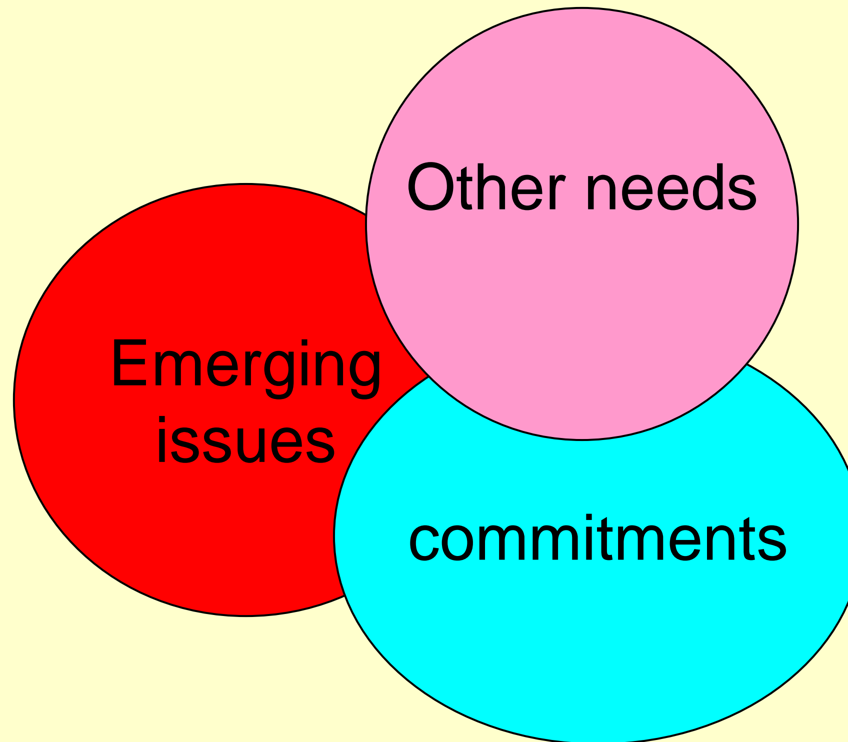
Former Deputy Minister of Health Province of BC



Consistency (and Coherence): Key Issues for BC

- Clarity of direction from Government:
  - politics
  - policy
  - resources
  - timeliness of decisions
- Roles
- Priorities
- Community Responsiveness
- Risk:
  - Quality
  - physicians
  - Resources

Government Priorities



Working Together: BC

Accountability:

- Ministry Service Plans
- Ministry Service Plan Reports
- HA Performance Agreement/ Letter of Expectation
- HA Service Plan/Redesign Plan
- HA Budget Plan
- HA public Board Meetings

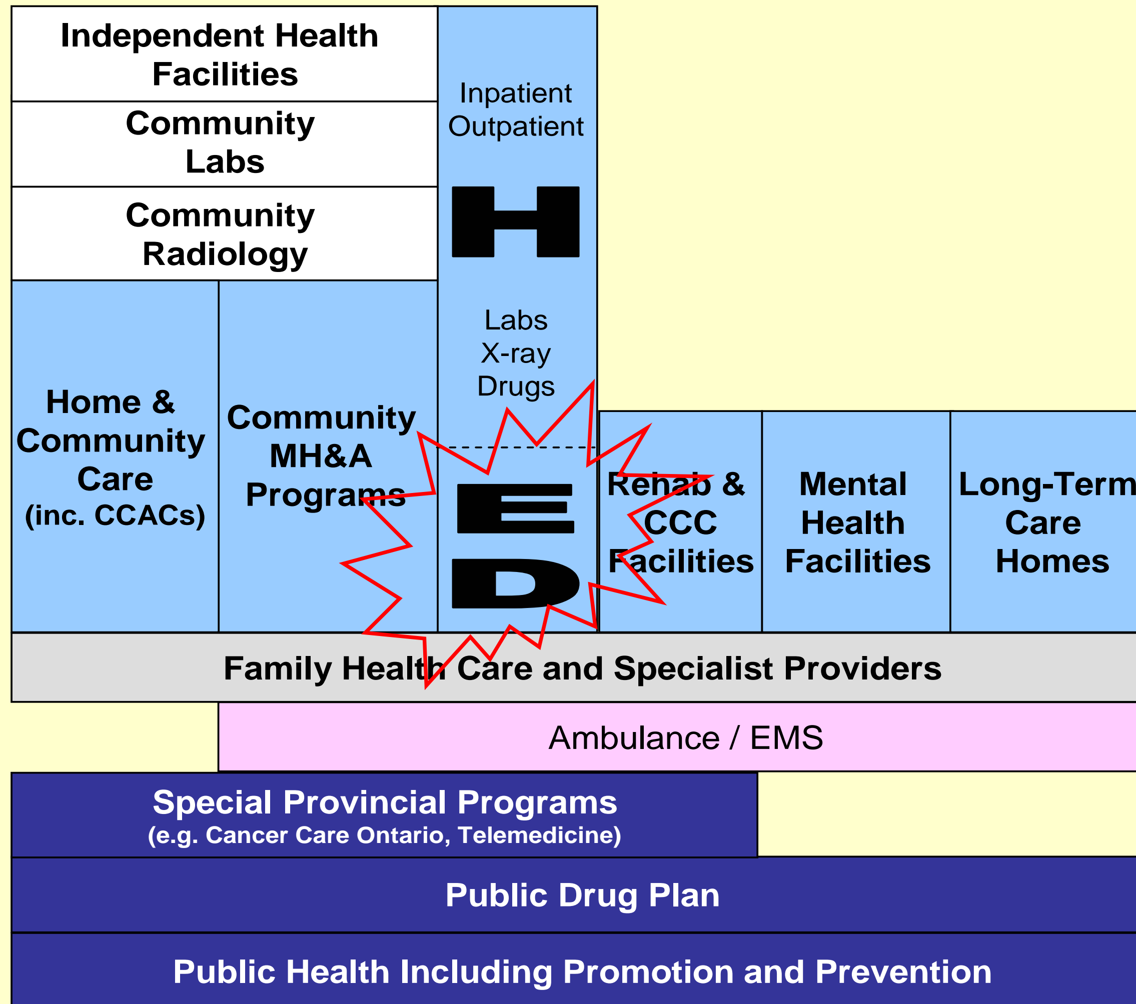
Helpful Structures

- Leadership Council
- Council of:
  - CFO's
    - Capital planners
  - VP Acute Care
  - CIO's
  - VP Medicine
  - VP Community Care
  - Mental Health and Addiction Leads
  - Medical Officers of Health
- HEABC
- Physician Secretariat

The Ministry: From Rowing to Steering

- Much more difficult role
- Some new expertise required
- Long view and effective scanning
- Comprehensive and integrated data analysis to support policy and sector
- Role confusion will occur - work to clarify
- Conceptual: ministry sets direction – Regions figure out how to get there
- Constructive relationships key
- Mutual respect, transparency, patience and ability to forgive

The Continuum of Care: Ontario



A system in balance enables patient care at the right time, in the right care setting

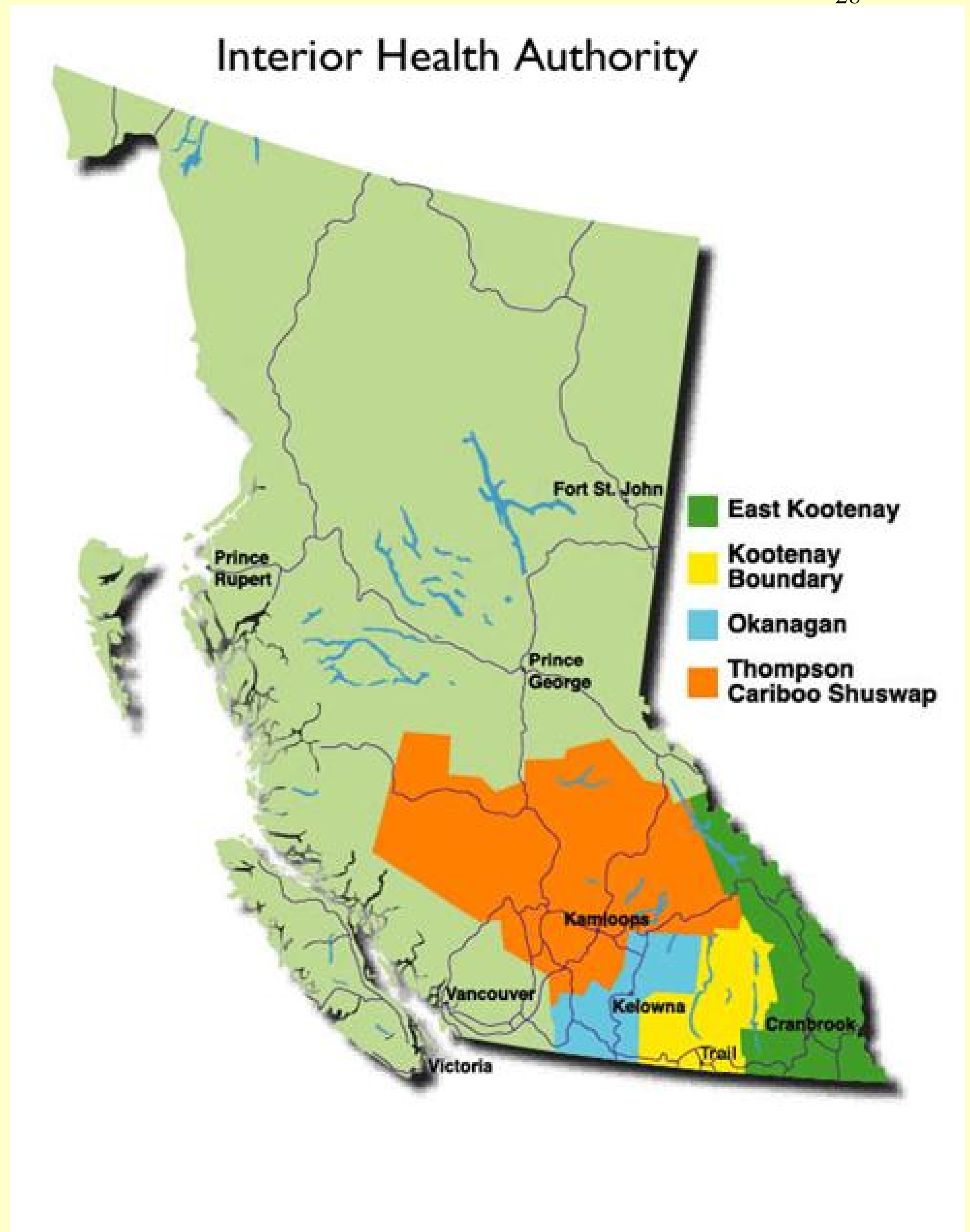
Community Responsiveness: Aligning priorities with Key Population Health Indicators

Population 750,000

Similar to BC average in:
- chronic disease rates
- life expectancy

Higher than BC average in:
- social assistance rates
- lack of high school completion
- children in care
- tobacco use

Lower than BC average in:
- population with low-income
- physical activity
- healthy eating



Shared Platforms: BC Nurse Line

Reasons for Calling the BC NurseLine
January 2003 - March 2004

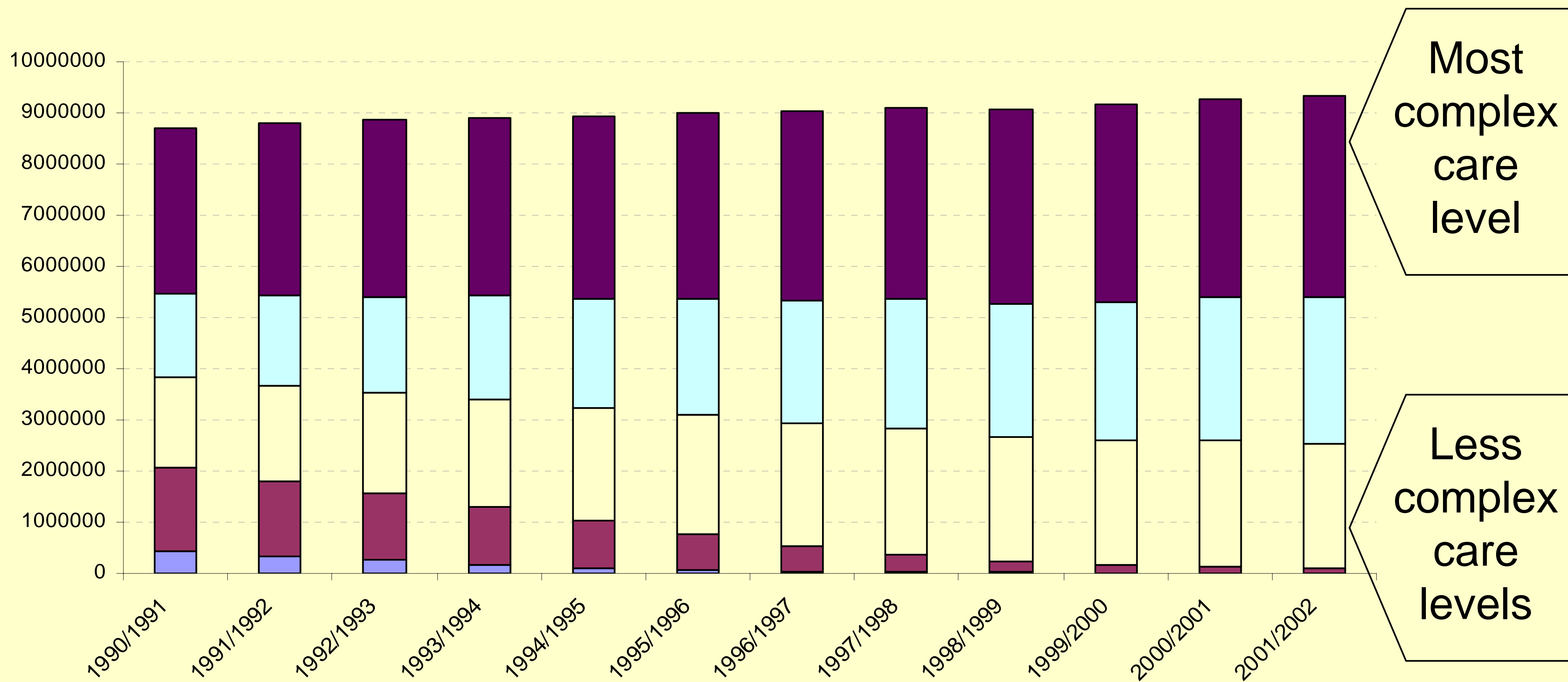
Reason	%
Considering ER	18.6%
Requesting Condition Info	16.6%
Requesting General Health Info	13.4%
Requesting Medication Info/Advice	9.5%
Considering MD Visit/Call	7.6%
Requesting Home Treatment Info	6.8%
Considering MD Visit Today	6.8%
Requesting Information	6.5%
BC NurseLine	5.0%
Wayfinding	4.1%
Public Health Alert	3.3%
Other	1.9%

0% 5% 10% 15% 20%

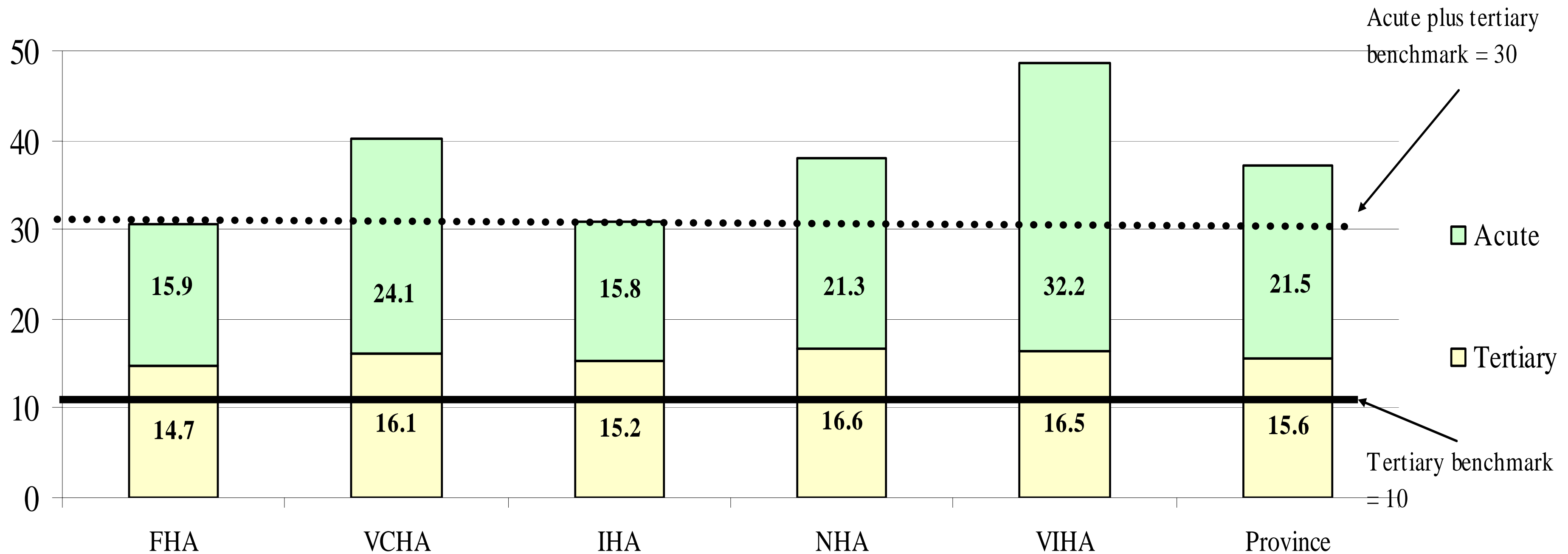
Based on all symptoms presented to the BC NurseLine

Policy Challenge: Planning for Continuum of Services for Frail Seniors

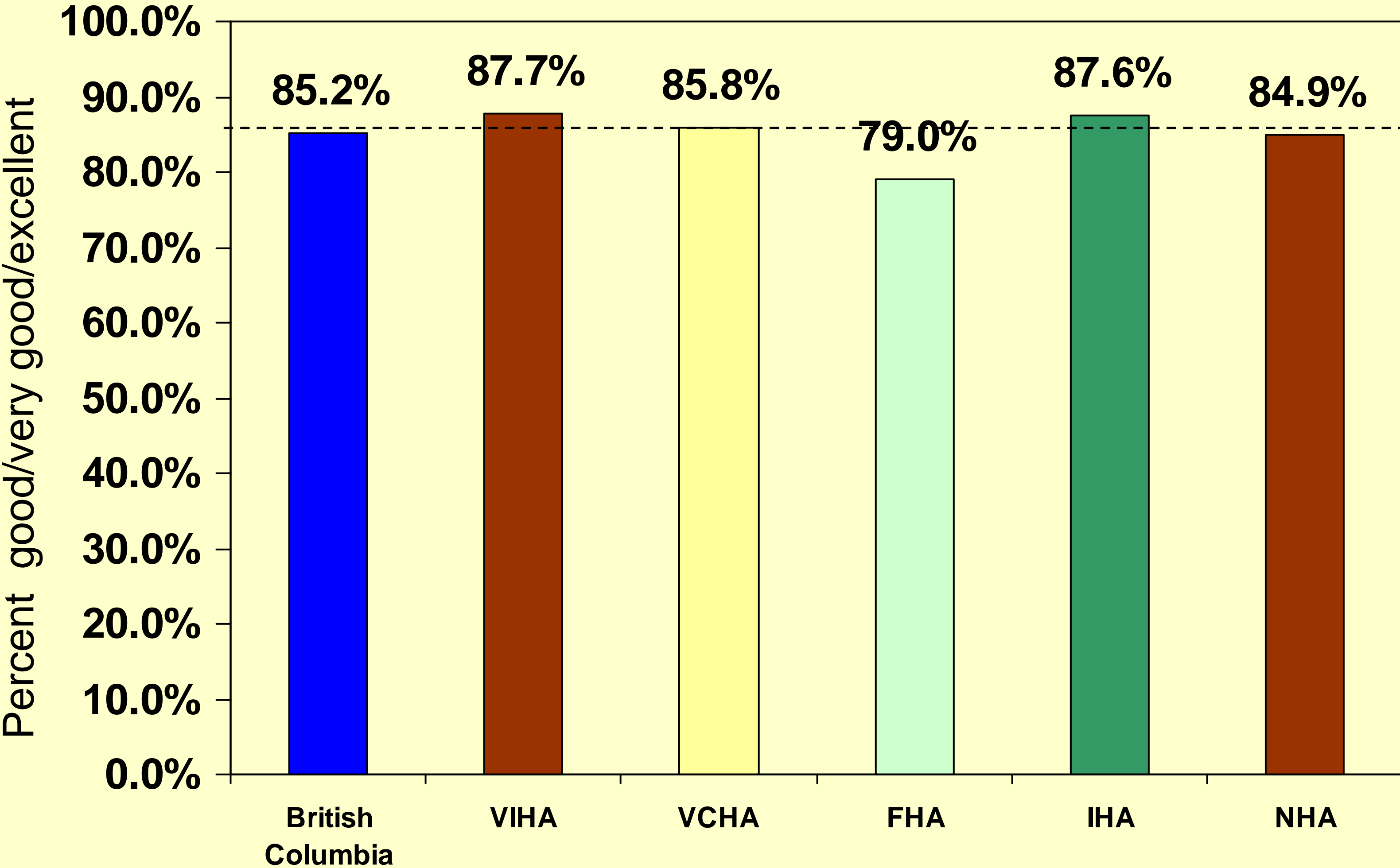
RESIDENTIAL CARE COMPLEXITY (BC)



Planning:
Politics versus Best Practice Approach

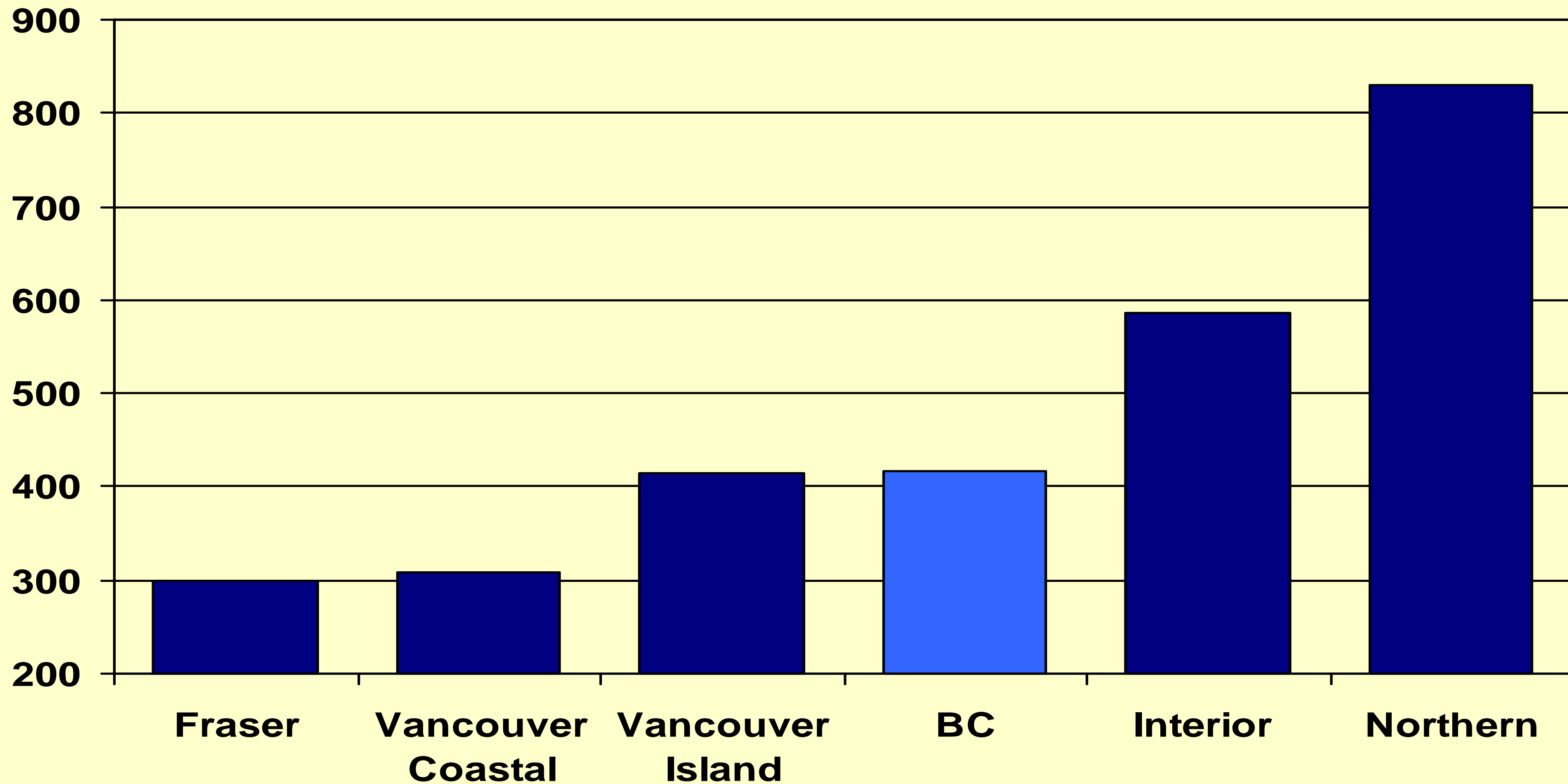


Comparisons will be made



Patient Perceptions of Care Experience in EDs, BC

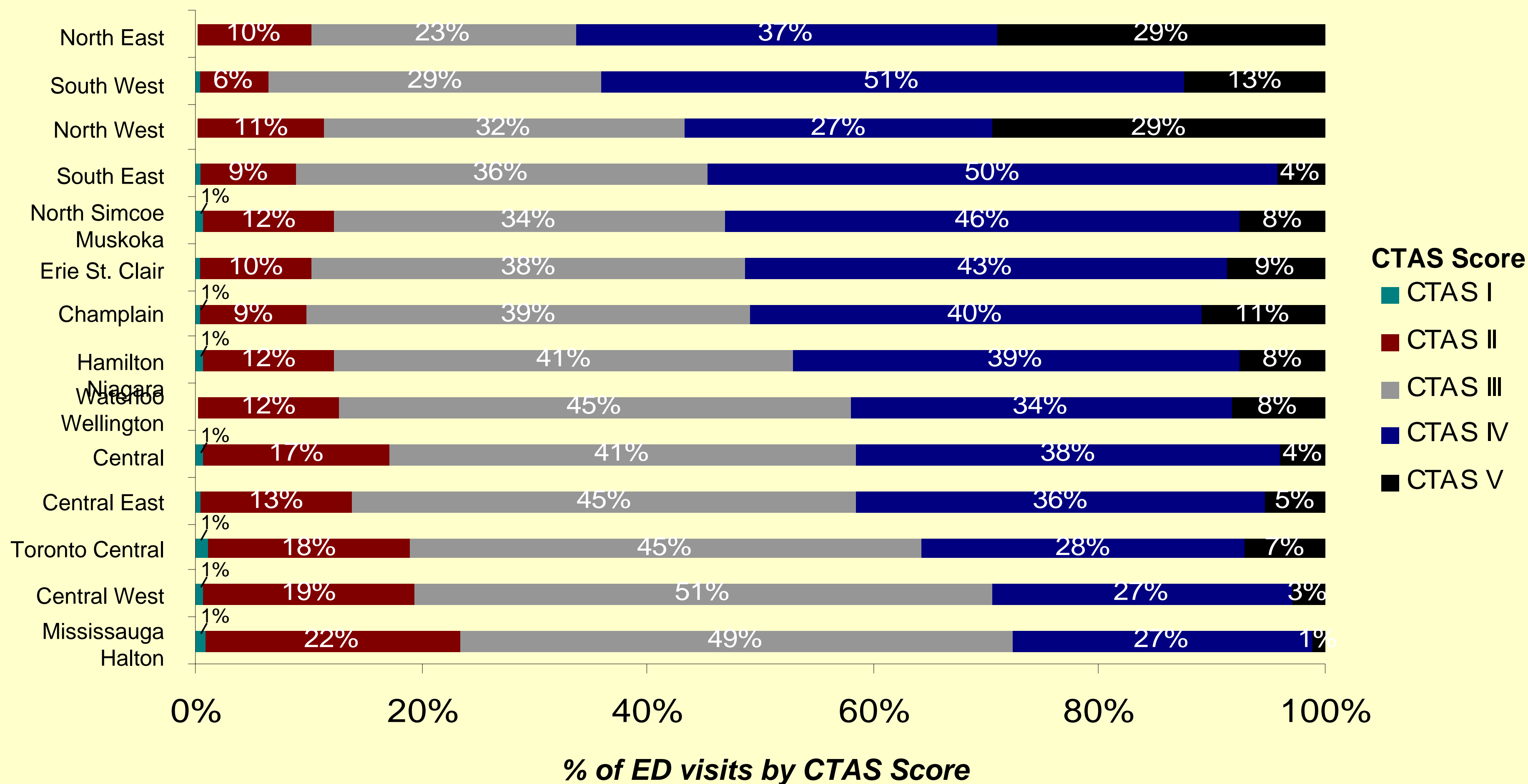
Comparisons across Regions



Source: HAMIS, PEOPLE 30

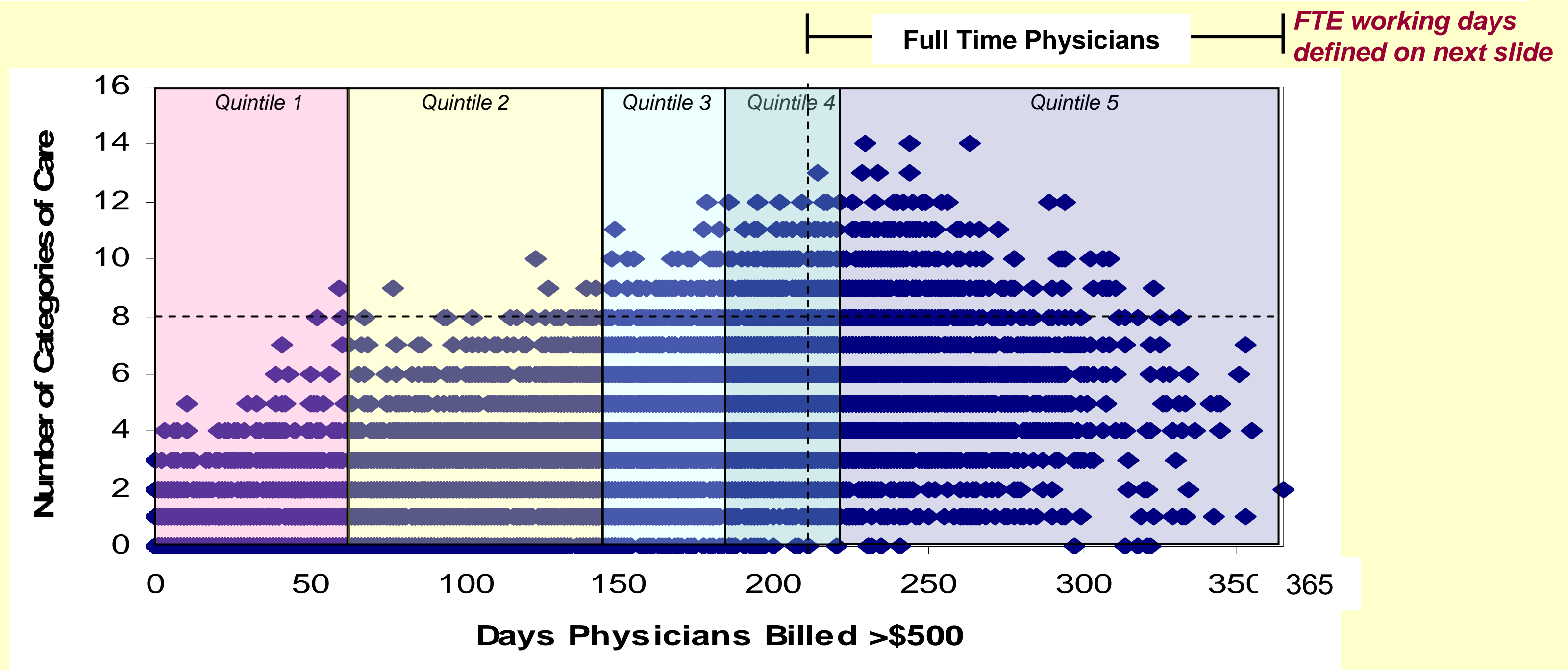
Accountability for Key Utilization Differences

Emergency Room Separations by LHIN and by CTAS IV & V 06/07



Analysis was conducted only on ER visits – 281,605 visits from UCC, Psych and Chronic/Rehab were excluded
Analysis excludes 122,731 visits that could not be matched to a Facility Type
Excludes LWBS, Includes OHIP Only, by Functional Centre, by Inpatient Admission & Triage
Source: PHPDB Data Warehouse, Ambulatory Care Database (NACRS), V17.09 – 2006-2007

Shared Issues: FP Workforce

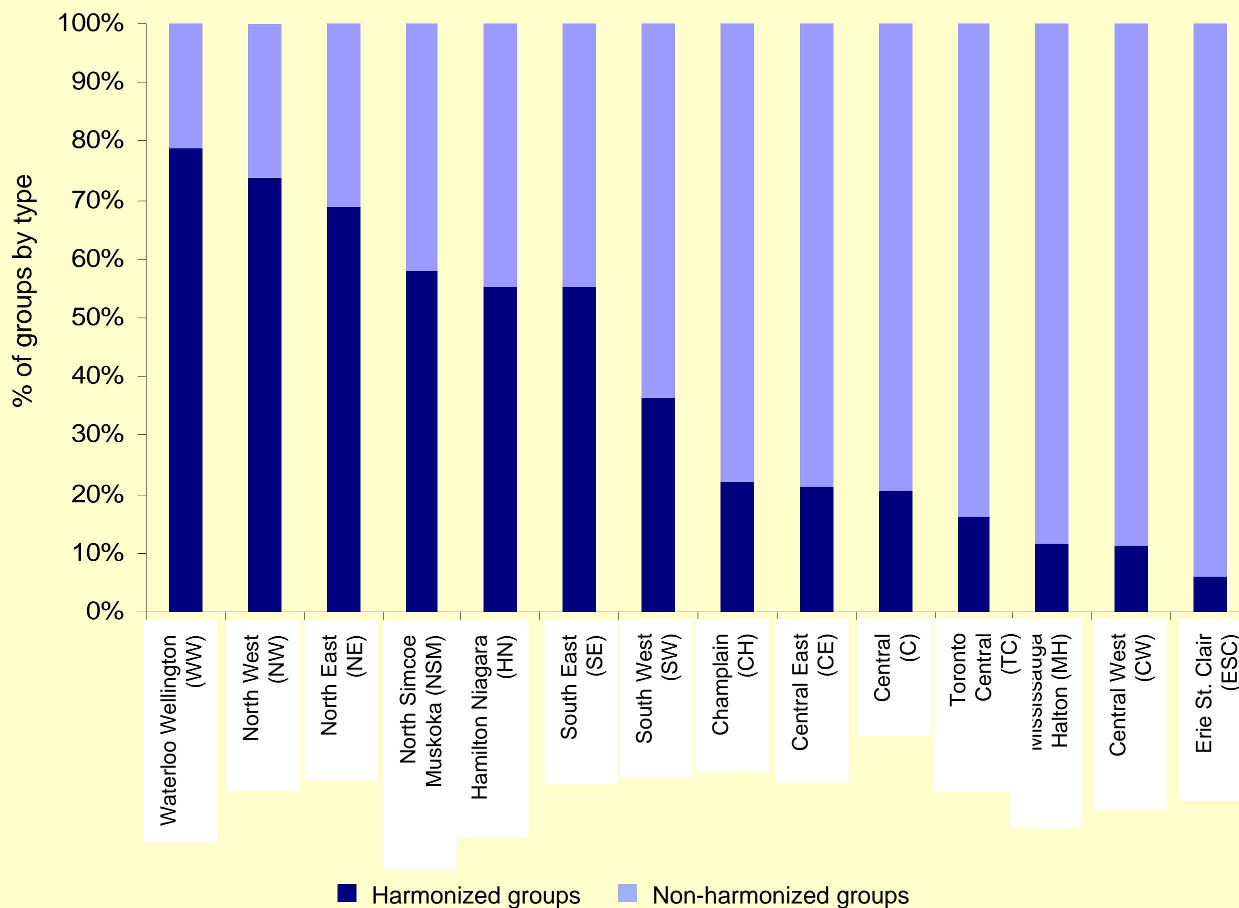


Each Quintile is about 2,290 FP/GPs

Note: FP/GP Quintiles have been calculated by the number of days where over $500 were billed.
**There are 11,448 FP/GPs; St. Joe's GPs (13) have not been included in the Classification of Models because of lack of clarity around the data*
Shadow Billing Included
SRP Master File, which has been used for Primary Care calculations has not been validated
Source: This data has been derived from FFS Database and SRP Master file provided by MOHLTC

Understanding Your Assets: Harmonized FP Groups

There are significantly more non-harmonized groups within urban areas such as Toronto Central, Mississauga Halton and Central



*Note: All CCM (1 group), 1 FHG group and 1 FHN group could not be assigned to a LHIN

Number of Groups

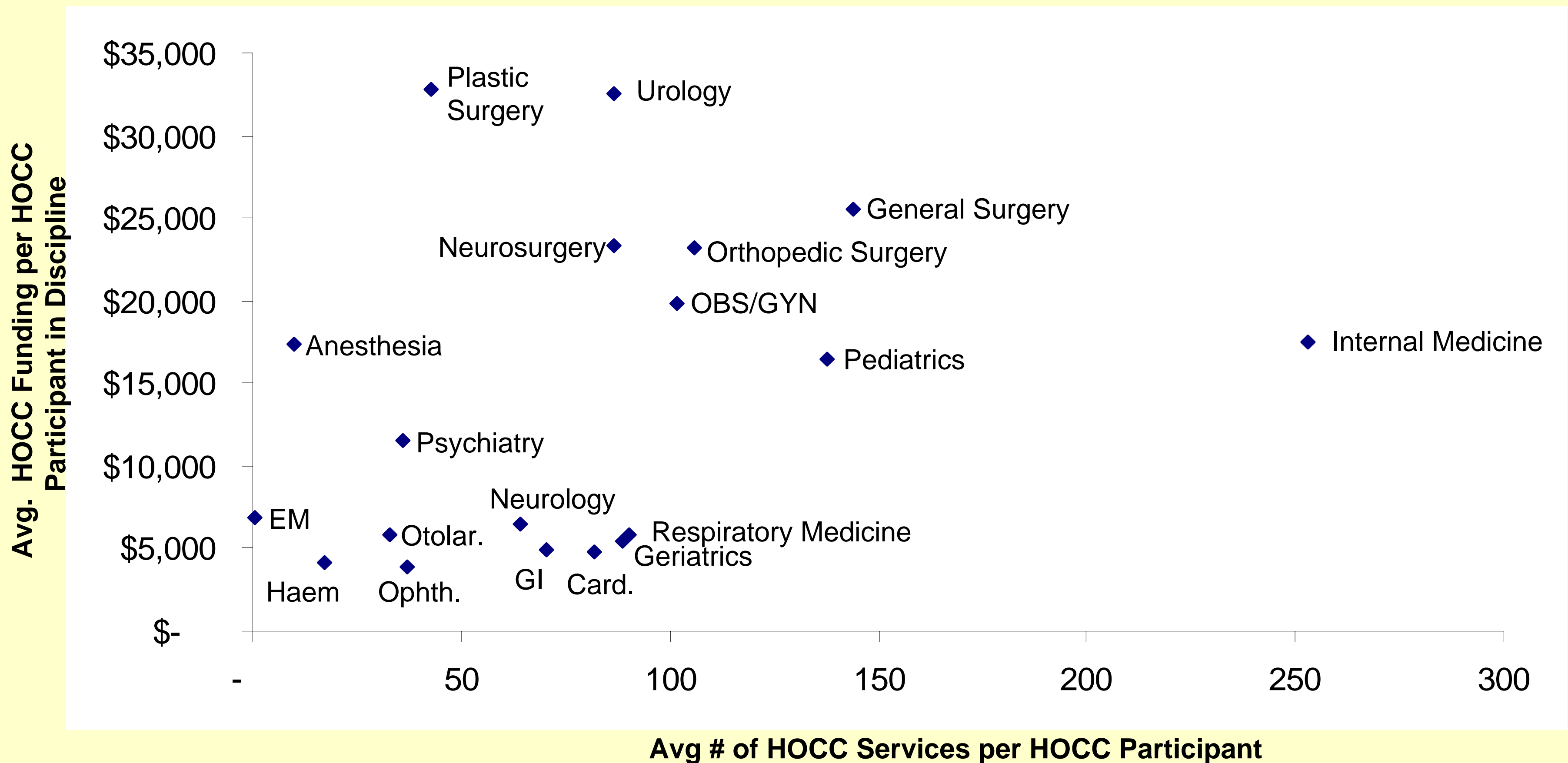
LHIN	Harm.	Non-Harm.	Total
WW	26	7	**33**
NW	14	5	**19**
NE	31	14	**45**
NSM	11	8	**19**
HN	37	30	**67**
SE	16	13	**29**
SW	20	35	**55**
CH	13	46	**59**
CE	7	26	**33**
C	10	39	**49**
TC	7	36	**43**
MH	4	31	**35**
CW	3	24	**27**
ESC	1	16	**17**
N/A	1	2	**3**
Total	**201**	**332**	**533**

*7 groups were excluded as they had less than 100 ED visits and were not representative

*When physicians were in multiple groups, they were assigned to the group that had the most number of patients rostered to that group (72 physicians were re-assigned)

*When assigning groups to LHINS, where physicians spanned across a LHIN the group was assigned to a LHIN based on where the majority of the group practiced

Working Together to Optimize Value for Investment for Patients



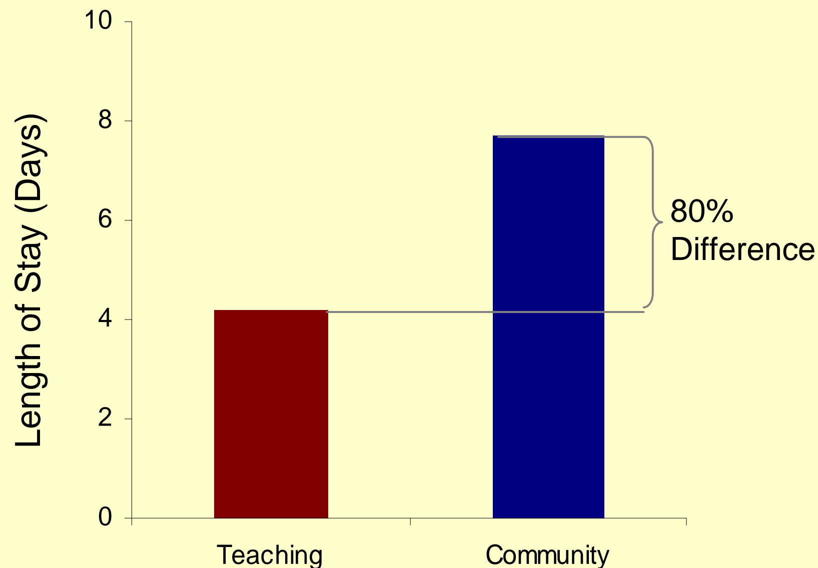
Note: The following subspecialties have been excluded: General Practice, General Thoracic Surgery, Clinical Immunology, Physical Medicine & Rehab, Rheumatology and Therapeutic Radiology

Deconstructing the Myths:

Duty of LHINs and Government

Orthopaedics Example (Hip Replacements)

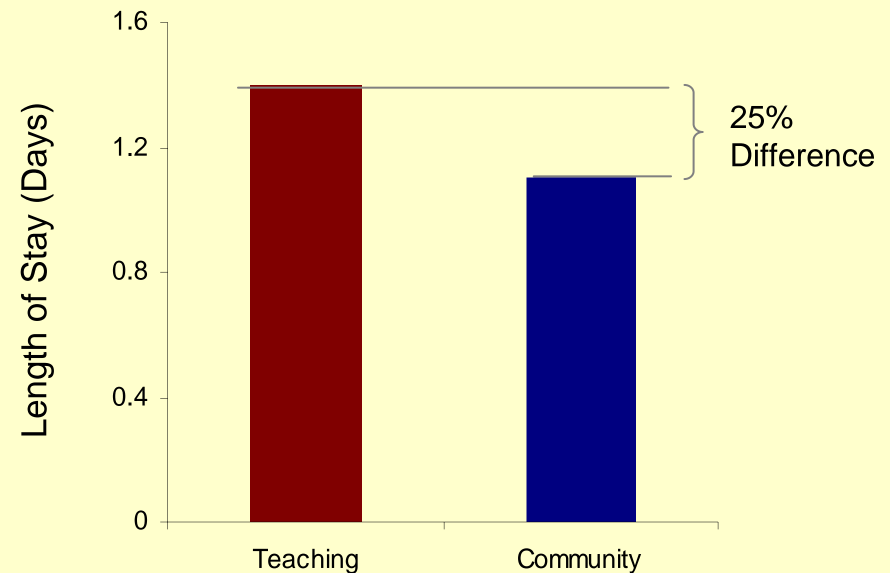
Cases normalized: for procedure, age, complications



Finding:
For Hip replacements, the teaching hospital had 50% Lower length of stay for similar cases

Newborns Example (Normal Newborn)

Cases normalized for: for delivery, complications, maternal age, maternal complications



Finding:
For Newborns, the teaching hospital had 25% longer average length of stay for similar cases

Moving to Improved Consistency and Coherence

Less Consistency	More Consistency
Community responsiveness without appropriate context	Fair transparent funding model
Competition for key roles	Good comparative risk, quality, Outcome and financial data
Emerging local issues (poorly handled!)	Strategic and pre-emptive issue management
Policy on the run	Commitment among LHINs to work together
Lack of clear gov't policy "please don't eat the daisies"	Robust HHR plans & mgement
Lack of comparative data	Identification and tracking of public Interest: • fiscal • health outcomes, population hlth • timely access to quality care

Our Learnings

- Only as strong as the weakest link
- Public understanding and support is key
- Public fights with government – pick your issue carefully
- Autonomy - remember your major “shareholder”
- Effective issue management - less policy on the run
- Working together – a winning strategy
  - common procurement, standards, consistency – balance standardized approach with local flexibility where appropriate and defendable
  - Optimize value for investment
  - Strength in numbers
  - Public expectation
- Key parameter: optimized health outcomes/access embedded in robust financial management