

## Appendix C

# Local Health Integration Service Priorities: Opportunities for Change

## Executive Summaries

Hamilton Niagara Haldimand Brant  
Local Health Integration Network

August 2006



# Best Practices

Dental care  
for children 2-6

Transportation

Eye Exams

Cultural needs of seniors

Physiotherapy

Silly rules

Fair wages

e-health

**If we could  
change  
one thing.....**

Whole person

Coordination

Recovery oriented  
mental health

A family doctor

No wait times

Interpreter services

Access

Prevention

Palliative care

Alternative medicine

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## INTRODUCTION

Community stakeholders and providers from Brant, Burlington, Haldimand, Hamilton, Niagara and Norfolk identified priorities in November 2004 for the pending Local Health Integration Network (LHIN). Approximately 400 people participated in a one-day session and deliberated on approximately 55 issues and opportunities for health system improvement. The outcome was 10 initial priorities to improve consumers' experiences in the health care system. These were described by a Steering Committee in a report to the Ontario Ministry of Health and Long-Term Care (MOHLTC) in February 2005.

The Steering Committee for the Hamilton Niagara Haldimand Brant Local Health Integration Network Priorities was invited by the LHIN to build on the momentum for change and identify planning or implementation strategies for the priorities. The champions for each of the priority areas have worked with their networks and communities of interest to identify opportunities for positive change across the LHIN. This is their report.

## INTEGRATION PRIORITIES FOR THE HAMILTON NIAGARA HALDIMAND BRANT LOCAL HEALTH INTEGRATION NETWORK

November 2004

Engage and learn from the community.

Promote healthy lifestyles.

Enhance access to child and youth services.

Assist seniors and persons with disabilities to live independently.

Provide support for persons with mental health and addiction issues.

Enhance care and support for elderly persons.

Improve quality of care at the end of life.

Develop an electronic health information system

Encourage collaboration among policy makers to promote healthy communities.

Continually monitor and improve health services.

Promote accountability among community and service providers.

The Hamilton Niagara Haldimand Brant LHIN continues to develop community engagement strategies, approaches to monitoring and improving health services, and relationships with networks and their roles and responsibilities.



## HEALTH PROMOTION AND DISEASE PREVENTION

Promote prevention and management of work-related illnesses and injuries by primary health care providers

### What Is The Problem Being Addressed?

Primary care providers are relatively ill-informed to recognize the signs and symptoms of workplace injury and illness. This lack of recognition leads to underreporting of occupational injury and illness. As a result, health resources are utilized to provide services and treatment that may be more appropriately the responsibility of the employer or the compensation system. The lack of recognition of signs and symptoms of work-related illness and injury minimizes the chances for identifying, rectifying and preventing workplace practices that contribute to these illnesses and injuries.

The occupational health system and the health care system operate in distinct and separate "silos". The lack of inter-sectoral communication, coordination and integration presents a barrier to the smooth transition of patients/workers to facilitate recovery, it prevents effective implementation of workplace-related illness and injury prevention programs, and it may contribute to escalating costs in both sectors.

### What is the impact, risk or opportunity cost of not addressing the problem?

An opportunity exists to reduce workplace related illnesses and injuries, to optimize health outcomes, and to use resources in a more cost-effective manner through improved communication, coordination and integration between the health care and occupational health systems within the Hamilton Niagara Haldimand Brant LHIN area.

Identify effective strategies to enhance understanding and communications between the sectors will lead to continued inappropriate use of resources and missed opportunities to minimize and prevent work-related illness and injury. Alternatively, primary care providers who are well-informed of the signs and symptoms of workplace-related illness and injury will be able to diagnose and treat conditions more quickly and effectively, resulting in better health outcomes along with reduced health and compensation system costs.

### What is the solution?

The proposed solution is the development and implementation of a demonstration primary care/occupational health model to prevent workplace-related illness and injury and to improve patient outcomes. The model will be developed to create better linkages between the occupational health system and the health care system. Primary health care providers will be engaged in the development of strategies that will facilitate uptake of best practices related to the identification of risk factors, and the diagnosis/treatment of workplace-related illness and injury, as well as strategies to optimize access to and use of existing resources.

### How will this make a difference?

This health improvement strategy will create healthier citizens by enabling the primary care system to improve its capacity to respond effectively to workplace-related illness and injury. The development and implementation of a primary care occupational health model, aimed at integrating the two systems, will lead to:

- A better understanding of unmet needs.
- Opportunities for improved coordination between the systems.
- Improved support for family physicians; enhanced patient outcomes.
- Reduction in the number of cases of workplace-related injury and illness.

The model will be designed and evaluated as a demonstration project, so that successful components can be replicated in other communities.

### Why is this the right solution?

This approach is essentially an exercise in facilitating improved coordination and integration of services through effective collaboration; an approach that is consistent with and fundamental to the HNHB LHIN mandate and ways of work. Through this exercise, representatives from both systems will be engaged in the development of the demonstration model for improving the connections between primary care and occupational health. Through this process there will be opportunity to create an environment whereby people from both the health and occupational health sectors continue to learn together, examine problems and develop solutions.



### What is the level of readiness/commitment to action this solution?

There is a high degree of readiness for this solution.

- A Steering Committee has agreed to guide the process. It will expand its membership as necessary. Furthermore, committee members have agreed to commit time and resources to the greatest extent possible to the development of this model.
- The Hamilton Family Health Team (HFHT) has secured resources to assist with the development of occupational health strategies within the Family Health Team. It is consistent with the mandate of the HFHT to make these resources available to help develop the primary care/occupational health demonstration model.
- The creation of the LHIN itself presents an opportunity to promote integration not only within the health care sector, but also in closely related sectors such as occupational health.
- Key stakeholder organizations in the community, such as Workplace Safety and Insurance Board (WSIB), Occupational Health Clinics for Ontario Workers (OHCOW), McMaster University and HFHT are all committed to finding better ways of working together

### Describe the Process Used to Develop this Health improvement Strategy.

The primary care occupational health strategy was developed by the Occupational Health and Primary Care Working Group. The group met three times over the summer to develop this strategy. Membership included representatives from WSIB; McMaster University; OHCOW; and the Hamilton Family Health Team.

## COORDINATION OF SERVICES FOR CHILDREN AND YOUTH.

### A Child Health Knowledge Exchange

#### What is the problem being addressed?

As hospitals have worked to contain costs, fewer children and youth are being seen in hospital settings. Children in hospitals are being treated for increasingly complex issues. This change has also increased the numbers of children and youth who receive health services in community settings. The change in service delivery has meant many pediatric health providers now work in smaller, community-based organizations, with decreased access to education about evidence-based treatment and best practices. As well, community hospitals report a lack of “critical mass” to offer education programs. Other community providers such as Community Care Access Centers (CCAC’s), Children’s Treatment Centres (CTC’s), and community Paediatricians report difficulties in accessing up-to-date information about clinical challenges.

#### What is the impact, risk or opportunity cost of not addressing the problem?

Without education about current evidence-based treatments and best practices, it is difficult to provide effective, high-quality health care services. The result may be increased morbidity and mortality, as well as increased resource utilization and costs.

#### What is the solution?

Working in partnership with the Department of Pediatrics, Faculty of Health Sciences, the Child and Youth Health Partnership (CYHP) will develop a Child Health Knowledge Exchange to develop and offer consistent, collaborative education and training events for child health professionals across the region.

#### How will this make a difference?

By working cooperatively we will maximize the use of educational resources, and ensure that all child health professionals have consistent access to training in evidence-based best practices. By identifying and implementing best practices across the region, we will work towards a consistent approach to service delivery and practices based on the best available evidence. We expect to significantly decrease the time between new evidence or best practices being described in the literature, and the consistent adoption of that evidence or practice in the field.



### Why is this the right solution?

Child and youth health providers have identified both knowledge translation and knowledge transfer as significant gaps across the region. Recent publications have noted that a more faithful adoption of evidence-based practices is more likely to significantly improve health-care outcomes than new research. We do not lack knowledge of best practices, but rather a systematic approach to applying that knowledge.

### What is the level of readiness/commitment to action this solution?

Members of the Child and Youth Health Partnership have identified sharing best practices and learning from each other as a strategic priority. The Department of Pediatrics, Faculty of Health Sciences, McMaster University has expressed interest in how they work collaboratively in providing education to child health professionals. McMaster Children's Hospital has endorsed the establishment of The Child Health Knowledge Exchange. The Ministry of Health and Long-Term Care has recently announced additional funding for "multi-disciplinary training of health professionals", directed at cross-disciplinary education. Resources to develop this initiative will likely come from a variety of sources, including internal resources and funding programs to which McMaster Children's Hospital will apply. One such program is the Allied Health Education Fund, announced in June, 2006 by the MOHLTC. Details of this program are currently under development.

### Describe the Process Used to Develop this Health Improvement Solution.

Members of the Child and Youth Health Partnership, a child health network of more than 25 child health service providers across HNHB LHIN, identified this as a strategic priority in November 2005. Under the leadership of the Child and Youth Health Partnership, discussions have taken place with local community hospitals, the Chief of General Pediatrics at McMaster Children's Hospital, and the Chief and Chair of the Department of Pediatrics at McMaster University. On-going consultation with experts in knowledge translation and knowledge transfer at McMaster University will guide the further development of this proposal.

## Electronic Child Health Network (eCHN) and its components, Professional Online Forum (PROFOR) and Health Information Network (HiNet)

### What is the problem being addressed?

Hospitals, physicians and community-based services do not currently have common access to children's medical records, especially records from other child health institutions. This often requires medical tests or histories to be repeated. Provision of care may be delayed until the information is received.

### What is the impact, risk or opportunity cost of not addressing the problem?

- Can lead to medical errors caused by inaccurate information.
- Can increase costs through unnecessary repeated tests.
- Can delay treatment as physicians/health care workers wait to get records or test results.

### What is the solution?

The solution to this issue is to implement the Electronic Child Health Network (eCHN) including the Health Information Network (HiNet). HiNet provides a depository of medical records, clinical notes, x-rays and test results.

The eCHN has been in operation since the fall of 1999. There are over 60 hospitals and Community Care Access Centres (CCACs) as members of eCHN. Over 5300 paediatric health care professionals are registered users.

McMaster Children's Hospital will "go live" with the HiNet medical record portion of eCHN in the fall of 2006. This health solution looks at expanding utilization of eCHN to all other eligible users in HNHB LHIN within three years.

### How will this make a difference?

The implementation of eCHN across HNHB LHIN will provide access to common medical records for children in HNHB LHIN. Of particular value is the access of medical records from McMaster Children's Hospital, the main tertiary/quaternary children's hospital for residents of HNHB LHIN.

eCHIN will focus on enrolling CCACs, Children's Treatment Centres, hospitals and paediatricians.

### Why is this right solution?

The implementation of eCHN is the right solution for HNHB LHIN because:

- It is consistent with the Information and Communications Technology e-Health Strategy being developed by the HNHB LHIN.
- It has proven to be effective in other areas of the province.
- It has a champion, McMaster Children's Hospital (MCH), willing to take a lead on the implementation.
- It has a network, the Child Youth Health Partnership (CYHP), that has supported the implementation of it.

### What is the level of readiness/commitment to action this solution?

McMaster Children's Hospital (MCH) has committed resources to this project and is scheduled to "go live" with the HiNet component of eCHN early this fall. There is a readiness by a number of child/youth health programs (members of the CYHP) to go forward with implementing eCHN after McMaster goes online, with most members of CYHP registering over the next year. The availability of MCH records will encourage other hospitals, physicians and community programs to enrol in eCHN so that they have access to the MCH records. Community programs indicated that since MCH is their primary referral site there was no purpose in enrolling prior to MCH being an active participant.

Funding for an expansion of eCHN into the broader community may be available through current or future funding the eCHN project receives. McMaster Children's Hospital will work with eCHN and the community partners to develop an implementation plan that includes an estimate of the resources required and strategies for obtaining those resources.

### Describe the Process Used to Develop this Health Improvement Solution.

McMaster Children's Hospital through the involvement of the CYHP has taken the lead on implementing the eCHN. MCH will be the first organization in HNHB LHIN to implement the HiNet component of the eCHN. Members of the CYHP have taken an active interest in the implementation of HiNet. There is support among members of the CYHP to be champions for implementing eCHN within their own organizations.

Members of CYHP have not been directly involved with implementation of HiNet at MCH. Rather, they have been monitoring the process of the implementation, gathering information and investigating the feasibility of implementation in their own organizations. There are currently 19 members of the CYHP.

## A Child/Youth Rehabilitation Network

### What is the problem being addressed?

The availability of acute and long-term child/youth rehabilitation services in HNHB LHIN is highly dependent on where the child/youth lives<sup>1</sup>. As well, significant changes are underway in how these services are delivered, as five local Community Care Access Centres (CCAC) consolidate and three local Children's Treatment Centres move from the Ministry of Health and Long-Term Care (MOHLTC) to the Ministry of Children and Youth Services (MCYS). Without planning and coordination there is significant risk that this vulnerable population will experience reductions in services available and/or increased wait times.

### What is the impact, risk or opportunity cost of not addressing the problem?

Short-term rehabilitation services are vital in providing timely discharge from inpatient units to home or community settings. Pediatric patients are a small part of CCAC caseloads, but often require complex and specialized services. There may be opportunities as CCACs consolidate, to decrease utilization of inpatient resources and improve patient care and outcomes.

Children and young persons with chronic or long-term rehabilitation needs often require a number of related rehabilitation services. A lack of coordination between MOHLTC funded resources and MCYS funded resources may lead to increased costs, duplication of efforts, and inequitable access to services. This may lead in turn, to increased health burdens and costs in young people with a range of disabilities.

### What is the solution?

The proposed health solution is the formation of a Child/Youth Rehabilitation Network (CYRN) for HNHB LHIN. The CYRN will work as a subgroup of the Children & Youth Health Partnership (CYHP), which is coordinated by McMaster Children's Hospital (MCH). The CYRN will bring together rehabilitation service providers, hospitals, Community Care Access Centres and Child Treatment Centers (CTCs), all of whom are involved in acute and/or long-term rehabilitation of children and youth. Initially, the Network will function as a consensus-building forum and will establish terms of reference and a work plan. It is anticipated that the first meeting of the Network will occur in early fall 2006.

<sup>1</sup>Dick PT, Kavanagh L. ICES Investigative Report Ontario's Mosaic of Children's Treatment Services. Toronto: Institute for Clinical Evaluative Sciences; 2005.



### How will this make a difference?

The CYRN will make it easier for child/youth rehab services to share information and establish best practice care standards for use across HNHB LHIN. This is particularly important as child and youth rehab services are provided by a mix of hospitals and community-based services, which receive funding from both the MOHLTC and the MCYS. There can be significant differences in care practices depending on the service provider.

### Why is this the right solution?

The development of the CYRN will provide a forum for collaboration that does not currently exist. Networks have been shown to be an effective method for promoting collaboration, best practices, and developing improved service outcomes.

### What is the level of readiness/commitment to action on this solution?

MCH through the CYHP is prepared to support the development of the CYRN. Members of the CYHP have also indicated that they support the development and involvement of their organizations in the CYRN. There is both a readiness and commitment to develop and implement the CYRN. A preliminary meeting with the Ministry of Child and Youth Services has been scheduled.

### Describe the Process Used to Develop this Health Improvement Solution.

The development of this health improvement solution was an outcome of the work completed by the Child and Youth Health Partnership during its first year and the vision of McMaster Children's Hospital. The CYHP involves 19 agencies from across the HNHB LHIN area. Working with MCH the Partnership developed a set of priorities that included:

- Advocating for an integrated child health system that focuses on the health of the whole child.
- Working with providers in social services, education, recreation, and community-based health services to improve children's health.
- Recognizing the effect that systems outside of the formal "health care system" have on the healthy growth and development of children.
- Advocating for the integration of children's services through a single planning and funding stream for child health and social services.
- Connecting with other networks and network projects.

- Examining evaluation and research networks for best practices.
- Developing information technology networks.
- Advocating for child health issues.
- Making connections with local community groups and networks.
- Sharing information and knowledge about child health.
- Advocating for increased attention on school-aged children, especially child and youth mental health services.
- Mapping and/or creating an inventory of child health services, from a “child-centric” point of view.
- Responding to growing concern about childhood obesity in our communities.

The development of the Network reflects a number of the priorities established by the CYHP. Specifically, the Network will help to make sure that child rehabilitation programs are connected and integrated with other programs/agencies supporting children’s health.

## Community Capacity to Assess and Treat Children and Youth with Mental Health Problems.

### What is the problem being addressed?

McMaster Children's Hospital (MCH) is developing a paediatric mental health outreach team as part of an integrated mental health program for children and adolescents. The program will consist of inpatient and outpatient components, and will work with both Ministry of Child and Youth Services (MCYS) and MOHLTC funded services. We want to ensure that children and youth are not hospitalized in the new inpatient unit unless absolutely necessary.

A key component to ensure that inpatient beds are used appropriately will be a thorough assessment of the difficulties the child or youth is experiencing. Community-based child/adolescent mental health programs may not have the capacity or skill sets to conduct specialized assessments or provide current best practice treatments. Additionally, responsibilities for child/adolescent mental health services are divided between the Ministry of Health and Long-Term Care (MOHLTC) and the Ministry of Child and Youth Services<sup>2</sup>. The separate funding silos have not always led to an integrated approach to child and youth mental health problems.

### What is the impact, risk or opportunity cost of not addressing the problem?

If community-based child and youth mental health programs do not have the capacity to conduct assessments or implement best practice treatments, then the result will be over-utilization of expensive inpatient services. This will result in young people being hospitalized away from their home communities, with a resulting disruption to their schooling and to their family.

### What is the solution?

The strategy proposed, to be lead by McMaster Children's Hospital, is to conduct a needs assessment in partnership with community-based programs and services in order to understand the capacity building issues of these programs and then to work with those community agencies to develop an action plan that addresses the education, training and capacity-building issues identified.

### How will this make a difference?

The needs assessment and action plan will help to ensure that McMaster Children's Hospital is supporting community-based programs to develop a comprehensive paediatric mental health system within HNHB LHIN. As well, the solution will result in community-based programs having access to the most up-to-date information and treatment techniques. Ultimately, this solution will improve patient care and outcomes.

<sup>2</sup> Barwick, M.A., Boydell, K.M., Stasiulis, E., Ferguson, H.B., Blase, K., & Fixsen, D. (2005). *Knowledge transfer and evidence-based practice in children's mental health*. Toronto, ON: Children's Mental Health Ontario.

### Why is this the right solution?

Providing services to children/adolescents as close to home as possible has been shown to improve compliance with treatment and improved outcomes in a number of studies. MCH has committed resources to developing capacity in local communities. Expanding existing capacity will ensure that community programs are working effectively with MCH as it works to fully develop the paediatric/adolescent outreach team and inpatient mental health unit.

### What is the level of readiness/commitment to action this solution?

Over the last several years a great deal of work has been done by MCH and the Regional Comprehensive Planning Group (RCPG) to plan for the development of the paediatric mental health outreach team and the inpatient unit. They have worked to develop coordinated intake processes, inventory children's mental health services and develop an overall model for the program, including the outreach team. More than twenty-five community agencies and hospitals have been involved in the process. All of these planning partners are interested and enthusiastic about the prospect of increasing their own capacity to provide mental health services to children and adolescents. Funding for this work has been committed by McMaster Children's Hospital over the next 12 months.

### Describe the Process Used to Develop this Health Improvement Solution.

The development of this health improvement solution is the result of several years' work by the Regional Comprehensive Planning Group. The RCPG is made up of representatives from community-based and hospital services across HNHB LHIN. The RCPG met recently for four half-day retreats to discuss various topics including the development of the outreach team. The RCPG recognized that further information needed to be gathered concerning the training needs of local programs to increase their capacity to deliver evidence-based treatments to clients and their families.

The RCPG has involved over 25 individuals from across the HNHB LHIN area. These individuals represent community-based agencies that are either mental health service providers or have clients who may access mental health programs. Additionally, the RCPG has representatives for local hospitals and CONTACT agencies.

Members of the RCPG have been responsible or involved in identifying issues related to the development of the paediatric/adolescent inpatient mental health program at MCH. The concept of an outreach team for the program was a direct result of the RCPG and their work.

## ASSIST SENIORS AND PERSONS WITH DISABILITIES TO LIVE INDEPENDENTLY

### Care pathways for a continuum of care

#### What is the problem being addressed?

Community support services (CSS) enable persons with disabilities and challenges to live independently in the community. Individuals needing service must navigate a highly complex and diverse system and frequently, health professionals and even other community providers are unaware of how to access community-based needed supports, with the result that access to and transitions between services are difficult and fragmented.

#### What is the impact, risk or opportunity cost of not addressing the problem?

Clients may not get the care they need in a timely manner resulting in increased disability, deteriorating health and premature admission/readmission to hospital or other facility. Lack of information and service coordination results in an over reliance on institutional and formal care; an inefficient use of resources.

#### What is the solution?

This health improvement solution will model an innovative planning approach to develop care pathways to transition individuals in three long-term care populations across acute, sub-acute and long term care services. Care plans will be developed for:

- Persons age 65 years and over with a fracture, discharged to home alone.
- A person with dementia taken to the emergency department for support because of caregiver burnout.
- A young person with acquired brain injury.

It will also develop a profile of CSS services and a guide for transition/discharge planning that includes the role of CSS as part of the service continuum.

#### How will this make a difference?

This solution will result in:

- Increased awareness of and access to CSS services.
- More seamless client/patient transition across sectors.
- Identification of service gaps and opportunities to enhance system capacity.
- More clients able to live independently in the community and home of choice.
- Fewer inappropriate admissions to institutions and improved caregiver health.
- Savings realised in the acute care sector.

### Why is this the right solution?

Community-based services support the health and wellbeing of people (primarily seniors) living in the community. The availability of CSS help enables shorter hospital stays, earlier discharge, and the use of more cost-effective outpatient procedures. Numerous community support and homecare organizations have identified the need for increased coordination and integration of CSS services and called for the strengthening of home care and community based supports within the care continuum.

### What is the level of readiness/commitment to action this solution?

There is commitment and willingness of providers to develop a LHIN-wide CSS network. A survey of agencies in the LHIN is already underway to develop a profile of community support services. Leads have been identified for the three client target populations selected for process mapping and care pathway development. Initial linkages have been established with the Geriatric Access & Integration Network.

### Describe the Process Used to Develop this Health Improvement Solution.

The proposed Health Improvement Solution was developed by a subgroup of an informal HNHB LHIN-wide network of community support services with representation from seniors' services, dementia services, and services for the physically disabled and brain injured. Network membership was also geographically diverse with representation from each area within the LHIN.

The proposed Health Improvement Solution was then reviewed with the LHIN-wide CSS network at a workshop in May 2006. Focus groups were held in May and July 2006 with the network steering committee, which represents both the geography and service provision variation within the LHIN. This was followed by a final review of the submission by the network steering committee in July 2006.

There is currently a survey of CSS agencies being undertaken to develop a CSS profile – this is important because of the diverse nature of services and variety of client populations served.



## SUPPORT FOR PERSONS WITH MENTAL HEALTH AND ADDICTION ISSUES

Improve access to services for people with concurrent disorders

What is the problem being addressed?

Services for persons with concurrent mental health and addiction disorders are frequently siloed and some have exclusionary admission criteria. As a result, some clients experience barriers receiving services from either the addiction or mental health systems, resulting in poorer outcomes in comparison to those without concurrent disorders.

What is the impact, risk or opportunity cost of not addressing the problem?

People may not receive the services they need and may continue to cycle through mental health and/or addiction services. This can result in strained system resources and reduced long-term treatment compliance and outcomes. Alternatively they may be disconnected from any service, and many other health and social service needs could remain unaddressed. There may be an increased incidence of ER visits as well as avoidable hospitalizations.

What is the solution?

Mental health and addiction service providers have committed to collaborative processes in order to:

- Share information on program successes, strengths and solutions.
- Provide leadership in uptake of best practices and standards of care.
- Develop a LHIN-wide plan for cross-training of staff.
- Enable cross-sector staff secondments.
- Investigate the feasibility of interagency service delivery teams and/or co-location of services in one location.
- Develop protocols for increased service collaboration and shared care between mental health and addiction programs.



### How will this make a difference?

This solution will:

- Increase capacity to provide integrated services for persons with concurrent disorders.
- Be a more effective use of limited program resources.
- Improve support access to services for clients and families.
- Better treatment compliance and improve health outcomes.

### Why is this the right solution?

This approach is consistent with the provincial policy documents “Concurrent Disorders Policy Framework”, “Setting the Course”, and “Making It Happen”; Health Canada’s Best Practices: Concurrent Mental Health and Substance Use Disorders, and the report of the Central South Mental Health Implementation Task Force.

### What is the level of readiness/commitment to action this solution?

There is leadership at the regional level, the regional tertiary care hospital and at some local tables. There is commitment across the HNHB LHIN to partner and share resources. Varying levels of resource availability, capacity and expertise may impact the ability to participate in planning and collaborative initiatives.

### Describe the Process Used to Develop this Health Improvement Solution.

The original integration priority for concurrent disorders was developed by a committee of mental health and addiction providers from across the HNHB LHIN. This document was developed by the Central South Mental Health and Addiction Network, comprised of representatives from all local mental health and addiction collaboratives within the boundaries of the LHIN. Local planning tables involve providers, consumers and other key stakeholders. The communities currently represented include the county of Brant, the city of Burlington, the county of Haldimand, the city of Hamilton, the regional municipality of Niagara, the Six Nations of the Grand River Territory, and the county of Norfolk. The mandate of the Network is to provide a collective voice for addiction and mental health consumers, families and service providers within the LHIN.

This work has been completed at the last three network meetings. Members share discussion results with and seek input from their local networks and other partners in their districts.

## QUALITY OF CARE AT THE END-OF-LIFE

Implementation of best practice approaches to education.

### What is the problem being addressed?

Service Providers require a standardized best practice approach for system-wide palliative/end-of-life care education that will enhance interdisciplinary knowledge, skills and competencies to effectively and consistently provide care to all patients regardless of the care setting or community in which they reside. To provide quality of life for the dying person and their family, their physical, psychological, social, spiritual, and practical expectations and needs must be addressed effectively. A consistent approach to palliative care education which incorporates the Canadian Hospice Palliative Care Association (CHPCA) Model is required to ensure service providers gain the required knowledge and skills to provide palliative/end-of-life care services based upon best practices.

### What is the impact, risk or opportunity cost of not addressing the problem?

The need for palliative/end-of-life care is increasing due to many factors such as a growing aging population, people living longer with multiple chronic illnesses, as well as increasing cancer rates. It is critical that within the local health care system that we have sufficient and well-prepared specialists and generalists from a variety of disciplines and care settings who are both knowledgeable and skillful in providing palliative/end-of-life care to meet this growing demand.

By the year 2020, it is estimated that there will be 40% more deaths every year (Carstairs, 2005)<sup>3</sup>. This will amplify the current demand for increased capacity and improved access to quality palliative care.

Failure to provide appropriate palliative care education can result in unnecessary client and family distress and suffering at end-of-life as pain and symptom management is not provided in an effective way.

Without a team-based, organizationally supported education program, holistic, enhanced Interdisciplinary team-based care will not be available to address all client care needs. There could be ongoing unnecessary and inefficient use of resources (e.g., emergency room and acute hospitalization). Finally, a seamless and integrated system would not be developed to support quality end-of-life care.

<sup>3</sup> *The Honourable Sharon Carstairs, P.C. Still Not There – Quality End-of-Life Care: A Progress Report. June 2005*



A consistent approach to system-wide palliative/end-of-life care education will promote:

- Palliative/end-of-life care common language.
- Understanding and communication between interdisciplinary palliative/end-of-life care providers.
- General and specialized interdisciplinary service provider knowledge and skills in palliative/end-of-life care.
- Local community ability to build individual and organizational knowledge and skill capacity.
- Consistent evaluation and measurement including determining the extent of transfer of knowledge to practice and the impact on organizational practice.

#### What is the solution?

The proposed strategy is a LHIN wide implementation of two best practice palliative/end-of-life care education programs. These programs will enhance knowledge and practice at all skills levels (basic, advanced and comprehensive training), across disciplines (physicians, nurses, personal support workers, pharmacist, volunteers, among others), and across care settings (hospital and community). These programs include:

The Southwest Learning Initiative:

- Fundamentals (Basic).
- Advanced Hospice Palliative Care Education (AHPCE).
- Comprehensive Advanced Palliative Care Education (CAPCE).
- The Pallium Learning Essential Application in Palliation (LEAP) program.

#### How will this make a difference?

The programs together build community capacity to provide quality palliative/end-of-life care wherever the client is receiving care and from whom. Program strengths lie with curriculum tailored to interdisciplinary teams and mentorship model. Clients and patients will benefit from skilled, seamless, coordinated and consistent care regardless of where they live and receive services and supports.

### Why is this the right solution?

Program outcomes are favourable and uptake in the HNHB LHIN aligns practice with a Provincial priority. The Southwest Learning Initiative has been endorsed by the Provincial End-of-Life Care Network, and several of the other Ontario EOL Care Networks are also implementing the initiative. The Pallium LEAP program has been acknowledged nationally as a best practice palliative/end-of-life care training program; it will be run in partnership with the Division of Palliative Care, Department of Family Medicine McMaster University, which has the Ontario site licence agreement to run the LEAP program

### What is the level of readiness/commitment to action this solution?

The four End-of-Life Care Networks in Hamilton Niagara Haldimand Brant LHIN have agreed to coordinate the implementation of these programs in their communities. Enablers to sustain implementation of the education programs include the ongoing availability of Palliative Care Initiative Funding and enhanced educator training capacity to provide advanced levels.

It is anticipated that Burlington candidates (as part of Halton) will be early participants in the first Fundamentals series this fall, followed by HNHB LHIN-wide implementation of all program levels by 2008/2009.

### Describe the Process Used to Develop this Health Improvement Solution.

These education strategies were developed initially by the Southwest Region in Ontario with a national collaborative of leaders and interested stakeholders for developing tools and resources for hospice palliative care.

Representatives of the four EOL Networks and their Education Committees have discussed, and agreed to adopt and participate in the uptake of the education strategy. Next steps include informing all EOL Care Network stakeholders of the initiative.

## Standard guidelines for assessment, treatment and symptom management

### What is the problem being addressed?

There is currently an inconsistent usage of standardized and validated symptom assessment tools, evidence-based collaborative care plans and symptom management guidelines for palliative/EOL care. As a result there are a number of key care delivery problems in the area of palliative and end-of-life care including:

- Inconsistent communication between health care providers.
- Inconsistent use of evidence-based practice.
- Inconsistent symptom management practices.
- Underutilization of available resources.
- Unmet patient and family needs.
- Discontinuity of care at points of transfer.
- Discomfort of physicians and other health care providers in managing symptoms.
- Lack of service coordination.

There is a provincial opportunity to utilize consistent, standardized and validated symptom assessment tools, evidence-based collaborative care plans and symptom management guidelines for palliative/EOL care.

### What is the impact, risk or opportunity cost of not addressing the problem?

Palliative/end-of-life care frequently involves multiple service providers working with each patient. Each service provider either has their own assessment tools, care plans and guidelines or sometimes none at all. The impact for the palliative patient is often having to repeat the same information over and over to each care provider. For the service provider there is a lack of consistent, accurate and comprehensive medical information regarding the patient's status. This results in an inability to appropriately provide timely and effective care to the patient.

The consequences of this fragmented and inconsistent approach is that the patient often experiences:

- Poor symptom control.
- Delays in appropriate referrals.
- Increased potential for unnecessary emergency room visits or a hospital stay.
- An increased chance of being unable to access the setting of choice during the last days of life.

#### What is the solution?

Implement an integrated best practice assessment, delivery and communication system known as the Provincial Palliative Care Integration Project (PPCIP) across HNHCB. This project incorporates the use of standardized, evidence-based tools for assessment and delivery of palliative/EOL care services that in Phase 1 will initially focus on cancer patients, and in Phase 2 be available for all palliative patients across all service providers and care settings.

#### How will this make a difference?

The standardization of symptom assessment tools, care plans and symptom management guidelines for palliative/EOL care will:

- Improve data available to health care providers.
- Eliminate the duplication of multiple assessments.
- Greatly improve patient pain and symptom management.
- Decrease unnecessary emergency room visits or hospital stays.
- Allow for faster referral to the most appropriate professionals.
- Increase access to the settings of choice during the last days of life.
- Increase system-wide efficiencies and cost effectiveness.

#### Why is this the right solution?

The project is based on a successful and proven palliative care integration initiative that was implemented in the South East LHIN region and is aligned with the Juravinski Cancer Center strategic plan for improved care. Preliminary

results from the South East have demonstrated a number of significant patient care and system improvements. The initiative improved symptom management, enhanced service integration and coordination, and reduced time to appropriate referral.

#### What is the level of readiness/commitment to action this solution?

Under the current guidance of Cancer Care Ontario and funded under the Performance Improvement Fund a provincial project governance structure has been established. A project leadership team, including a quality improvement advisor, a clinical lead, a provincial improvement coordinator, technology team, performance measurement/evaluation team, communication team and one project manager per regional Cancer Centre is available to guide the local implementation. Additionally, coaches from the original Kingston project will be available as a functional team that will support the central project team and assist with regional roll-out and implementation (e.g., coaching and education).

Locally, a Regional Steering Committee will be established by the Juravinski Cancer Centre consisting minimally of:

- Regional Cancer Centre Vice President (or designate) – Janet Noble.
- CCAC CEO (or designate) – Ingrid Fell.
- EOL Representative – Julie Darnay.
- Regional Project Manager – To be hired.
- Palliative Care Program Committee Physician – Dr. Sharon Russell.

The total extent of the initial role and involvement of the four HNHB EOL Care Networks is not completely clear. However, given the size of the HNHB LHIN area and the eventual involvement of only 1 PPCIP project manager for this area, we suspect that Networks responsibility could range from assisting the regional PPCIP project manager to undertaking full local community implementation.

#### Describe the Process Used to Develop this Health Improvement Solution.

The strategy was developed by the Southeast Region. Regional cancer programs, regional End-of-Life Care Networks and other regional partners interested in participating in the PPCIP were asked to conduct and provide an assessment of readiness based on defined criteria. Regions were required to self-identify, thus minimizing the risk of assigning regions to an inappropriate project cluster.

The HNHB LHIN End-of-Life Care Networks are working collaboratively with the Juravinski Centre. Discussions have included the HNHB EOL Care Network Chairs and the involvement of their local Steering Committees.

## SPECIALISED SERVICES FOR FRAIL SENIORS

### A Geriatric Access and Integration Network

#### What is the problem being addressed?

Elderly persons are the most frequent users of the health system. Frail elderly comprise approximately 10% of persons age 65 years and over and are at risk for adverse conditions because of uncoordinated and inappropriate care<sup>4</sup>. Their health conditions are characterised by multiple co-morbidities, they need intensive case management and coordinated and flexible care to meet their needs effectively and efficiently.

#### What is the impact of not addressing the problem?

The Hamilton Niagara Haldimand Brant LHIN has the largest cohort of seniors among all Ontario LHINs. Persons age 65 years and older will comprise approximately 18% (265,643 persons) in 2016. Optimal quality of life for frail elderly persons is at risk in communities where the health system does not organize and align its resources for client centered care, chronic disease management, shared client information for planning and decision making, and knowledge transfer.

The need for health care services and supports increases with the onset of chronic disease, increased activity limitation, social isolation and complexity of condition. From client and family perspectives, specialized geriatric services (e.g. geriatrician and psycho-geriatrician services) are instrumental in helping people manage complex medical conditions, preventing premature deterioration of health and avoiding unnecessary hospitalization and/or inappropriate use of resources. However, specialized geriatric services are sometimes difficult to find and access, services are not always available close to home, care options are not tailored to clients' and carers' needs, and comprehensive care options are not organized around changing, co-morbid conditions. Among providers, the range of available services and supports may not be known, the increasing complexity of client and patient conditions requires ongoing skills' enhancement and interdisciplinary case relationships, and, tools to support coordinated and timely access to services e.g. patient information systems, are not in place.

The advent of the LHIN is an opportunity to renew and develop practices and ways of work among providers and patients, and others, that will make a difference to frail seniors' health outcomes, enhance effective program performance, efficiently align LHIN resources, and influence a provincial agenda for seniors' health.

<sup>4</sup> Baycrest. July 2006. *Responding to the Health Needs of the Elderly: A Synthesis with Policy Recommendations for Ontario*. Page 3

### What is the solution?

The Geriatric Access and Integration Network (GAIN) will be strategic and purposeful collaborative among stakeholders and will propose and coordinate LHIN wide strategies to optimize the quality of life for frail seniors. Stakeholders include those who use and will use specialized geriatric services, and providers, educators, funders, policy makers and researchers. The goal of the collaboration is an interconnected network of specialized geriatric health care services to promote:

- Strategies for optimal care and support for frail elder health in the LHIN.
- Equitable access to specialised geriatric services in hospitals and in the community.
- Enhanced connectedness among services to make it easier for people to get the right service at the right time consistent with their preferences, and easier for providers to organize and deliver best practice care.
- Allocation of resources consistent with need and desired outcomes.

Related requirements to support deliberations for future action include assessments of:

- The level of support and commitment for a collaborative network.
- The resources available to support frail seniors' health: a report card on the basket of services, access points and protocols, care path planning and assessment, provider connectedness, performance measures, evidence of best practice, among others.
- Improvement opportunities.
- Best practices in integrated service delivery models for frail seniors.

### How will this make a difference?

Collaboration for an informed, connected and evidence based system of care and support for frail seniors will result in informed choices and care plans among clients, patients and carers, timely access to services, fewer inappropriate admissions to any service including hospitals, and, healthier frail seniors with more confidence in the health system. Providers will benefit from purposeful relationships and initiatives for planning, knowledge transfer and peer support.



### Why is this the right solution?

The LHIN signals shared responsibility and accountability for health outcomes and health system performance. The GAIN stakeholders and early discussants recognize the need for an integrated delivery model – one that promotes better connectedness and efficient and effective resource allocation for client centered approaches.

The GAIN initiative is an opportunity to influence primary care reform initiatives in the LHIN e.g. family health teams' chronic disease management strategies, implementation of electronic information systems and Provincial strategies for frail elder care and support.

GAIN is focused initially on specialised services for frail elderly, and in subsequent phases can expand its foci on the appropriate service basket to support independent and less frail seniors. At this early stage of its development, the GAIN initiative also presents the broader LHIN community with an opportunity to explore and pilot the ways and means of effective collaboratives. The outcomes will help frame the approaches to enhance the capacity of other collaboratives to achieve community health outcomes.

### What is the level of readiness/commitment to action this solution?

The Geriatric Access and Integration Network (GAIN) was first among all priorities at a November 2004 LHIN wide session. In June 2006, 40+ representatives from among service providers met to begin the dialogue on the role and function of GAIN and committed to cooperation and collaboration. Many groups and networks focused on seniors' health care are seeking ways to reduce duplicative efforts, ensure they are working on the right issues with the right people to improve frail seniors' health outcomes, and leverage limited resources. The GAIN project raised some \$20,000.00 among key LHIN stakeholders to launch planning and relationship building.

While the GAIN is in its infancy, this does not preclude planning and implementation of strategies that, with adequate resources, will help improve system capacity, coordination and integration. Examples of current strategies include:

- The Dementia Education Program for Family Physicians, a LHIN-wide physician capacity building strategy for enhancing family physician knowledge of geriatric issues. It includes training in screening, assessment and symptom management for psycho-geriatric patients.

- Partnerships among key leaders in the provision of specialized geriatric services within Hamilton Niagara Haldimand Brant LHIN to:
  - o Improve the coordination and availability of gerontology educational materials for best practice geriatric care across the continuum of service providers, particularly for the long-term care sector.
  - o Improve the quality of care for residents and employee safety in long-term homes through staff training in best practice approaches to the management of challenging behaviour associated with dementia.
- Implementation of the Geriatric Emergency Management (GEM) program, whereby Clinical Nurse Specialists are placed in emergency departments to inform and assist other health professionals regarding the unique care needs of seniors.
- Further promotion and coordination of efforts to continue to integrate advance directives into health care facilities as standard best practice.
- Further implementation of the Hospital Elder Life Program across the LHIN. This program utilizes volunteers to enhance in-hospital care for seniors.

**Describe the process used to develop this health improvement solution:**

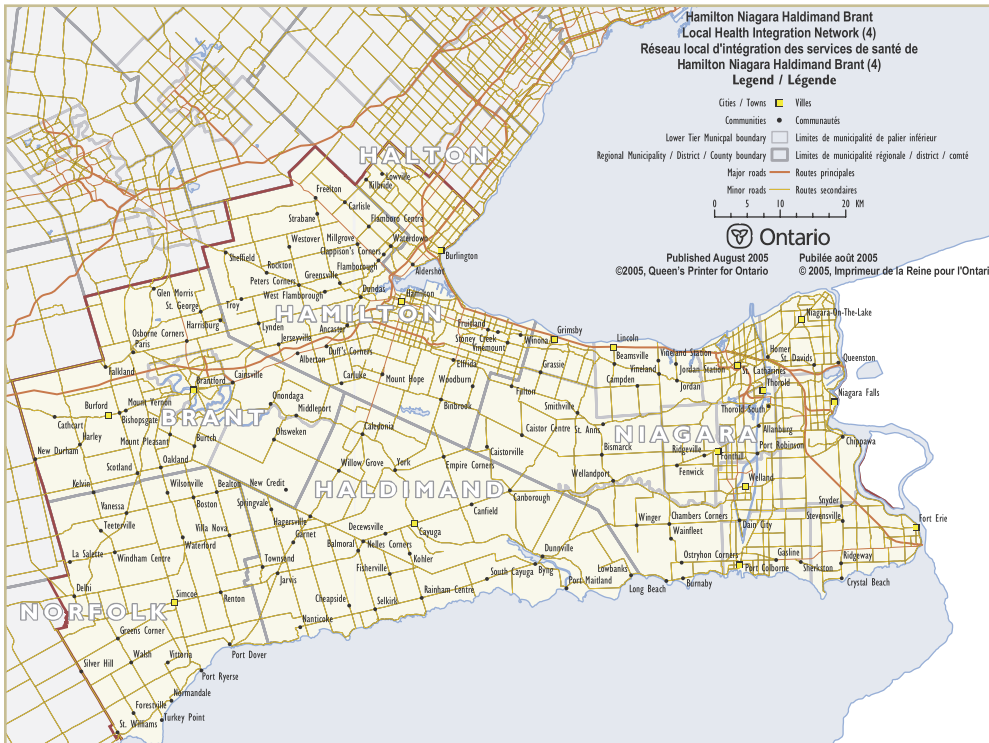
In June 2006, a leadership team facilitated a GAIN workshop session at which 40+ participants from among HNHB LHIN service providers developed a vision, mission, and guiding principles, and proposed goals for the network.

Next steps include a forum in Fall 2006 co sponsored by GAIN and the Hamilton Niagara Haldimand Brant LHIN for specialised care services and affiliated stakeholders networks to begin the process of examining and developing the approaches and tools that enable collaboratives to work effectively. Following this, LHIN wide discussions will continue on the scope and opportunity of the collaborative to optimize frail senior's health, the range and role(s) of collaborative participants, and confirmation of shared aspirations for change.



*Hamilton Niagara Haldimand Brant*  
**LOCAL HEALTH INTEGRATION NETWORK**

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



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