Local Health Integration Networks (LHINs)

Laying the Foundation for Integration In Ontario

Prepared for
"Breakfast with the Chiefs"
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Ontario

A call to adventure

" Whatever you can do, or dream you can, begin it."

Goethe

Life on the "Frontier"

- *" It was like an army of generals, with neither soldiers nor sergeants. It is tough to assign work to people sitting around a table, who have spent much of their professional lives assigning work to others."*
- *" A vision has been provided. It is our job to make that vision a reality. It is our job to transform the system. An immense undertaking, and a much-needed undertaking!"*
- *" Ashleigh Brilliant was right – It is an exciting time; I will have to run to be in the lead; there is lots of support; and, together, we can do it!"*
- *" If life's like a roller coaster, you might as well sit at the front."*

Why take on the integration challenge?

We believe we can make a difference.

FROM

- Patients making their own way through a complex health care system that is:
  - A fragmented, silo-based health system – an uncoordinated collection of services and repeating case histories to various health care providers.
  - Separate health care provider planning and funding.

Making a difference…

TO

- Improved accessibility of health services to allow people to move more easily through the health system.
- Local health system funding and performance monitoring.
- Local system integration and service coordination.
- Community involvement in local health system planning and setting of priorities.
- Breaking down institutional barriers to integration and collaboration.

Around the World, Across Canada, and Back to the LHINs

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Context

- All Canadian provinces and the major countries that are part of the Organization for Economic Cooperation and Development (OECD) have placed health care decision-making closer to the point of impact and sought to develop integrated approaches at the local level.
- Internationally, regionalization is deeply ingrained in some parts of Europe (Nordic countries, England) and under further development in most EU countries, Australia and New Zealand.
- In the US, regional systems include private corporations (Kaiser Permanente) and publicly funded systems (Veterans Health Administration) with defined patient populations.

Context (continued)

- In Canada, regionalization was endorsed in principle by the Hay Commission report in 1964 and re-endorsed by the Premier's Council in 1993.
- All countries/provinces implemented multiple reforms to structure, payment and delivery systems at the same time.

International themes

- Focus on increased accountability, transparency and improved management of health systems has led to complex parallel processes of *centralization* of regulatory functions and *de-centralization* of administrative functions.
- Differs from country to country and province to province by the degree of authority transferred to the regional level and the degree of autonomy from the centre.

International themes (continued)

- Common drivers and approaches:
  - Unacceptable variation in health between regions and populations.
    - Needs-based allocation of resources.
  - Citizens demanding improved access and quality.
    - Citizen participation, patient rights and increased public reporting.
  - Variation in health outcomes by provider and technical complexity.
    - Better performance management by separating purchasing from the provision of care and standardizing quality management.
  - Fragmentation along the continuum of care.
    - Increased integration between health and social service providers for seniors, children and mental health clients.
  - Rising costs and demand pressures.
    - Improved managerial and technical efficiency at central level.

National themes

- All provinces and the Northwest Territories have devolved the management of the health system to a sub-provincial authority.
  - PEI (pop. 133,000) is returning to central ministry management.
- Québec was the first province to establish regional authorities (1989-1992) and Manitoba was the most recent (1997/98).
- In all provinces, except Québec, the boards of health service providers were dissolved and the regional structure took over the direct administration of services
  - Québec is currently amalgamating governance structures for the purpose of creating integrated delivery networks.

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National themes (continued)

- Other forms of regional structures pre-dated health authorities in many provinces (District Health Boards in NS, Community Health Councils in BC).
- In some provinces (Québec, Newfoundland and Labrador), the regional structures also manage social services.
- No province or territory has undertaken a comprehensive review of the impact or outcomes.

The Ontario context

- Over the past four years, health costs in Ontario have grown by the following annual averages:
  - Overall health care by 8%.
  - Drugs for both MOHLTC and MCSS, by 12.6%.
  - Hospitals by 8% - 1 out of every 7 dollars in government spending goes to hospitals.
  - OHIP payments by 6.1%.
- Health's operating budget and % of the government's total spending, 2005-06.
  - $32.9 B – includes funding that was transferred to Ministry of Health Promotion.
  - 46%, excluding interest on public debt.
- Population growth and more individuals living longer.
- Increasing prevalence of chronic diseases and overlapping conditions (diabetes, cardiac, cancer, arthritis, etc.).

The Ontario context (continued)

- Magnitude and complexity.
  - Single providers with budgets larger than entire ministries of health and more outpatient visits than the population of smaller provinces.
  - Five academic health science centres and a new one on the way in the north (most provinces have one or two major centres).
  - 22 hospitals in Ontario have teaching or research affiliations with the health science centres.
- Long, rich tradition of community-based governance.
- Extensive experimentation and practice with various voluntary models of collaboration and coordination.

Health system transformation in Ontario

"Our vision is of a system where all providers speak to one another in the same language, where there are no longer impenetrable and artificial walls between stakeholders and services: a system driven by the needs of patients, not providers."

The Hon. George Smitherman, Minister of Health and Long-Term Care

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The mandate for change

"What matters most for patients is whether care is there for them and their loved ones in times of need. They want better access to the right care, at the right time, in the right place."

- On September 9, 2004 - Minister Smitherman announced the Health Results Team transformation agenda – 2.5 year time frame for implementation to March 2007:
  - Improving access and wait times.
  - Advancing primary care reform – Family Health Teams.
  - Information management.
  - System integration – Local Health Integration Networks.

Approach to developing LHINs

- Key aspects of the Ontario solution.
  - **LHINs will not be providers of direct service.**
  - **LHINs will not require consolidation of existing provider governance structures.**
  - **LHIN boundaries are permeable.**
  - **LHINs will enable integration of services by agreement, negotiation and funding.**
- A phased approach to implementation of LHINs.
  - **Evolution of LHIN authority** and governing structures over first 18 months.
  - **Phased-in functions** with full functionality expected by April 2007.
  - **Phased-in performance expectations** and outcomes defined by the ministry.

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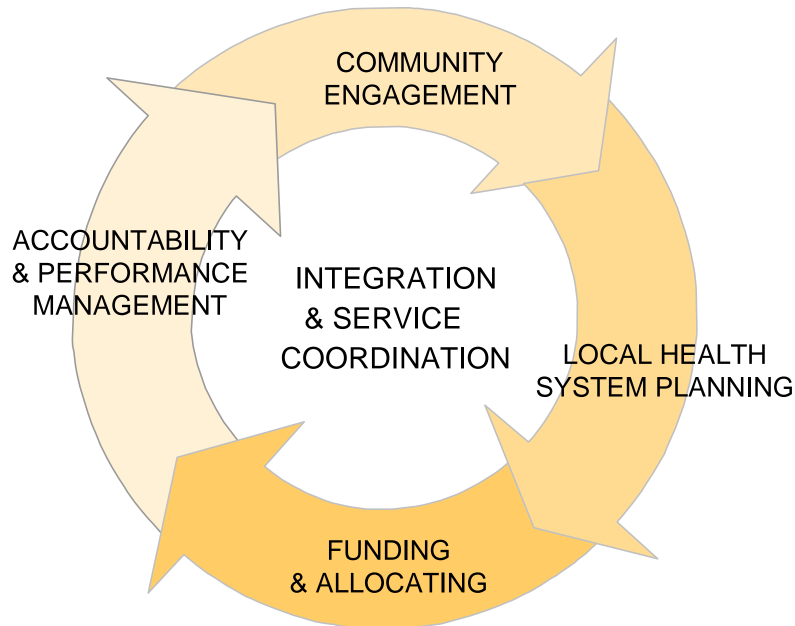
Achieving an integrated system

- Achieving integration goals will depend on the ability to foster a culture that supports the LHINs' role as leaders of integration and coordination at the local level.



Integration outcomes:

- ***Seamless experience*** for user, where boundaries between organizations are minimized.
- ***Improved match*** between single services provided and the multiple needs of clients and families.
- ***Effective and efficient*** use of system resources and capacity.

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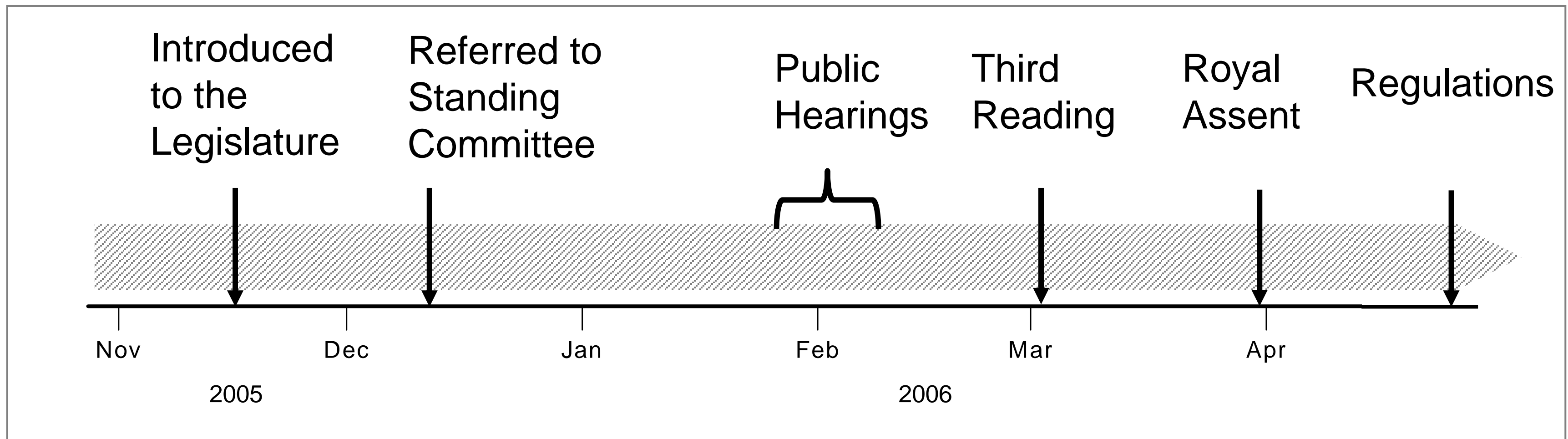
Status of legislation

- Legislation, regulations, and policy:
  - Gives LHINs the authority and tools to enable local system change.
  - Sets out responsibilities for system partners.

Local Health System Integration Act, 2006



LHIN areas of responsibility

- LHINs will be responsible for nearly two-thirds of the ministry's $35.4 billion budget.
- The following health service providers will be accountable to and receive funding from LHINs:
  - Public and private hospitals
  - Community Care Access Centres (CCACs)
  - Community support service organizations (e.g., personal assistance services, homemaking, friendly visiting)
  - Community mental health and addiction agencies
  - Community Health Centres
  - Long-term care homes.
- This represents more than 2,000 service providers in the province.

LHIN decision-making

- **Integrated Health Service Planning (IHSP) -** LHINs will develop a 3 year local strategic plan, guided by a provincial plan and direction:
  - Developed in consultation with the community, providers and experts
  - Includes planned integration strategies
  - Informs detailed Annual Service Plan.
- **Integration directions** – while the goal is collaboration, LHINs could make decisions in accordance with their IHSP requiring a service provider, for example to:
  - Provide or stop providing a service, or quantity of services
  - Transfer a service from one location or provider to another
  - Take action necessary to implement an integration identified as a priority in the IHSP.
- **Service provider accountability and allocation/funding** - LHINs will assume powers to:
  - Negotiate and sign accountability agreements and service plans
  - Allocate operating funds and approve providers' service plans/budgets.

LHINs – “Our history”

- 14 corporations established in June 2005.
- 42 founding board members and 14 CEOs announced June 2005
  - Community-based nomination process to recruit board members – 59 public information sessions in 46 cities and towns held in fall 2005.
  - 42 additional board members appointed through the public appointments secretariat in January 2006.
- CEOs started work August 22, 2005.
- Operational start-up, offices opened in fall 2005.
- LHIN leaders hosted 37 “Meet and Greets” across the province in the summer with leaders of health care organizations.
- Initial staff recruited (two senior directors, executive assistant and office manager) for each LHIN by January 2006.

Where we are now

- Waiting for the appointment of 42 new board members through the community-based nomination process to complete board complement (spring 2006).
- Addressing operational start-up issues.
- MOHLTC/LHINs gelling as teams
  - Regular meetings of Minister and Chairs
  - Regular meetings with DM, ADM and CEOs.
- Working with Regional Offices to develop transition plans.
- 2006/07 Accountability Agreement between MOHLTC and LHINs.

The next 6 months

- Engaging and integrating approximately 300 new staff and 126 board members (spring 2006).
- Community engagement (spring 2006)
  - Supportive provider feedback.
- Progress Reports (summer 2006).
- LHIN Governance Leadership Model (fall 2006).
- HAPS/HAA's involvement (summer/fall 2006).
- Integrated Health Service Plans (fall 2006).
- Annual Service Plans (fall 2006).

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Community engagement

- Community engagement is a core function of LHINs.
- The Local Health System Integration Act 2006:
  - Requires LHINs to develop a local integrated health service plan with input from the community.
  - Sets out requirements for community engagement by LHINs and health service providers.
  - Requires each LHIN to establish a Health Professionals Advisory Committee as part of its community engagement process. This committee, which will be comprised of physicians and other regulated health professionals, will provide advice on clinical matters.
- LHINs will use a variety of methods, such as:
  - Expert panels, focus groups, telephone surveys, electronic panels, think tanks, and open houses.
- We need more sophisticated methods to provide better confidence in our understanding of the population's perspective on issues.

Integrated Health Service Plans

- Consistent template for all 14 LHINs.
- Transitional in nature.
- Guided by MOHLTC transformation agenda and reflect local issues.
- Will identify integration opportunities and priorities.
- To be finalized in fall 2006.

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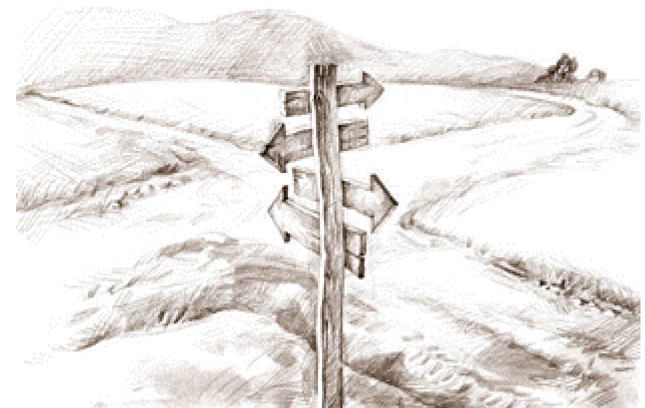
Roadmap for Integrated Health Service Plans

- Provincial Context.
- LHIN local vision.
- Environmental scan – local need and context.
- Resource analysis – human, fiscal and capital capacities.
- LHIN priorities for change.
- Current activities.
- Action Plan.



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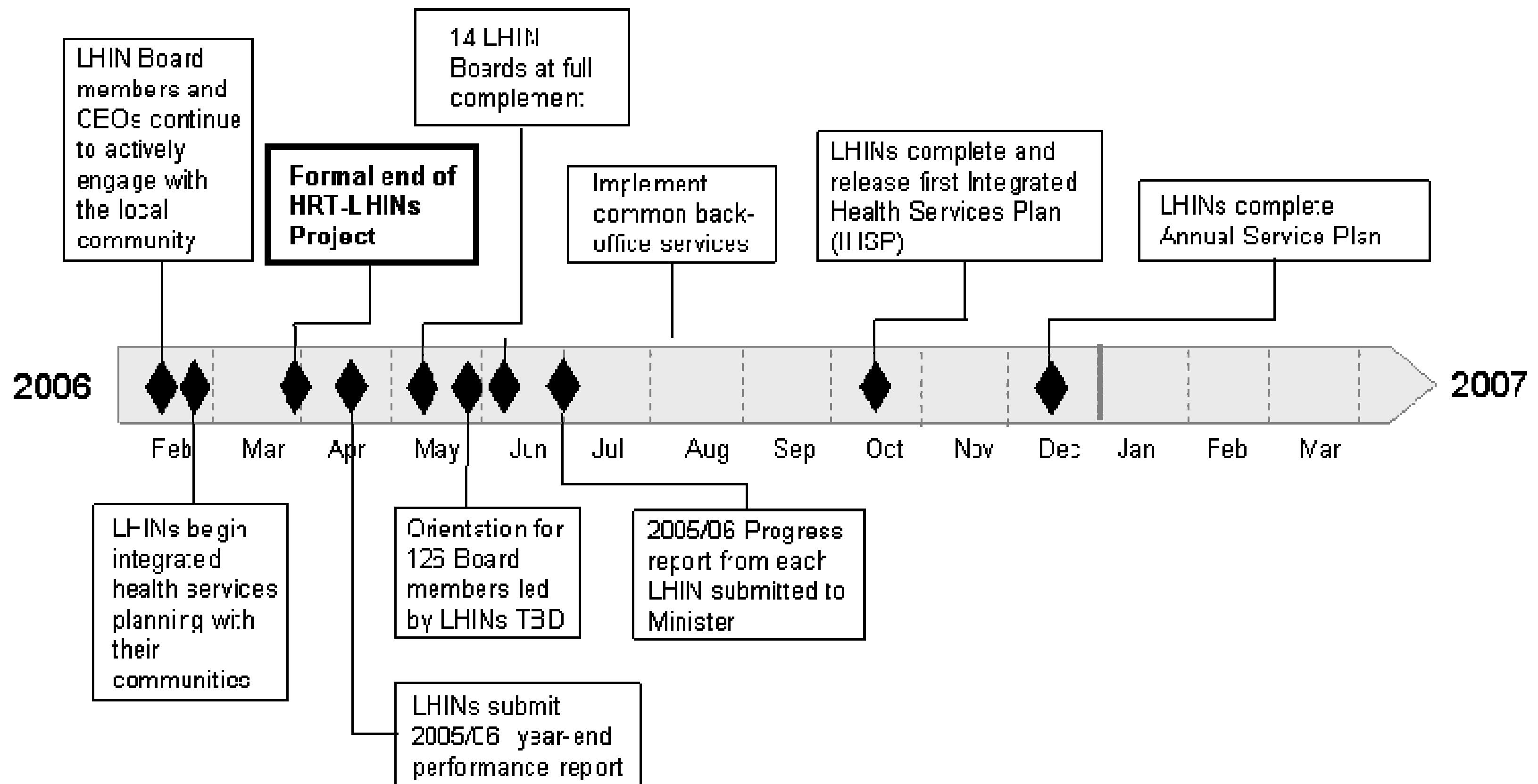
Next Steps for LHINs



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Challenges

- Time
  - Need time to build capacity, infrastructure and systems
  - Need time to gain knowledge
  - Need time to earn the confidence of the field/public.
- New direction and structure for the Ministry is underway.
- Managing expectations.
- Establishing mechanisms for working with providers and stakeholders outside the LHINs′ mandate.

Summary – *a system view*

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"The most effective way to do it, is to do it."

Toni Cade Bambara

(author African-American)

Your Turn

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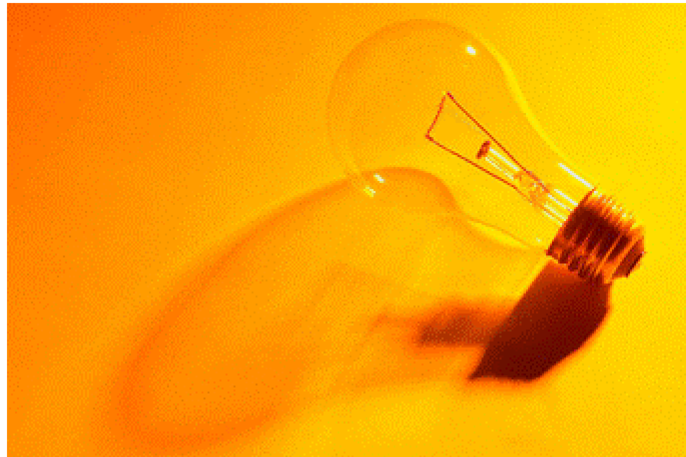

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