Health Results Team First Annual Report 2004-05

October 2005

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."*

George Smitherman
Minister of Health and Long-Term Care, 2004

Introduction

This report details a focused array of efforts, milestones and achievements meant to deliver on the vision, promise and challenge of Minister Smitherman in September, 2004. One year later, our comprehensive, sustainable and effective plan on improving patient access to health care for both today and tomorrow is in full swing. We know from patients and providers that access has improved. It is our hope that this presentation of results achieved will demonstrate to the health community and providers the effectiveness of the government's plan. Most importantly, that we are rebuilding the hope and trust Ontarians have for their Medicare system of universal access.

Nothing less should be expected and the pace of change will continue until the work is complete.

When we started out on this journey of renewal, we had a vision, a plan, and principles to operate by. Along the way, our encounters and experiences have made us the wiser. Learning has given us the knowledge of when to be flexible and when to push, when to listen and when to execute.

Praise is deserved for the health care stakeholders and the ministry itself, which have embraced the cause of improving patient access within a values- and evidenced-based, efficient, integrated and sustainable high-quality health care system. The successes of the Health Results Team would not have been possible without the generous offerings of their time, energy, expertise and creativity.

As the Executive Lead for the Health Results Team, it is my privilege to inform the ministry, the Minister and the government that it has at its disposal exceptional change leaders – from the Leads of the Health Results Team with a track record of success, to the experienced leadership of the ministry itself. From the start they have responded to the Minister's challenge and focused on results, execution and momentum, with the belief that alignment will follow.

Finally, our team must acknowledge the leadership and support provided by Premier Dalton McGuinty and Minister Smitherman, both of whom have been actively engaged in this plan for change. Through direct interactions, both leaders have never wavered in their commitment to the plan and the need to obtain real results. We are honoured by the opportunity to serve.

The team is already engaged in the next phases of the government's plan. We are aligning the elements – people, resources, information, structures – into a new health care culture that promotes improved access to patient-centred, quality health care. We will continue to push the agenda hard in one direction, turn upon turn, and build momentum until the point of breakthrough.

Respectfully submitted on behalf of the Health Results Team.

Hugh MacLeod
Associate Deputy Minister
Executive Lead, Health Results Team
Ministry of Health and Long-Term Care

September 9, 2005

"We must act to rebuild confidence in medicare"[1]

On September 9, 2004, the Honourable George Smitherman, Minister of Health and Long-Term Care challenged us to rekindle the **confidence and trust** of citizens in their treasured universal health care system.

The Ministry of Health and Long-Term Care was charged with delivering a results-driven and evidence-based plan to improve access to patient-focused and integrated health care services. This was no small undertaking. Unlike previous system improvements, the Minister's objective could not be reached through incremental changes to funding, additional regulations or processes. Rather, the success that was demanded by the Minister for the people of Ontario required a transformational change not only of systems and processes, but also in ideas and culture.

"Transformation must begin with a new way of thinking and behaving"

The Health Results Team: Mandate & Principles

In order to realize this renaissance, Minister Smitherman created the Health Results Team – an innovative model enlisting the skills, knowledge and energy of recognized change agents from both within and outside of government. For the past year, the appointed Leads of the Health Results Team have been engaging and working with all parts of the health care community – from community board directors, senior government and elected officials, and academics to front-line workers, health care clients and citizens – to **improve access** through short and long-term solutions that were patient-focused, results-driven, integrated and sustainable.

From its inception, the Team has been guided by a clear mandate for change and key foundational principles by which to achieve that change ***(see box, page 3)***. At the core of our efforts has been a commitment to the mission and principles of our health care system: ***to provide universal and equitable access to quality health care services.*** The goal of our transformation efforts has not been to challenge this important social contract, but to recommit ourselves to its purpose and ends.

In our first year, improving access to health care services has required the use of different change leadership strategies. In order to secure immediate results and generate momentum and confidence, the team has served as change agents focusing on transactional or short-term goals such as increasing the number of surgical procedures, laying the foundation for the establishment of new service delivery and planning models, or taking stock of our information resources.

These short-term and practical transactional activities or "wins" have provided us the **leverage** to begin the more important but difficult task of **system change**.

The Health Results Team has operated with the understanding that the speed of implementation and change is important. Sometimes, the speed of our efforts has necessitated implementing recommendations and ideas as they are discussed, correcting on the fly and, like a sailboat, tacking and recalibrating while moving forward.

[1] Unless otherwise noted, quotations belong to the Minister of Health and Long-Term Care, George Smitherman, and were delivered at major public engagements held in February and September of 2004.

Making transformation a reality is an iterative process that has to date required an extensive and transparent engagement process: involving and informing thousands of members of the health care community.

As **system change** leaders, we have and continue to engage the health care community with new questions and conversations in order to develop innovative, responsive solutions. By building on our plan and activating new models of reasoning, the Team and its health care partners are changing and aligning the structures, processes, information, resources and incentives of the current system into a new culture that will fundamentally improve access to health care services.

Health Results Team: Guiding Principles

- **Commitment:** A commitment to defending and renewing the mission of universal medicare.
- **Engage:** Actively engage and consult the health care community in a comprehensive and transparent manner.
- **Accelerate:** Test assumptions, challenge artificial barriers, and anticipate the future.
- **Think System:** Align planning and investments to create innovative and sustainable systems' solutions rather than recreating silo-based ones.
- **Leverage:** Harness existing resources, partnerships; employ incentives.
- **Focus and Execute:** Select a limited number of core transformational strategies and pursue achievable results.
- **Quality:** Instill a discipline of quality, evidence-based outcomes.
- **Measure:** Use better information to enhance decision-making, demonstrate results, and improve accountability.
- **Inform:** Keep elected decision-makers informed of our progress, challenges and next steps in an open and transparent fashion.

Recapping Our Plan

In this report, the outline of our strategic plan will only be briefly described. Rather than extensively restate the problems faced by our current health care model – along with our plans to correct them – the purpose of this report is to communicate our progress to date, the strategy and tactics we have deployed. Insofar as the report highlights the progress of the past year, it effectively is a prelude of the progress to come.

System Integration: Local Health Integration Networks

GOAL: Create an integrated health care system

SCOPE: Establish the Local Health Integration Networks (LHINs), including their organizational and functional design and implementation.

Within the Health Results Team, the System Integration Team led by Gail Paech, has been charged with the responsibility of implementing structural and system change to better plan, coordinate and fund the delivery of health care services at the local level, through the development of Local Health Integration Networks (LHINs).

LHINs are the next evolution of health care in Ontario: They are a made-in-Ontario solution intended to capitalize on our community strengths and resources, at the same time as addressing our specific challenges in delivering care in such a diverse province. They are premised with the understanding that community-based care, reflecting the needs of that community, is best planned, coordinated and funded in an integrated manner within and by that community.

The government is establishing 14 LHINs, geographically-based non-profit organizations designed to plan, integrate and fund local health services, including hospitals, community care access centres, home care, long-term care, mental health and addictions within a specific geographic area.

LHINs: The Made-In-Ontario Solution

- Will respect and strengthen local governance of health delivery organizations
- Will not provide direct services
- Will be built and work alongside community voices
- Will not be hard boundaries for patient access or physicians.

Improving Access and Wait Times

GOAL: A comprehensive system that ensures Ontarians receive timely and appropriate access to health services by December, 2006.

SCOPE: Wait time reduction in five key areas: cancer surgery, cardiac procedures, cataract surgery, hip and knee total joint replacement, and MRI exams.

"Wait times is the most visible symbol people use to gauge whether they are getting timely access to the care they need."

When it comes to taking the pulse of the health system, wait times is one of the most important ways the public measures the quality of the health care they receive and decides how well the system is working.

The problem of prolonged wait times cannot be resolved through increased investments in surgical volumes alone; wait times is the symptom of a larger problem related to access and resource management. For this reason, Dr. Alan Hudson and his team have forged a comprehensive Wait Time Strategy that is tackling the problem with a coordinated plan that includes both transactional and system change fronts:

- Significantly increasing the number of procedures to reduce surgical backlog and improve immediate access
- Investing in new and more efficient technology
- Increasing access, quality and efficiency through the standardization of best practices, coaching teams, and accountability for both clinical and operational functions
- Spearheading a provincial critical care strategy to improve health outcomes, access and surgical throughput in the hospital system
- Creating a Wait Time Information System that will systematically collect and report accurate and up-to-date data on wait times to allow better decision-making and increased accountability.

Family Health Teams: Advancing Primary Health Care

GOAL: Keep Ontarians healthy by improving access to interdisciplinary primary health care models that provide comprehensive patient-centred care

SCOPE: Implement 150 Family Health Teams by 2007-08.

Experience world-wide informs us that effective primary health care is the foundation of a healthy population and sustainable health care system. Ontario has a proud and innovative tradition in providing primary health care in models that meets the needs of its various communities. Family Health Teams mark the evolution of the Ontario experience that will keep our health care services world-class.

Family Health Teams will improve access to primary health care through the introduction of interdisciplinary health teams. These teams are being developed with cooperation and input from both the community and the providers so that they meet the primary health care needs of the population they serve.

Given the diversity of Ontario's communities, along with the complex relationships and needs of the various health professions, implementing 150 Family Health Teams represents a significant transformational challenge. Dr. Jim MacLean and his team have adopted some guiding principles to help meet the needs of the government, communities and providers during the development and implementation of prospective Family Health Teams ***(see box below).***

While Family Health Teams will be responsive to these different needs, they will share the same objective: improve patient access to care and promote the wellness of the communities they serve.

"[Family Health Teams are] an important part of our plan to improve health care, and sustain medicare for years to come, and represents a major leap forward" Premier Dalton McGuinty, April 15, 2005

Family Health Teams (FHTs): A Principled Implementation

- **Flexibility and Choice**
  FHTs will recognize the diversity of communities across Ontario and will be flexible regarding the size, scope and focus of Teams.
- **Community and Provider Partnerships**
  Community representatives, local health delivery organizations and health care professionals will be encouraged to work together to develop Teams that reflect the unique needs of the population.
- **Build on Existing Models and Successes**
  FHTs will build upon the strengths of existing models and learn from their challenges.
- **Team Based Care**
  FHTs will be interdisciplinary teams of providers, including physicians, nurses, nurse practitioners and other health care professionals.
- **Local Integration**
  FHTs will work to develop collaborative partnerships that will improve access and continuity of care.
- **Patient Focus**
  Through patient enrollment and population based health planning.
- **Evidence-Based Balanced Approach**
  Encourage use of evidence-based practice, continuous re-evaluation, along with flexibility for innovation and responsiveness to local concerns.
- **Transparency and Consultation**
  FHTs will be designed, developed and implemented through a process of open communication and transparency.

Information Management

GOAL: To build a health care system people can count on by providing decision-makers across the health care system with timely, accurate and relevant information that will improve health system performance and accountability.

SCOPE: Improve the ability of the Ministry of Health and Long-Term Care, Local Health Integration Networks, and health care providers to produce objective, timely and accurate information that will enable improvements in health system management, quality, and publicly demonstrating accountability.

"The lack of a common technology platform and information base in our system doesn't just slow things down it seriously compromises patient care."

Information and data flows are the critical "wiring" of any health care system.

But obtaining health information today is not as simple as turning a light switch. A health system built on a faulty "wiring system" will produce the wrong information at the wrong time; wastes energy and falls short of full capacity; cannot be managed optimally; and, most importantly, cannot demonstrate performance against its key accountabilities.

With close to 100 separate health information databases in operation, health care planners, managers, researchers and analysts are finding it more and more difficult to access the right information they need; it is either missing or is coming up short. Health care providers and managers without appropriate access to information cannot reasonably improve patient access to health care services.

Committed to improving access within a sustainable health care system that generates the confidence of Ontarians, the government, providers and the public require accurate and comprehensive information to measure the performance of the health system. Despite the existing 2,000 performance indicators in use in Ontario, many are of limited use because they are either difficult to interpret, provide only limited information, or do not relate to the government's key health priorities.

Closer to the patient bedside, the Information Strategy is working with other major government initiatives on weaving patient-level data on wait times and disease management that will be integrated into the provincial information management system that will include Local Health Integration Networks and the Ontario Health Quality Council. Dr. Adalsteinn Brown and team are leading this critical effort.

Information Management: Principles for Change

- Build on existing strengths inside and outside the ministry
- Reduce impact and burden of data collection on providers and bureaucrats
- Use technology as an accelerator, not a solution
- Maintain transparency of process inside and outside the ministry
- Integrate information management reforms into existing structures

Bringing the Elements Together

"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."

In our first year alone, the milestones met and results achieved against our plan have been considerable. Listing these achievements in detail here would overwhelm the intent of the report: build confidence that we are achieving results against the government's plan.

The elements of our plan share a single objective: Improving access to health care services for the people of Ontario. Whether this be shortening wait times for selected services, or providing greater continuity of services between the hospital and home services, or obtaining primary health care to stay healthy or better manage chronic illnesses, or creating an information system that improves care delivery and coordination, the end goal is the same: Improving access "to the right care, at the right time, in the right place." Improving access requires associated improvements in quality, efficiency, integration, accountability, and sustainability.

To demonstrate the interdependence of our plan, we are reporting on first-year results across the various components of the strategy by using some common themes:

1. Engagement, Consultation and Collaboration
2. Building the Capacity of the Health System
3. Better Information, Better Decisions: Improving Accountability
4. Laying the Foundation for Integration

While our project teams have certainly found efforts to date to be mutually supporting, we anticipate that they will become increasingly intertwined with as they mature and take shape, especially with the coming of age of Local Health Integration Networks and Family Health Teams.

1. Engagement, Consultation and Collaboration

Consultation is the cornerstone of transformation. The Health Results Team's approach has been to seek solutions in concert with stakeholders and communities. Not only do they bring practical experience from the front lines of the health care system, but also their direct participation is essential to building the confidence and support that will sustain the transformation for years to come.

New relationships are formed by new dialogue, and the Health Results Team has been innovative in engaging all levels of stakeholders. It has utilized new methods of communications, new participants, multiple and different structures, new teams and channels, such as interactive web links, print media, regular bulletins and updates, expert panels, actions groups, local provider groups and established provincial organizations.

Engaging the Community

Barbara Hall, Lead for Community Relations with the Health Results Team, has drawn on her extensive community connections and distinguished public career to ensure the diverse voices from community groups and associations involved in local planning are heard throughout the implementation of the strategy.

Barbara, along with other Health Results Team leads, have traversed the province to meet with thousands of health care providers and leaders, associations, patients and community members, to give updates, uncover new perspectives and concerns, and seek input on solutions to important issues.

"That's what our government's plan to transform health care is all about: taking Medicare to its necessary next step – creating a comprehensive and integrated system of care that is shaped with the active leadership of communities and driven by the needs of the patient."

Consultation with Ontario's health care community and the broader public is important for another reason: modeling a new behaviour that enlists, builds and leverages provincial and community networks and leaders that will be important to the long-term success of the Local Health Integration Networks, Family Health Teams, and the renewed Ministry of Health and Long-Term Care.

Local Health Integration Networks are less about imposing a new structure in the health care system than about building new relationships that will work across providers and sectors. As such, the implementation of LHINs and their future success relies on their ability to build and leverage capacity for planning, engagement and service coordination within their local health communities.

Because LHINs and Family Health Teams mark a significant cultural change in health care, we have sought to involve and keep informed the public, health care providers and other stakeholders through a variety of ways, notably:

- **Two-way communication:** Regular bulletins have been posted on a designated section of the ministry's web site about policy updates and LHINs rollout, as well as an opportunity for communities and stakeholders to provide feedback. For example, as a result of the questions posed to the health care community in Bulletin No. 1, the ministry received a total of 430 submissions containing valuable information.
- **LHIN community workshops:** In November and December, 2004, the System Integration Team organized and held workshops in all 14 LHIN communities with a wide range of citizens, health care providers, community and patient advocacy organizations. The approximately 4,000 people attended the workshops identified existing and future integration priorities.

  Self-identified leaders in each of the 14 LHIN communities worked with other volunteers to give shape to these integration priorities. We supported this process by hosting a Community Planning Forum to enhance the preparation of Integration Reports and engage LHIN communities. Over 200 people attended this January, 2005 event.

  The final 14 Integration Priority Reports were submitted to the ministry in February, 2005. After some analysis, we created a summary report that captured the key findings of all the reports. All Integration Priority Reports and Summary Analysis document were posted on the ministry's web site (www.health.gov.on.ca/transformation) so that the learning and information can be shared more broadly. The founding LHIN boards and CEOs have been provided with this information to guide LHIN integrated health system planning.

Fast Facts on LHINs Consultation

- 430 submissions in response to Bulletin No. 1
- 4,000 people participating in LHIN Community workshops
- 200 attendees at LHIN Community Planning Forum
- 30 organizations represented on LHIN Action Group

- **FHT Community and Stakeholder Dialogues:** In December, 2004, Dr. Jim MacLean and the Primary Health Care Team visited 16 communities to present information on Family Health Teams and discuss opportunities for participation. In total, over 250 physicians, providers and community representatives attended the sessions and over 800 information resource kits were shared with participants.

System Change Supported by Action Groups and Expert Panels

Each element within the Health Results Team has set about establishing, engaging and employing a diverse range of expert panels and action groups to help us drive our short and long-term plans for renewal. This engagement has been critical in demonstrating that the government's renewal process is inclusive, transparent, iterative and credible. By harnessing the collective knowledge and expertise in our health community, we have been rewarded with an unprecedented level of cooperative spirit to finding real solutions that will improve access to health services. Furthermore, this partnership marks new ground for the Ministry of Health and Long-Term Care as it undergoes its own journey of renewal.

Below is a summary of the action groups, partnerships and expert panels established:

Local Health Integration Networks:

The LHIN Action Group: A provincial Action Group providing expert advice on the design and implementation of LHINs. 29 organizations are represented, including home care providers, community support service providers, community mental health service providers, community health centres, long-term care facilities, Community Care Access Centres, hospitals, local public health agencies, French language health service providers, physicians, nurses, and ministry Regional Offices.

LHIN Working Groups: In conjunction with the work of the Action Group, additional working groups were formed to advise on specific matters related to LHIN implementation. They include ***Academic Teaching Hospitals Working Group, the French Language Working Group, and the Aboriginal Working Groups***

Family Health Teams

Family Health Team Action Group: Established in December 2004, the Group provides expert advice on operational and implementation matters related to the establishment of Family Health Teams. The Action Group is composed of provincial associations and health care experts representing: family physicians, nurse practitioners, nurses, community mental health service providers, community health centres, hospitals, public health, rehabilitation service providers, municipalities and researchers.

Family Health Team Working Group: Established in June, 2005 in accordance with the government's Memorandum of Understanding with the Ontario Medical Association. The forum provides an opportunity for discussion and problem solving around physician participation and interests in Family Health Team implementation.

Access and Wait Times

Expert panels were established for the five key services, as well as for wait times information management and for surgical processes. Members of the expert panels included leaders from academic and community hospitals, physicians, nurses and other front-line staff.

Institute for Clinical and Evaluative Studies Atlas: Access to Health Services in Ontario: Provincial first with 27 experts engaged.

MRI and CT Expert Panel: Provincial first with 11 experts engaged.

Cataract Expert Panel: Provincial first with 12 experts engaged.

Hip and Knee Joint Replacement Expert Panel: Provincial first with 15 experts engaged.

Cancer Committee: 14 experts engaged.

Surgical Process Analysis and Improvement Expert Panel: Provincial first with 22 experts engaged

Ontario Critical Care Steering Committee: Provincial first with 44 experts engaged.

Ontario Critical Care Expert Panel: 18 experts advising on implementation of Provincial Critical Care Report

Wait Time Information Management Action Group: Provincial first with 18 experts engaged.

To date the expert panels for Wait Time Information Management, MRI/CT, Cataracts, Critical Care and the Surgical Process Analysis and Improvement have submitted reports and recommendations to the ministry. Reports from the Cancer, and Hip and Knee expert panels are expected in September.

Common themes in the reports include the importance of standardized practices to support safe care, the efficient and effective use of resources, information to monitor outcomes, clear accountabilities for performance, appropriate funding levels and approaches, the innovative use of human resources, knowledge transfer and dissemination of best practices, and integrated networks of care.

The ministry has already begun implementing many of the recommendations of these reports, such as: expanding the hours of operation for MRI units; using efficiency ratings as part of the criteria for allocating funding; using coaching teams to improve efficiency, quality and capacity; and learned from Expert Panels' recommendations on priority ranking schemes and targets. Many other recommendations can be implemented by hospitals as the reports have been widely circulated to hospital administrators throughout Ontario.

Information Management

The Information Management team has integrated the use of experts in order to meet specific deliverables within its project plan. Examples include:

Data Gap Analysis: 36 experts – managers with experience using data within the MOHLTC; senior executives in hospitals; consultants; researchers – engaged.

Ontario Health Planning Data Guide: 125 owners of information holdings and potential users engaged.

First Clinical Data Blitz: Close to 200 hospitals' record coders and supervisors engaged representing 113 hospital.

Selection and vetting of indicators for the first Health System Scorecard: 20 experts representing major performance organizations.

Survey of Ontario Hospitals' Health Records Departments: 142 Directors and Managers of Health Records from Ontario hospitals.

National Scan of Data Management Practices: Survey of other provinces on their data management practices and lessons learned.

We have also partnered with the Ontario Health Information Management Association, The Change Foundation, and the Ontario Hospital Association, and held special conferences with a focus on how to produce better data through the sharing of best practices and the adoption of standards.

Working with our Ministry Partners

The Health Results Team is not a team unto itself. While we have been tasked with specific and time-limited goals, they cannot be achieved without a coordinated effort with the broader Ministry of Health and Long-Term Care. To this end, each of our teams has established innovative solutions such as horizontal models of decision-support, project teams, and information sharing. Examples include the LHIN Action Group, the Information Management Internal Action Group, the Family Health Teams application review, the Primary Health Care Transformation Committee, and the Access and Wait Times Executive Working Group. In the later example, key senior executives from across the Ministry of Health and Long-Term Care meet bi-weekly to discuss project deliverables, share information, develop strategies, and resolve key operational activities that may have an impact on either the Wait Time strategy or other ministry business. The Executive Working Group provides not only a forum for assigning key responsibilities that ensure the wait time strategy is implemented across the ministry in a coordinated and consistent fashion, but also provides a change management forum in preparation when the ministry and LHINs will assume responsibility for the initiative.

To support our plan, we have also conducted special Town Hall meetings to inform, engage and learn from ministry staff. And because building a healthy Ontario requires a concerted effort across government, we have engaged other ministries in our transformation agenda.

Drawing Upon Expertise: HRT engages thought leaders in other forums

In addition to the expert panels, advisory groups, and other partnerships, we have sought the collective intelligence and support of health leaders from across Ontario and other jurisdictions.

- **14 LHIN Community Workshops** engages local experts resulting in Integration Priority Reports.
- **LHIN Funding Think Tank** was held in November, 2004 with experts from across the Canadian health care system. This session obtained leading advice from other jurisdictions for the ministry as part of its considerations for a new funding model.
- **LHIN Planning Think Tank** involved representatives from other jurisdictions as well as academics and experts from Ontario and MOHLTC staff. Held in February 2005, this session was designed to inform the ministry and eventually the LHINs, on best practices for local health care planning activities. A report was created which outlined key planning principles.
- **Primary Health Care Transition Fund Summit:** In December, 2004 the Primary Health Care Team held a one-day workshop that brought together over 160 primary health care practitioners, researchers and academics, provincial policy-makers, government officials and Health Canada to share preliminary findings from Ontario's Primary Health Care Transition Fund projects. Ontario has funded over 100 projects, many of which have strengthened the capacity of communities to extend access to interdisciplinary primary health care services and galvanized community partnerships to support Family Health Team development
- **Joint Conference on Case Costing Data** was conducted by the Information Management Team with the MOHLTC, the Change Foundation and the Ontario Hospital Association. 140 hospital representatives were involved.
- **OHA Conferences on Improving Access:** The Access and Wait Times Teams have sponsored three OHA-conducted conferences that have supported improving access to health services: Improving Surgical Process Efficiency to Reduce Wait Times; Reducing Wait Times to Improve Access To Care; and Wait Times: Governance Authority.

Keeping the Decision-Makers Informed and Confident

Improving access to health care services is a high priority for Ontarians, and therefore a high priority for Ontario's elected leaders. As an innovative model of government management, the Health Results Team has also been given a public profile not typically experienced in the public service. As such, it has been a top priority of the Team to keep the Premier and Minister informed of our progress against the plan. To this end, we provide a bi-weekly progress report that outlines achievements and key next steps. These reports have helped build confidence that our work is on target.

To make further certain progress against results, the Premier chairs a monthly Health Results Team meeting that brings together key-decision makers to focus on targeted issues. The Minister also holds similar meetings on a more frequent basis. These meetings provide the team the opportunity to demonstrate progress and, more importantly, receive direction on moving the plan forward. In sum, these direct meetings have been vital to our collective success.

2. Building the Capacity of the Health System

Much of our plan for improving access to health care has been about building new and sustainable capacity in the delivery system. We have initiated a multifaceted approach – one that includes both short- and long-term strategies. Most importantly, these solutions have been designed within a framework of fiscal management that intends to curb the historically unsustainable growth of health care expenditures, often at the expense of other important social investments.

In addition to improving the overall capacity of health care services by LHINs, our plan has focused on these streams:

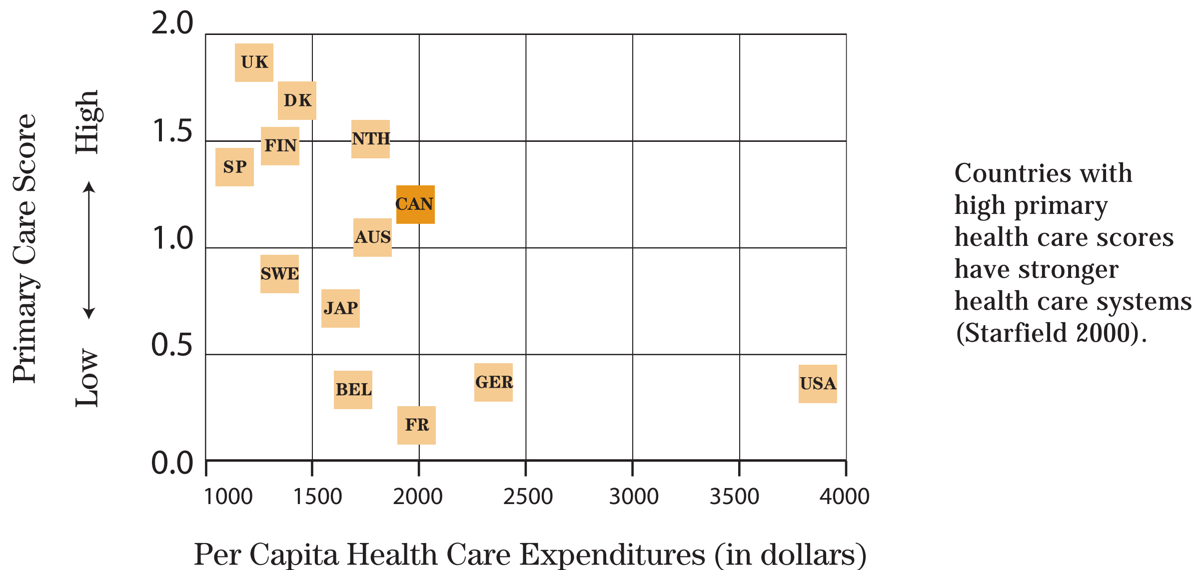
- Improving overall system capacity by improving access to primary health care through Family Health Teams and other key initiatives in family medicine and primary care.
- Targeted investments in selected surgical procedures and other technologies that are tied to standardized performance objectives.
- Freeing up analytic, health human resource and physical capacity through data rationalization and operational efficiencies, and build analytic capacity in the provider community. (See box on page 18 for an example of increasing capacity by eliminating unnecessary data collection)

Family Health Teams: Improving Capacity by Improving Health

Research and experience informs us that countries with strong primary health care systems have lower overall costs and healthier populations (see chart on following page). To improve access to primary health care services that will focus on health promotion and help patients prevent or better manage chronic disease, the government is building on its tradition of providing leading primary health care through the establishment of 150 Family Health Teams by 2007-08. In particular, the objective is to:

- Expand access to health care to over 2.5 million Ontarians – including reducing the number of Ontarians without a family physician
- Deliver comprehensive services in health promotion, disease prevention and chronic disease management to maintain and improve the health of Ontarians
- Improve local health care services integration with the primary health care system
- Increase the number of interdisciplinary care providers available to patients

Primary Health Care Drives Health System Performance



Countries with high primary health care scores have stronger health care systems (Starfield 2000).

The response to our plan was unprecedented. 900 Family Health Team Information Kits were distributed to interested communities and providers. Our first call for proposals – from which we intended to select 45 FHTs for spring 2005 implementation – generated 214 applications from a variety of providers and communities from across the province.

Taking this as an opportunity to push the agenda forward and meet the growing need for access to primary health care, the Premier and the Minister of Health and Long-Term Care announced on April 15, 2005, that opportunities to form 52 Family Health Teams and three networks of Family Health Teams in Hamilton, Barrie and Peterborough would be advancing to the implementation stage. **This exceeded our original plan to introduce 45 Family Health Teams.**

"Family Health Teams mean healthier Ontarians, a stronger health care system and a better quality of life for people in communities across the province" Premier Dalton McGuinty, May 14, 2005

FHT Implementation Guides

- Governance and Accountability
- Developmental Grant Application
- Strategic and Program Planning
- Business and Operational Development
- Physician Compensation
- Collaborative Team Practice
- Interdisciplinary Provider Compensation
- Interdisciplinary Team Roles and Responsibilities
- Transitional Funding
- Information Technology
- Patient Enrollment
- Telephone Health Advisory Service
- Independent Health Facilities Licensing
- Community Funding Partnerships
- Chronic Disease Management and Prevention
- Health Promotion and Disease Prevention
- Local Community Integration

Recognizing the diversity of Ontario's communities, our approach has been to allow for flexibility regarding the size, scope and focus during the start-up phase of FHTs. We have been assisting these teams during the start-up phase with business and operational planning, including the development of up to 17 guides and tool kits (see box on previous page), and making available grant funding to help them get the advice and resource support they need. Teams progress through 6 phases of development (from Formative through to Operational). Each of the phases are supported with specific guides and tools. Each Team has been assigned a site co-ordinator who acts as their one window into the ministry and program development.

While Teams are at various stages of readiness, it is expected that several Family Health Teams will be operational by early Fall 2005. The Hamilton Family Health Team Network, which is expected to begin operations in early autumn, provides a leading example of the Family Health Team vision. The Hamilton Network brings together nine groups of primary care physicians totaling 109 physicians leading teams that include nurse practitioners, mental health workers and registered dieticians who will work collaboratively to develop an integrated approach to delivering primary health care services. **They will provide comprehensive primary health care services to over 245,000 patients from different sectors of the city of Hamilton**. The Hamilton Family Health Team Network will link with local hospital services, Hamilton CCAC and public health to enable patients to better serve their community. Of the 109 physicians, 40 currently have mental health services for their patients. Through participation in the Family Health Team's quick-win programs the patients of the other 69 physicians will also receive access to mental health services. All Family Health Team patients will also benefit from new children's mental health and addictions programs.

Early Success: HRTs implementation of Family Health Teams is having early success with its quick-win strategy.

The Petawawa Family Health Team opened its doors July 19. Nurse practitioner De-Ann Sheppard told local media that, "we've had people cry when we tell them they have some place to be looked after."

"The great thing is that a lot of the stuff is minor so the nurse practitioner can very well handle it and it frees up time for the doctors to handle the diagnoses and more serious issues," added Ed Chow, director of operations for the PCFHC board.

Finally, our Primary Care Team continues to strengthen community capacity and knowledge on primary health care interdisciplinary team development in extending public access to interdisciplinary care health services through over 100 Ontario's Primary Health Care Transition Fund projects funded through a one time Federal Grant Program. Here are two sample projects that are directly improving access to health care – often for those patients who need it most:

A Program of Outreach Facilitation in Family Health Networks *(University of Ottawa)*
This project establishes an outreach intervention program for Family Health Networks (FHNs), delivered by specially trained nurses, to increase delivery of recommended preventive services, improve chronic illness management and prescribing patterns.

Diabetes Screening, Risk Management and Disease Management in a High-Risk Mental Health Population – An Evaluation Project *(Lawson Health Research Institute)*
This project will assess how patients with serious mental illness and diabetes are currently being managed by their family physicians and pilot a community-based, multidisciplinary diabetes clinic model within this population to improve management of diabetes.

Family Health Teams are the pinnacle and flagship piece of the government primary health care transformation agenda. Equally important to Ontario citizen's access to care are the thousands of providers practicing in various delivery models. Over the last year these models and programs have been expanded and strengthened. These physician groups provide comprehensive primary health care with extended hours of access to over 4 million enrolled patients (an increase of 1.6 million in the last year). The interest in new models of practice has been growing steadily with now over 5,000 family doctors (an increase of 1,800) in the past year. Through these models, patients also have access to an integrated nurse-led telephone health advisory service where information is shared with their family physician and a physician from the practice group is on call.

Access and Wait Times: Responsibly Increasing Capacity by way of a Rational Purchasing Process

The government investment in increasing surgical capacity for selected services is unprecedented. Within our first year, we will have undertaken two waves of surgical volume allocations based upon local demand and provider capacity. The strategy's allocation process forms part of a continuum that uses an innovative and rational approach to increasing capacity, while leveraging the opportunity to make significant quality and efficiency gains.

In consultation with the Ontario Joint Policy and Planning Committee, our first task was to establish a price for each procedure that reflects the total cost that hospitals could incur for completing the extra cases. Full-funding allows hospitals to increase the number of procedures in the five key service areas, without diverting resources from other services.

Hospitals were then surveyed to see how many extra cases they could handle without running into human resources concerns or requiring capital improvements. Hospitals then signed a contract with the ministry, pledging to complete these extra cases in addition to the number of procedures they regularly carried out annually. Hospitals also agreed to strict accountability conditions, which included reporting wait times data to the ministry, and ensuring that the extra cases would not be at the expense of other non-priority services.

In effect, the ministry became a purchaser of these extra cases, rather than a traditional funder of health services. The contracts – called purchase service agreements – are signed by the ministry and hospital representatives and strengthen the link between increased capacity, and efficiency, safety and quality. The result is a dramatic increase in performance and accountability. The collection of new data allows the government to better target its resources for the greatest impact on wait times, while at the same time ensuring hospitals have the information they need to run an efficient, safe and high-quality operation.

In the last quarter of the **2003-04**, and building on the information obtained from the hospital survey, the government launched **Phase 1** of surgical capacity investments to reduce wait times:

- $14.5 million for an additional 1,680 hip and knee replacement surgeries and rehabilitation services
- $1.5 million for an additional 2,000 cataract surgeries
- $10 million for an extra 1,700 cancer surgeries
- $5 million to extend the hours of operation of existing MRIs at 29 hospitals, delivering 19,000 more exams in 2004/2005.

"Our Wait Time Strategy will provide people with faster access to better health services, to reduce their pain and suffering and keep them healthier, longer". Premier Dalton McGuinty, May 27, 2005

A year-end audit of additional hospital volumes achieved has shown that overall the province has met or exceeded all its targeted increases. While a few hospitals were unable to complete all their allocated cases – and the ministry is recovering the wait time funding for the uncompleted procedures – other hospitals were able to further boost their volumes and completely cover any shortfall.

In **May 2005**, **Phase 2** allocations were announced, with the largest increase in a decade for cataract surgery, hip and knee replacements, and MRI scans. These extra cases in fiscal year 2005-06 include:

- $53.3 million for 6,700 more total hip and knee joint replacements,
- $12 million for 16,000 additional cataract surgeries
- $47 million for 7,000 more cardiac procedures
- $26.7 million for 4,800 additional cancer surgeries
- $15 million for 58,500 more MRI exams by continuing to extend hours of operation at existing MRI machines

Total Surgical Capacity Increases

Compared to 2003-04, Phase 2 allocations (2005-2006), Ontario will have increased capacity by:

- 17 per cent more cardiac procedures
- 28 per cent more hip and knee replacements
- 16 per cent more cataract surgeries
- 42 per cent additional MRI scans

Early hospital performance reporting indicates that hospitals again are hitting their targets and on track to meet these volume increases.

The performance reporting requirements of the wait times purchase agreements, in tandem with the advice provided by our expert panels, has provided additional opportunity to enhance capacity through improved efficiency and decreased variation of performance. With the support of data and expert advice from health care leaders, we are maximizing existing resources by identifying efficiency opportunities.

"Dr. Hudson's team will provide me with a step by step blueprint for how we will tackle wait times in this province. And in one year's time, I will report on our progress against this blueprint."

Mitigating the Risk to Other Services

Some critics fear that reduced wait times in cancer, cardiac and cataract surgery, hip and knee replacements and MRI exams will result in unintended longer wait times for other health services. While there has been no evidence to support such claims, we nonetheless have recognized the potential for this unintended consequence and put in place several mitigating strategies:

- Hospitals receive full funding for their extra volumes, including all costs associated with the procedure, such as anesthesia, so they do not need to divert resources from other services to complete the wait times volumes.
- Hospital administrators sign an agreement stating that taking on the additional volumes will not adversely affect other services.
- Investments in new technology such as MRI and CT machines, as well as improvements in efficiency to the surgical process, are benefiting all health services, not just the five key areas.
- Identified potential for increasing surgical capacity through operational improvements. With the aid of our coaching teams, hospitals will expect efficiency improvements that will benefit all surgical processes.
- Our Wait Time Information System is being built to accommodate all surgical processes in the province at a future date.
- The Health Results Team is leading improvements to Ontario's critical care resources that will improve access, throughput and quality for the entire hospital system (see box below).

Improving the Capacity and Quality of Ontario's Critical Care Resources: Health Results Team Leading Critical Care Improvements

It has been estimated that critical care accounts for about 5-10 per cent of acute care hospital bed occupancy and as much as 34 per cent of hospital budgets.

Patients who need critical care come from operating rooms, the emergency department and hospital wards. If critical care is not available, surgeries can be delayed or cancelled, wait times for surgeries and emergency services increased, and patient safety substantially reduced.

The Ontario Critical Care Committee recommended improving access to safe critical care by organizing services better, providing critical care supports, reducing the need for critical care through early intervention, targeting efficiencies through better management, and advancing best practices and knowledge transfer.

The Critical Care Expert Panel, chaired by Dr. Alan Hudson, is moving forward on an implementation strategy that will improve the access and quality of critical care that will have a positive impact on all hospital procedures.

Improving Capacity and Efficiency Means Improving Quality Outcomes for the Patient

Given the large investments in surgical capacity the government has made in reducing wait times, it is important that increased surgical volume doesn't jeopardize the quality of the services patients receive. There is little gained by increasing hip and knee replacements, for example, if a large number of patients require revision surgery because of improper rehabilitation or an infection. Furthermore, clinical process experts have told us that delayed and cancelled surgeries are symptoms of inefficient and ineffective practices that waste human, financial and capital resources.

Rather than risk adverse quality outcomes, our strategy on improving accountability and efficiency has provided us with tactical leverage to improve the quality of services received at the patient's bed side. For example, we have included specific requirements related to quality to the purchase agreements with hospitals.

In the fall of 2004, the Wait Time Strategy put a call out for special projects that would encourage innovation and improve efficiencies in hospitals. Nearly 200 submissions were received. After reviewing submissions, 18 were approved for funding through the Wait Time Strategy's Education Fund and 36 proposals were approved for funding through its Innovation Fund, at a total cost of $5.8 million.

The approved proposals support projects including: ways to improve operating room efficiencies and better coordinate the flow of patients as well as formalizing teaching standards for front-line health care professionals. In addition to these quality improvements, there are several projects (see box below) that directly improve the quality of patient care by improving case management and integrating hospital and community care. For example, the Access and Wait Times Strategy has provided incremental funding for patients receiving hip and knee joint replacements to Ontario's Community Care Access Centres. In this way patients can receive proper rehabilitation and other personal services in their home – where care is less costly and the patient outcomes improved.

Education and Innovation Projects: Advancing Quality Care by Improving Efficiency

Examples:

- Nursing First Assistants set up in Sault Area Hospital, expanding support for surgeons performing hip and knee replacements.
- Tracking patients at Humber River Hospital, through entire health service experience, starting with primary health care and going through to community and rehab.
- Toronto Joint Network – 26 health care organizations link to increase capacity, improve patient education and reduce length of hospital stays by offering rehab at home.

Each one of the expert panels providing advice to our Access and Wait Times Strategy has identified areas where we can improve capacity with **existing** resources and improve quality outcomes. The Surgical Process and Improvement Panel, in particular, provided in its report 22 recommendations and best practices to improve efficiency, many of which directly improve system capacity and patient access.

The Ministry has already taken action on a key recommendation from the Surgical Process and Improvement Panel to create Expert Improvement Coaching Teams to help hospitals improve peri-operative efficiencies. In this quality improvement initiative, identified as a best practice in other successful health reforms efforts worldwide, teams of experienced peers in effective management of peri-operative resources will assist hospitals enhance access and quality of services through improved operating efficiency. In the short term, hospitals would request an assessment by the team through a formal application process. In the longer term, the teams could use benchmark targets to identify hospitals needing coaching assistance in a peri-operative and other processes.

In addition to these efforts, many of the 101 operational grants funded through The Primary Health Care Transition Fund put a spotlight on improvements to quality of care (see box below for examples).

Primary Care Transition Fund: Advancing the Quality of Primary Health Care

Examples

Voluntary Accreditation Project in Primary Care/Family Practice ***(Ontario College of Family Physicians and McMaster University)***
This project will develop tools for quality assessment in family practices and develop and undertake an interdisciplinary assessor training workshop based on best practices across Canadian jurisdictions and internationally.

Using Performance Indicators and Benchmarks in Primary Health Care ***(University of Toronto)***
This project will assess PHC performance and identify benchmarks and best practices that can be used by family physicians and nurse practitioners to improve the quality of care.

Comparison of Models of Primary Health Care in Ontario ***(Institute on Health of the Elderly)***
This research project will study four models of primary health care in Ontario: Community Health Centres, Family Health Networks/Primary Care Networks, Health Service Organizations, and Fee-for-Service. It will describe the four different models; study and compare the quality of care; and, explore opportunities to link with administrative databases to study quality of care.

3. Better Information, Better Decisions: Improving Accountability

Renewal of our health care system cannot take place without a more vigorous accountability system – where parties know their roles and responsibilities, what is expected of them, and have the means to measure results against those expectations. While government will define through pending legislation and LHIN implementation, future accountability structures, it understands that effective accountability requires fulfilling mutual responsibilities, building capacity for effective change, and a shared commitment to continual quality improvement. At the heart of effective accountability relationships is credible information that supports decision making, builds trust and transparency.

In the beginning of our mandate, we found that even basic questions about health care in Ontario couldn't be answered: What were wait times for key procedures? How much of the data being collected was actually being used to improve health services? How many additional patients could get access to primary health care services if providers worked in teams instead of in a silo? No one knew. And since no one knew, no one rightly assumed responsibility

We have assumed responsibility and are beginning to get hard answers to these important questions. The effort is helping to develop a health care system that dramatically reduces the guesswork and inefficiencies. Key accountabilities are being defined so people know what they are responsible for. And we are working to integrate and align the health system around key health strategies and performance measures in order to foster real performance improvements.

Access & Wait Times: Improving Accountability through New Purchasing Agreements

One of the reasons why wait times increased during the last decade was that while everyone was responsible for access, no one was responsible or accountable for actual wait times. Before the Wait Time Strategy, Ontario residents and clinicians had to rely on rumours and anecdotes about health care wait times because the real data was scattered across the province, locked in the offices of individual surgeons. It was very difficult for family doctors to know where to refer a patient to a specialist with a shorter wait time. That is changing.

One of the first actions of the Wait Times Strategy was to assign accountability to hospital boards and their administrators for managing their institutions wait times.

LHINs will eventually assume accountability for monitoring and ensuring access to services in their areas. They will be aided by the collection of wait time data from hospitals in their area, as well as the many initiatives of the Wait Time Strategy.

In addition to this new accountability relationship, we employed a competitive process to allocate additional funding for new surgical volumes related to cancer and cardiac surgery, hip and knee total joint replacement, cardiac surgery, cataract surgery and MRI. This process allowed us to set the conditions of the purchase agreement, including standardized pricing, efficiency standards and reporting requirements, as well as sensible human resource strategies. The accountability and purchase agreements signed with successful hospitals require the provision of wait time, quality and safety data for the complete volume of the selected procedures. This information is used to drive decisions on future allocations and system improvements. Wait time data is collected electronically with the new Wait Time Information Office, and will be posting, and regularly updating, the data on the ministry's public web site this fall.

Less Data, More Information

Improving results through more effective accountability relationships doesn't necessarily require more data, but better information. In fact, to build better accountability relationships, our comprehensive data rationalization plan is reducing the burden of data collection and reporting felt by health care providers. We are simultaneously cleaning house by eliminating redundant, poor quality or low value data while closing critical information gaps. An overhaul of data collection and information management is fostering a new era where accurate and timely data allows resources to be better targeted to have maximum positive effect. It will also save time and money, free up limited health care resources, and ensure a consistent emphasis on equitable access to quality care across the province.

Freeing Capacity: Three Tonnes of Paperwork Eliminated from the System

By eliminating one-third of paper reports produced by Ontario's Community Care Access Centres (CCACs), we have made it less of a burden for them to report to the MOHLTC on their budgets and the services they deliver. Less paperwork means an estimated 20,000 hours of staff time put to better use, and that case managers now have more time to spend with clients.

Here are some of the first-year accomplishments of our information management strategy:

Ontario's First Roadmap to Ontario's Health Information Holdings
In May, we published the Ontario Health Planning Data Guide, Ontario's first guide to many of the previously undocumented authoritative sources of health data. The guide provides a comprehensive roadmap to close to 100 electronic sources of data for use by local and system-wide health care planners and analysts involved in research, policy development, and information management.

Ontario's First Major Clinical Data Blitz for Hospitals
In collaboration with the Institute for Clinical Evaluative Sciences, the Hospital Report Research Collaborative, the Canadian Institute for Health Information (CIHI) and the Joint Policy and Planning Committee, and in conjunction with the MOHLTC's Finance and Information Management (FIM) Branch, we completed the first-ever clinical data blitz with Ontario hospitals. These province-wide sessions were designed to improve the quality of the acute inpatient and ambulatory care data submitted to CIHI by all Ontario hospitals. Hospital health record coders, as well as their direct supervisors, from across the province took part in the sessions.

Ontario's First Directory of Decision Support Experts
This directory of data analyst experts will be used as a decision support tool within the MOHLTC and by the LHINs.

Charting Information Flows Across the Health System
For the first time ever, we now have an accurate depiction of the value chain of health information. We now know how information makes its way across the health system from its point of origin to its ultimate destination. Specifically:

- Where and how data is collected, and by whom;
- Where the data is stored and how the data flows between the various databases and data warehouses;
- Who has access to what information; and
- Who makes decisions based on that information.

Data Quality Improves Quality of Patient Care: Information Management Team Establishes Ontario's First Physician Documentation Expert Panel

As a first step in establishing Local Data Management Partnerships – a collaborative partnership among health care providers designed to ensure better data quality – we have set up Ontario's first Physician Documentation Expert Panel. This panel consists of physician champions from each Local Health Integration Network (LHIN) who will be responsible for reviewing recommendations from previous data quality studies on improving chart documentation and for providing advice on how to move forward.

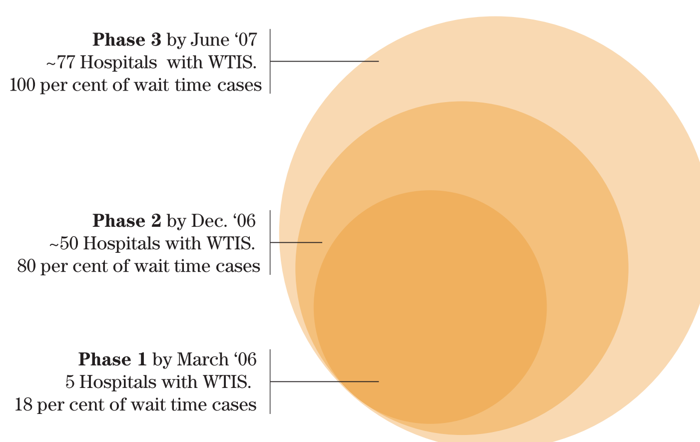
Information Drives a New Model of Access Management

Within our strategy to improve access and reduce wait times, we have established a Wait Time Information Strategy (WTIS). With the support of a provincial health information expert panel, work has begun on a single province-wide information system for hospitals participating in the Wait Time Strategy. This system will: allow doctors and managers to better understand and prioritize who is on their waitlist; provide information to funders who are evaluating hospitals on how well they manage wait times; and provide information to the public on what wait times are at individual hospitals. In other words, the WTIS is not a static tool; it is an interactive mechanism to better manage access to health care services for hospitals, physicians and the public. The wait time information system will also play an important role in assisting LHINs better coordinate access to health services as they assume more responsibility.

The business, functional, technical and security requirements of the Wait Time Information System have been finalized and vendor proposals have been evaluated. At the time of this report, the successful vendor was being determined with the software development work to begin immediately. Five hospitals have been chosen to rapidly implement the new system, with the goal of establishing the system by March 31, 2006. The next round of hospitals will start implementation immediately afterwards. The target is to complete implementation in approximately 50 hospitals – which represent 80 per cent of Wait Time Strategy funded volumes – by December 2006.

During Phase 1 of the Wait Time Strategy, the decision was made to replace the use of the Ontario Joint Replacement Registry (OJRR) as the primary system for orthopaedic surgical wait time reporting. A more comprehensive and streamlined process for collecting wait time and post-surgery surveillance data will be used, with direct reporting to the WTIS and Canadian Joint Replacement Registry (CJRR). A transition strategy for the OJRR was developed collaboratively by OJRR's management, the London Health Sciences Centre, the Canadian Institute for Health Information and the ministry. The transition strategy was approved in July, 2005, and implementation is underway. Direct reporting of orthopaedic data to the Wait Time Information Office and to CJRR will begin in October, 2005.

Implementation Timeline for Wait Time Information System



Demonstrating our Accountabilities to the Public

One of the challenges of the Health Results Team was to improve public confidence and trust in the Canadian Medicare model. With this in mind, we recognized the need to communicate transparently with the public and providers on our plan and results achieved.

A critical first step of our Wait Time Strategy was to determine current waiting times for the selected services. Without this baseline information, we would not have been able to accurately discern the scope of the problem, evaluate and implement improvement strategies and resource allocations, and fulfill our accountability for reducing wait times. Thus, in April, 2005 the Institute for Clinical Evaluative Sciences (ICES) released its report ***Access to Health Services in Ontario***. Commissioned by the Wait Time Strategy, the report offered the government and all Ontarians the first clear and credible picture of wait times for selected services, along with baseline data (fiscal year 2003-04) for each of the 14 Local Health Integration Networks.

Following a transparent and independent process, the ICES reported on significant variation between LHINs – even neighbouring LHINs – in their wait times, as well as the number of procedures per 100,000 people. The data will not only continue to help the ministry direct resources appropriately in order to achieve greater equity of access, but provides the standard by which our efforts in reducing wait times will be judged.

The ICES report, updated wait time information submitted from hospitals, the reports of our expert panels, as well as other information on the strategy and advice to patients, have all been made available on Ontario's first comprehensive wait times web site. Similar information on LHINs, Family Health Teams, and Information Management are available to the public through the internet and print media.

Ontario's First Wait Times Website Launched

- The government launched the Wait Time Strategy website at www.health.gov.on.ca and clicking on the Wait Time Strategy link.
- This website, an important tool for transparency, including information by LHIN boundaries. This fall, the web site will include current wait times by individual hospital, with the data being regularly updated.
- The website contains other practical information for patients and the public about access to health care.

Furthermore, our Information Management team is creating Ontario's **First Health System Scorecard** that will provide government and the public an accurate read of overall system performance. It will support the work of the Ontario's Health Quality Council and enable us to measure and track the quality, value and sustainability of the health system, as well as report on the success of provincial health system strategies.

4. Laying the Foundation for Integration

All elements of the Health Results Team are focused on improving patient access to health: getting the right care, at the right time and in the right place requires a focused effort to integrate the delivery of health services within not only the continuum of disease-specific care but also across the patients' life's span. The government has introduced Local Health Integration Networks as a structural adjustment to improve integration among providers. But more importantly, LHINs will spear head a new culture of patient-focused and community-based health care through provider, patient and community partnerships that will plan and deliver accessible, timely, integrated, and quality health care.

Building on and learning from the experience of other jurisdictions, LHINs represent a made-in-Ontario solution that differs from other decentralized system management models. For example, LHINs will not directly provide health care services in their areas and will preserve the governance of existing health care organizations. Further, LHIN boundaries do not prevent people from seeking health care services outside their own LHIN areas; people will continue to be able to choose their health care provider as they do today.

LHIN functions will evolve over time. Subject to the necessary legislative approvals by the Legislature, they would begin by working with health providers and community members on local health system planning. They would then move to co-ordinating services in their LHIN area and eventually they would be providing funding and resources to local health providers. As LHINs evolve and drive system change, the ministry's role and structure will also evolve.

In our first year, the results we have achieved against our staged LHIN implementation plan have been impressive. And while many would like to have the results come faster, we and the government have adopted an iterative implementation process, allowing us to listen and learn from concerns, questions and ideas. And we are providing the opportunity for the newly appointed LHIN Chairs and CEOs to engage, learn and prepare their communities for this significant change in health care management.

Below is a summary of the additional implementation results achieved (other results related to engagement, accountability and capacity improvements are stated elsewhere in this report). These results could not have been realized without the strong and courageous commitment from government to pursue a path of integration that every other jurisdiction in Canada has completed, but no previous Ontario government followed. And in doing so, we have created a model that suits the unique needs of Ontario's health system – its patients, providers and their communities.

LHIN Boundaries
With the support of the Institute for Clinical Evaluative Sciences (ICES), LHIN boundaries were determined by applying evidence-based methodology. Subsequent consultation with the public and other stakeholders resulted in refinements that are consistent with municipal and regional boundaries. Maps of the final LHIN boundaries and other related information (demographic, community and provider listings) have been made available to the public and stakeholders via the ministry's web site at www.health.gov.on.ca/transformation

LHIN Governance and Appointment of Leadership
Fourteen founding LHIN board chairs and 28 board members were recruited and appointed. In June, 2005, LHINs were established under the Corporations Act. 14 founding CEOs were then also recruited and appointed. The recruitment process was comprehensive, open and transparent and involved hundreds of applications from across Ontario.

LHIN Board and CEO Orientation
Following the appointment of LHIN Boards and CEOs, the LHIN-System Integration team designed, planned and conducted a series of initial orientation activities that are critical for the successful start-up and future operations of the LHINs. Orientation included meeting other LHIN executives and board colleagues, community and health care partners (see box this page), and selected government officials.

LHIN Leaders Get Started: Community Sessions Provide First Engagement Opportunity

In a series of 37 "meet and greet" sessions across the province in July and August, founding LHIN boards and executives were introduced to their health care partners in the LHIN communities. This helped build an understanding of local health priorities and develop relationships. A total of 1,444 stakeholders attended the sessions.

Operational Start-Up
Ensured the timely and effective LHIN start up by developing "turnkey" operations to support the establishment of standardized LHIN infrastructure, including office space, information technology, business process and infrastructure supports, and LHIN back-office supports.

Wind-Up of Ontario's District Health Councils
After 30 years of providing advice to the Minister of Health, the government decided to build on the model of community planning with the introduction of LHINs. This required the closure of District Health Council (DHC) operations. This was completed by March 31, 2005. Our transition team successfully carried out both a balanced change-management plan – that required timely but respectful handling of DHC staff – and a knowledge transfer plan that preserved the DHC legacy for future community planning. DHC documents and publications are available at **www.dhcarchives.com**. Our team documented important lessons learned following an evaluation of the process.

As LHINs mature, they will be greeted with a wealth of information and resources that have been created by the other initiatives within the Health Results Team. Our Teams are collectively supporting and preparing for an integrated health system managed by LHINs. Resources such as Information Management group's new directory of decision support experts, or the Wait Time Strategy's baseline wait times data broken down by LHIN boundaries, will help LHIN leaders plan for and further improve access to care. And in the case of primary health care, currently outside the scope of LHIN management, our Primary Health Care Team has initiated a one-year pilot of placing coordinators in the LHIN areas who will help advance and foster opportunities to implement service coordination and integration between LHINs and Family Health Teams.

LHINs provide a new table, and with it a new conversation with system participants about local pressures and opportunities. Building on a rich Ontario tradition, LHINs represent a collective strengthening and challenging of local governance, community networks and local intelligence. They will test and reward community governance for new behaviours, such as building and leveraging strategic relationships, improved service networking and tracking their contribution to the common good of a healthy Ontario. In doing so, LHINs are the catalyst of integration that will improve access and patient outcomes, and inspire confidence in Ontarians' treasured public healthcare.

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