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Understanding LHINs: A Review of the Health System Integration Act and the Integrated Health Services

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1.0 PURPOSE

This report provides background information about Ontario's 14 Local Health Integration Networks (LHINs). This includes an overview of Bill 36 (the Local Health System Integration Act, 2006) and a summary of the contents of each LHIN's Integrated Health Services Plan (IHSP) particularly as it relates to community support services (CSS) and community support service agencies (CSSAs). It concludes with a discussion of key issues for consideration by CSSAs as the rollout of the LHINs continues.

2.1 BACKGROUND

Ongoing concerns about the sustainability of publicly-funded health care, in the face of changing demographics, economic pressures, and shortages of health human resources, set the context for the Ministry of Health and Long Term Care's (MOHLTC) transformation agenda. In 2004 the MOHLTC announced its intention to transform Ontario's health care system in an effort to achieve its vision of "(a) healthcare system that helps people stay healthy, delivers good care to them when they get sick and will be there for their children and grandchildren". The transformation agenda included four key components:

1. Improving access to primary care;
2. Reducing wait times for high-demand surgical and diagnostic procedures;
3. Developing an information management system, including an electronic health (e-health) record;
4. Creating Local Health Integration Networks (LHINs) in 14 geographical regions across the Province.

As detailed below, LHINs are organizations that will take over key responsibilities from the MOHLTC to oversee and manage the delivery of health care at the "local" level. LHINs will be responsible for planning, funding and monitoring hospitals, home care (Community Care Access Centres (CCACs)), community support services, community mental health and addictions services, and long-term care (LTC) facilities (albeit not doctors, drugs or public health).

The stated principle underlying the creation of the LHINs is that health care services are best managed at the local level where they can be delivered in an integrated manner, and with input from community members. LHINs are seen to be a mechanism for overcoming existing health care "silos", and improving integration and coordination of services that will hopefully lead to a more efficient, accountable and sustainable health care system in Ontario. According to the MOHLTC, "LHINs are a critical part of the evolution of health care in Ontario from a collection of services to a true system that is patient-focused, results-driven, integrated, and sustainable."

Unlike regional health authorities in other Canadian jurisdictions, LHINs will not be direct service providers; they will fund services provided by existing and/or new provider organizations that will maintain their own governance. LHINs will enter into contracts called "service accountability agreements" with local service providers that will set expectations regarding the scope, nature and volume of services to be provided under LHIN funding.

The relationship between the MOHLTC and each LHIN will also be governed by an accountability agreement, as well as a memorandum of understanding that will detail funding, services and standards to be maintained by the LHIN, a plan for spending within a budget allocated by the province, and expected health service and system outcomes. As of April 1st, 2007, all LHINs are required to have accountability agreements with the Ministry.

Although considerable responsibility has thus been devolved to the LHINs, the government will continue to act as "steward" of Ontario's health system by retaining control of strategic policy-making, direction and standard-setting, and also continue to deliver province-wide programs and services. LHIN budgets will be determined by the MOHLTC, with LHINs having no ability to raise additional funds.
A visual diagram of the MOHLTC's stewardship activities can be found at:
http://www.health.gov.on.ca/english/providers/transition/pdf/dep_memo_011806.pdf

Under the Local Health System Integration Act (Bill 36) each LHIN was required to develop an Integrated Health Services Plan (IHSP) for the three-year period starting in 2007. IHSPs are strategic plans that include a vision, strategic priorities and directions, as well as subsequent actions for providing integrated services. Key elements of these plans are summarized below.

2.2 BILL 36: LOCAL HEALTH SYSTEM INTEGRATION ACT, 2006

Bill 36, the Local Health System Integration Act, was passed by the Government of Ontario in March 2006. It sets out the legal framework for the establishment and functioning of the LHINs. The complete Act can be found at:
http://www.e-laws.gov.on.ca/DBLaws/Statutes/English/06l04_e.htm

2.2.1 PURPOSE OF THE ACT

The purpose of the Act is "to provide for an integrated health system to improve the health of Ontarians through better access to health services, coordinated health care in local health systems and across the province and effective and efficient management of the health system at the local level by local health integration networks". 2006, c. 4, s. 1 [1].

2.2.2 LHIN GOVERNANCE

LHINs are Crown Agents. The Lieutenant Governor in Council (ie. Cabinet) will appoint their members and their Board of Directors (sections 3-4).

Each LHIN must have a Board of Directors with no more than nine members (appointed by Order in Council) that may hold their position for up to three years, with the possibility of re-appointment for one additional year. LHIN boards have the power to pass by-laws and resolutions, though certain by-laws may require the Minister's approval (specific conditions not given in the Act). LHIN boards are required to meet at least four times per year with meetings open to the public, however there are also provisions within the regulations for meetings to be held "in camera" (closed sessions).

The LHINs are required to act honestly and in good faith for the best interests of the LHIN. To this end, they are required to conduct an annual audit, and submit an annual report to the MOHLTC (including audited financial statements) that will be tabled in the Legislature. The legislation also requires that the LHINs work collaboratively with the Ontario Health Quality Council, an independent body that monitors the quality of publicly funded health care in the province, and to provide it with information as requested. More information about the Ontario Health Quality Council can be found at: http://www.ohqc.ca/en/index.php

2.2.3 LHIN RESPONSIBILITIES

LHINs will:

- promote the integration of the local health system
- identify, plan for and make recommendations to the Minister about health service needs and funding needs
- engage the community in planning and setting priorities for that system
- respond to concerns that people raise about the services that they receive
- evaluate, monitor and report on the performance of the local health system and its health services
- assist in the development of the provincial strategic plan
- improve the integration of the provincial and local health systems and improve the coordination of health services
- improve access to health services and enhance continuity of health care
- disseminate information on best practices and promote knowledge transfer
- bring economic efficiencies to the delivery of health services
- fund health service providers for services and equipment
- enter into agreements to establish performance standards and ensure the achievement of performance standards by health service providers that receive funding from the network

- ensure the effective and efficient management of resources
- do anything else the Minister specifies by regulation (section 5)

2.2.4 HEALTH SERVICE PROVIDERS (HSPs) UNDER THE LHINS

Under section 2 of the Act, many, but not all publicly funded HSPs, will fall under the auspices of the LHINs including:

- Public hospitals
- Divested psychiatric facilities
- Community Care Access Centres
- Community mental health and addictions agencies
- Community support services organizations
- Community health centres
- Long term care facilities (charitable homes for the aged; municipalities that maintain homes for the aged; nursing homes)

Note that the LHINs will not have responsibility for:

- Physicians, dentists, chiropodists, optometrists and corporations of these health professionals
- Public health
- Ambulance services (both emergency and non emergency)
- Laboratories
- Provincial networks and programs

2.2.5 FUNDING AND ACCOUNTABILITY

As agents of the Crown, LHINs will be funded by the MOHLTC based on terms and conditions that it deems appropriate. The Minister will enter into an accountability agreement with each LHIN for a minimum of one year at a time. Accountability agreements will contain:

- Funding amounts for the LHIN
- Services, standards and targets that must be achieved
- A plan for spending of allocated funds
- Expected health care and system outcomes

In the event that the Minister and LHIN are not able to reach an agreement, the Minister retains the power to unilaterally set the terms of the agreement for the LHIN.

Section 17 of the Act contains a provision that gives authority to the Minister to allow LHINs that have retained savings due to efficiencies to reinvest portions of their savings back into their local health system.

The LHINs will also enter into an accountability agreement with each health service provider that it funds. Funding of health service providers will be based on terms and conditions that the LHIN considers to be appropriate (i.e. based on funding from the MOHLTC, the accountability agreement with the Minister, and requirements in the Act's regulations).

This section of the Act also stipulates that, with the exception of Community Care Access Centres (CCACs), LHIN boundaries will not affect where a person receives their health services. LHINs are prohibited from entering into any arrangement that restricts a person to receiving health care exclusively in the area in which they reside.

2.2.6 LABOUR RELATIONS

The Act allows for the Public Sector Labour Relations Transition Act, 1997 (PSLRTA) to be amended in order to make integration activities within the LHINs possible, even as they impact upon health service providers.

The Act also provides a framework for resolution of labour relations issues that are the result of public sector restructuring. PSLRTA addresses union issues such as bargaining agents, seniority rights, and collective agreements. Essentially, amendments to PSLRTA would expand the power of the Ontario Labour Relations Board (OLRB) so that it applies to "health services integration" in addition to its current application to operational mergers, and hospital restructuring. The Act would require the OLRB to continue to consider factors such as the extent to which labour relations problems could arise from integration in its decision-making, and would provide for these decisions to be made prospectively (before the integration takes place). The Act also allows for new sections to be added to the PSLRTA in order to apply to circumstances in which health service providers funded by the LHINs are subject to partial integration (e.g., some but not all programs / services are transferred).

2.2.7 COMMUNITY CARE ACCESS CENTRES (CCACs)

The Act allows for numerous amendments to the Community Care Access Corporations Act, 2001 that return them to non-profit status. CCACs have already been re-aligned to match LHIN boundaries, so that 42 CCACs have been amalgamated into 14. CCACs are now able, as they did originally, to select their own boards and hire their own executive director, instead of having them appointed by Cabinet.

2.2.8 INTEGRATION AND DEVOLUTION

The keystone of Bill 36 is system integration at the local level. That said, the definitions of integration under specific circumstances are broad. For example, under the Act HSPs such as CSSAs are required to identify opportunities for integration with other

health service providers in order to improve coordination and delivery of services to people. However, the scope and nature of such integration is not defined.

Under the legislation, LHINs (as well as the MOHLTC under certain circumstances) will have the power to integrate their local health system through funding allocations, integrating services across health service providers and others (that are funded by the LHIN), and through formal written decisions that require a funded provider to "integrate". Required integration of this kind could come in many forms including requiring HSPs to:

- start or stop providing a service
- change the volume of services provided
- transfer a service from one location or entity to another
- take any necessary steps to achieve integration (e.g., to transfer or receive property) (section 25).

There are also restrictions on the LHINs regarding their authority to make integration decisions. These include:

- integration efforts must be consistent with the LHIN Integrated Health Services Plan (IHSP – see below);
- decisions can only be made regarding those HSPs that receive funding from the LHIN;
- while the LHIN can alter funding and move services, it cannot require an organization to cease operations altogether;
- integration cannot involve transferring charitable property to a service provider that is not a charity; and,
- integration decisions regarding religious organizations cannot require the offering of services that are contrary to their religious beliefs.

The legislation also stipulates that LHINs are prohibited to integrate in a manner that forces people to pay out-of-pocket for the service in question, unless permitted by law. LHINs must provide written notice of its intention to "integrate" HSPs, including naming all parties involved, and outlining timelines for actions to be taken.

Under the legislation, there is a process by which HSPs may challenge an integration decision made by a LHIN (or the MOHLTC). HSPs have 30 days to apply to the LHIN for reconsideration of an integration decision, which the LHIN must then consider. Once a decision has been handed down regarding the integration issue, no further requests for one-time reconsideration will be accepted. There is no provision for further appeal.

This section of the legislation also allows for HSPs to integrate their services with another provider by their own initiative. In order to do this, HSPs must provide its LHIN with 60 days notice, and the LHIN will retain power over the final integration decision

(i.e., to proceed or not). Once again, HSPs will have 30 days to apply for reconsideration of decisions made by LHINs in these circumstances.

2.2.9 INTEGRATED HEALTH SERVICES PLANS (IHSPs)

As steward of the health system the MOHLTC will develop a provincial strategic plan to guide the work of the LHINs. Each LHIN is required to produce an Integrated Health Services Plan (IHSP) that is consistent with the province's strategic plan, the funding of the LHIN by the Minister, and any regulations under the Act. The IHSP development process, which is now complete, was required to include input from the community. Similarly, HSPs including CSSAs are required to engage community members as they set priorities and develop their own strategic plans. Detailed information on the nature and scope of "community engagement" is not provided in the Act.

A key component of the Act's section on community engagement and planning includes a focus on engaging Aboriginal and First Nations, and French language health planning entities. These are priority areas for the MOHLTC and required priorities for the LHINs. The Act also requires that each LHIN establish a health professionals advisory committee (by appointment) as a part of its community engagement process that includes members of regulated health professions such as physicians.

3.0 INTEGRATED HEALTH SERVICES PLANS

In the fall of 2006 LHINs began to release their Integrated Health Service Plans to the public. This section describes the process involved in developing IHSPs, and summarizes the contents of the plans particularly as they related to CSS and CSSAs.

3.1 THE BASICS: WHAT IS AN INTEGRATED HEALTH SERVICES PLAN?

Sections 15 and 16 of the Local Health System Integration Act, 2006, specifies the required contents of the IHSPs:

"The integrated health service plan shall include a vision, priorities and strategic directions for the local health system and shall set out strategies to integrate the local health system in order to achieve the purpose of this Act." 2006, c.4, s.15(2) [1].

"The integrated health service plan shall be consistent with a provincial strategic plan, the funding that the network (LHIN) receives under section 17 and the requirements, if any, that the regulations made under this Act prescribe." 2006, c.4, s.15(3) [1].

"A local health integration network shall engage the community of diverse persons and entities involved with the local health system about that system on an ongoing basis, including about the integrated health service plan while setting priorities." 2006, c.4, s.16(1) [1].

3.2 THE PROCESS OF DEVELOPING IHSPs

As stated, LHINs have developed their IHSPs based on engagement with the community, the province's strategic priorities, and practical advice from the Ministry. In preparation for the IHSP development process, and as required by the Act, the MOHLTC provided LHINs with its five strategic directions that will form the basis of its 10-year Provincial Health System Strategic Plan (expected mid-2007). The five strategic directions are:

1. Renewing community engagement and partnerships concerning health care
    - Ensuring that community awareness and engagement remain core elements / processes in local health system planning
    - Building partnerships with other participants in the local health system including Public Health and primary care groups
    - Ensuring active participation in local community planning processes

2. Improving the health status of Ontarians
    - Improving the health of all Ontarians, especially groups with the poorest health status
    - Enhancing uptake of provincial disease screening programs

3. Ensuring equitable access to health care for all Ontarians no matter where they live
    - Reducing wait times for key services
    - Eliminating barriers to access
    - Instilling appropriate supports to enable Ontarians to age in the most appropriate place
    - Ensuring more effective health human resource planning and management

4. Improving the quality of health outcomes
    - Placing the consumer at the center of planning and coordination of health services and chronic disease prevention and management
    - Improving integration and coordination of health services and facilities related to disease prevention, health promotion, diagnosis, treatment, rehabilitation, and palliative care that is based on the population's needs
    - Building leadership and participation in continuous quality improvement of the health system

5. Establishing a framework for a sustainable health system
    - Providing equitable allocation of health resources according to the health needs of the population
    - Optimizing use of available resources to deliver health care
    - Increasing efficiency of service delivery

- Basing planning and decision-making on evidence, analysis of needs and value of investments
- Increasing use of appropriate care settings
- Moving toward an electronic health information system
- Ensuring financial stability

The LHINs are also being given guidance from the MOHLTC as they begin to take over management of Ontario's health care system. The Ministry's Health System Intelligence Project developed a health planning toolkit to assist LHINs in their system planning work. The toolkit is comprised of seven modules that are aimed at providing conceptual, practical and evidence-based advice to LHINs. They include: the Planning Process, Assessing Need, Evidence-Based Planning, Community Engagement and Communication, Understanding Integration, Establishing Priorities, and Assessment and Evaluation. More information regarding the toolkit can be found at: http://www.health.gov.on.ca/transformation/providers/information/resources/analyst_toolkit.pdf

3.3 IHSPs: SUMMARY OF CONTENTS

This section provides a summary of the fourteen IHSPs with a focus on contents relevant to CSSAs. Appendix A provides a snapshot of individual IHSPs along key dimensions. Given that the majority of community support services clients are seniors, particular attention has been given to this group.

3.3.1 STRATEGIC PRIORITIES AND SPECIAL POPULATIONS

Special populations refer to groups that received special focus within the IHSP when reporting on health demographics and needs. The health issues faced by a special population may have surfaced through community engagement, review of demographic and utilization data, or through other planning activities.

For example, consistent with legislated requirements, 13 IHSPs place focus on both Aboriginals and French-speaking people as priority populations. Seven IHSPs also identify diverse/ethno-racial populations (in general) as being of special interest. Other populations of interest include: the homeless, and gay, lesbian, bisexual, transgendered and transsexual people. However, few IHSPs actually provide details regarding how the health needs of these populations will be addressed.

Strategic priorities identified within the IHSPs are population-specific, needs-based (i.e. chronic disease management) as well as systemic (i.e. improving access, sustainability) in nature.

3.3.2 SENIORS

Thirteen of 14 IHSPs have strategic priorities that are population-specific.

All IHSPs address seniors' issues at some point, although to greater or lesser degrees. However, only nine have population-specific strategies for seniors/frail elderly. Some IHSPs have addressed seniors' issues under larger system strategies such as "availability of long term care services" (South East and North West LHINs), or issues of access to health services (North Simcoe Muskoka LHIN).

For example:

- LHINs such as Central West, Central East, South East, and North West have explicitly stated that CSS will be included in provision of services to seniors. Some LHINs also refer to "aging in place" as a preferred outcome for seniors, implying that there is an increased role for CSS within the LHINs.
- Many IHSPs have broadly stated their strategic plans with respect to seniors, with a potentially implicit role for CSS. For example, South West, Waterloo Wellington, Mississauga Halton, Toronto Central, Central and Champlain LHINs have either selected, or will select an integrated service delivery model for seniors.

3.3.3 DIVERSE (ETHNO-RACIAL) COMMUNITIES

Eleven of 14 IHSPs make some mention of the health needs of diverse communities.

Of these, 7 LHINs indicate that they will have concrete plans (i.e. action plans, specific strategies) to address issues of diversity and/or cultural competency. For example, the North East LHIN will develop an Access and Equity Model that will ensure equitable distribution of resources based on, for example, age, gender, race, geographic location, and socio-economic status. This dimension is particularly important given the diversity of Ontario, especially within certain LHINs such as Toronto Central.

Some LHINs are specific about addressing the needs of diverse seniors. For example, Central West LHIN has identified that improving access to services for diverse seniors is a priority.

3.3.4 RURAL/URBAN ISSUES

Many LHINs have addressed rural and urban issues within their IHSPs. In particular, 7 (Erie St. Clair, South West, Waterloo Wellington, South East, Champlain, North East, and North West) address distance from and to care and transportation issues for residents in their communities (within rural areas).

The Toronto Central LHIN has developed an "Integrated Energy and Environmental Plan" in order to address energy and environmental health issues in an urban context. The plan focuses on: energy conservation, water, waste, emissions, land use, and transportation.

3.3.5 SUSTAINABILITY/EFFICIENCY

As noted earlier, health system sustainability is one of the Ministry's five strategic directions that LHINs were required to address in their IHSPs.

Eleven LHINs have explicitly addressed the issues of sustainability and efficiency in their IHSPs. The Waterloo Wellington LHIN calls sustainability its "burning platform".

Most IHSPs refer to "back office" efficiencies as a mechanism for reducing costs in the system. The North Simcoe Muskoka IHSP describes back office efficiencies as the integration of non-clinical services (i.e. administrative and support services) in order to achieve cost savings through promoting bulk purchasing power, shared overheads and reduced administrative costs. Integration in this context could include: administration and payroll, information technology, food and laundry services, and purchasing of office supplies and materials. According to its IHSP, the North Simcoe Muskoka LHIN will begin a pilot project for integrating non-clinical services in 2007 that will be expanded to other areas in 2008.

3.3.6 LINKAGES BETWEEN ALTERNATIVE LEVEL OF CARE (ALC) DAYS, LONG-TERM CARE (LTC) WAITS, EMERGENCY ROOM (ER) VISITS AND CSS

ALC/LTC/ER issues have been addressed in all IHSPs. The Health Results Team of the Ministry has created a performance scorecard for each of the LHINs. Scorecards include 20 indicators (and several sub-indicators) of system outcomes such as ALC rates, LTC wait list and use of ERs. LHINs are expected to meet Ministry performance expectations in each of these areas. Each LHIN has been given its scorecard and is aware of where it stands in relation to their other LHINs. This places pressure on the LHINs to address these issues within their strategic plans [3].

Twelve of 14 IHSPs have made links between reducing cost and/or waits in these areas and a potentially enhanced role for the CSS. Nevertheless, most LHIN IHSPs are vague with respect to action steps to be taken to address these issues.

4.0 DISCUSSION

The IHSPs outline priorities and strategic directions for LHINs during the 2007-2010 period. However, as noted, most IHSPs provide few specific operational plans or functional details. This means that even where specific delivery models have been selected (i.e. Mississauga Halton LHIN's "ASSIST" model – see Appendix A for details) it

is yet to be determined what roles CSS and CSSAs will play. This means there is considerable scope for CSSAs and other HSPs including hospitals, CCACs and LTC facilities to shape LHIN planning and action.

In this connection, particular opportunities for CSS are presented by MOHLTC's strategic directions which emphasize the need to relieve pressures on hospitals, and to provide care, whenever possible, in the community [4,5].

However, to take full advantage of such opportunities, and achieve the potential of CSS within integrated health systems, CSSAs may wish to think and work proactively about how best to ensure that the services they provide are "on the radar screen" and that planners have a full appreciation of their crucial role in maintaining the well-being, quality of life and independence of individuals and carers, while moderating demand for more costly hospital and institutional care.

Three possible actions are outlined below.

ACTION 1: ACTIVELY ENGAGE WITH THE LHINs

LHIN councils, committees and networks are positioned to play an important, ongoing role in decision-making as the LHINs consolidate their authority and become fully operational.

For example, the Toronto Central LHIN will have 6 advisory councils - 3 professional councils and 3 community councils that address their top 3 strategic priorities (mental health and addictions, seniors and rehabilitation). These are formal structures whose membership will ultimately be determined by the LHIN. Additionally, LHINs may also seek or receive input from informal structures such as working groups and networks.

Note that although most health professionals are not under LHIN authority, their concerns and interests will influence LHIN decision-making through the council structure. In this connection, powerful organized groups such as the Ontario Medical Association are now actively engaged across the province in structuring these councils to ensure that their interests are heard. Note also that CSSAs are not guaranteed similar representation; they will need to work even harder to get to the decision-making table.

CSSAs thus need to identify and pursue opportunities to engage the LHINs both formally and informally. Although CSS are currently "on the radar", LHINs will be faced with many hard choices as they begin to make resource allocation decisions. For example, LHINs will have to demonstrate progress in addressing key health system problems such as high numbers of ALC beds, unnecessary use of ER services, and lengthy wait lists for LTC beds. They could do this by directing more resources to the acute and LTC sectors, or they could invest in CSS which moderate demand for these

more costly services, while also improving the lives of individuals and carers. The case for CSS will have to be made on an ongoing basis as decisions are made.

ACTION 2: BUILD STRATEGIC PARTNERSHIPS WITH OTHER HSPs

A fundamental goal of the LHINs is to move away from a "non-system" characterized by a lack of integration and coordination between health care "silos" to a system which is capable of providing seamless, cost-effective care across the continuum.

While they take significant resources to establish and maintain, strategic partnerships among CSSAs, as well as between CSSAs and other HSPs (e.g., hospitals) would seem to offer considerable potential to strengthen the role of CSS.

Partnerships, particularly those which extend across sectors, provide tangible evidence that CSSAs are committed to cross-sectoral thinking and action, aimed at achieving a true, integrated care system. For example, a number of ongoing collaborations between CSSAs and hospitals (e.g., Home At Last), aimed at discharging patients on time and providing appropriate community-based supports, clearly demonstrate not only that CSSAs can take the lead in engaging providers across the continuum to solve key system problems, but also that CSS have a crucial role to play in care delivery. In addition to enhancing care for individuals, such partnerships also build political capital, create allies, and keep CSS on the LHIN radar.

Partnerships which address system issues such as reducing fragmentation, increasing efficiencies and overcoming operational barriers, stand to raise the profile of individual organizations and the sector as a whole [5,6,9]

ACTION 3: ANTICIPATE AND LEAD INTEGRATION AT SYSTEM AND ORGANIZATIONAL LEVELS

As noted, Bill 36 requires HSPs to identify and pursue integration opportunities with other providers, although the scope and nature of such integration is not defined. Recall also that LHINs have the authority to force integration by directing a HSP to start or stop providing a service, changing the volume of services provided, moving a service from one location to another, or taking any other steps deemed necessary to achieve integration.

Thus, there will be growing pressures for CSSAs to consider ways to integrate their services [4]. For example, many IHSPs explicitly note the need to achieve back office efficiencies. The aim is clearly to ensure that relatively fewer resources are used for administration, and that more go to direct service delivery [5].

Another option is collaborative service delivery, possibly using a "lead agency" model, where individual CSSAs continue under their own governance, but coordinate care. For

example, one CSSA in a geographic area could be identified as the first point of contact for consumers and other HSPs, in turn, directing queries and service requests to an appropriate provider. More complex models could involve the lead agency also conducting a preliminary needs assessment and taking on or arranging case management where needs exceed a determined threshold. In this way, CSSAs could position themselves as "system navigators."

Collaborative governance also presents opportunities. For example, in her presentation to OCSA member agencies in October 2006 at the annual meeting, Maureen Quigley suggested that boards should reframe their traditional role and understanding of the scope of governance as moving beyond the individual organization to include interdependence and shared accountability (with other providers) for integration initiatives within the LHIN. She suggested that boards should understand that the "best interests of the corporation" now involves collaboration with others to improve the integration of health services delivery to effectively meet community health needs [9].

5.0 CONCLUSION

The health care system in Ontario is changing. With the LHIN implementation process quickly unfolding there is still much to be clarified about the role, functions and scope of power of these new entities. The integrated health services plans released by the fourteen LHINs provide a snapshot of the key priorities and directions over the next three years. With few details regarding the operational roll-out of the strategic plans, there are important opportunities for CSSAs to be proactive in shaping the agenda.

In addition to providing low cost / high impact care in the community, CSS offer many other strengths and areas of expertise to the LHINs. CSS have an important history of using and supporting volunteers in their governance and service delivery; the sector is experienced in running its operations using alternate funding sources such as charitable dollars and fee-for-service; and CSS understand community engagement and participation - a key focus of the LHINs [5]. CSSAs can further leverage their strengths, and respond positively to challenges by actively engaging LHINs, establishing partnerships, and developing innovative service integration models.

Appendix A

Snapshot of LHIN Integrated Health Service Plans (IHSPs)

Note: This chart is intended to provide a brief snapshot of the **contents** of the IHSPs that were deemed to be of particular interest to Ontario Community Support Association member agencies. For further details please see the complete IHSPs (links provided in Appendix B)

LHIN	Special Populations identified in IHSPs	Population-specific strategies	Focus on diverse (ethnoracial) communities	Focus on seniors and the role of CSS in providing services to seniors	Link between ALC/LTC/ER and CSS	Councils / Committees / Networks / Working Groups (relevant to CSS) (current and future) **only those reported in IHSPs	Rural / Urban Issues addressed within IHSPs	Plans to ensure Sustainability / Efficiency of the system
Erie St. Clair 1	• Aboriginal community	• Seniors • Mental Health and Addictions	Yes • Diversity is identified as a guiding principle for decision-making (no details)	Yes • "Supporting People at Home" framework to be developed • Focus on improving system navigation	Yes • Reducing dependence on hospital-based care is a priority • Focus on reducing ALC, ER visits by providing care in the community	Yes • LTC and Common Care working group • ALC working group	Yes • Intention to improve access in rural areas	• Focus on backroom integration
South West 2	• Aboriginal community • Francophone community • Diverse communities	• Seniors • Adults with complex needs	Nothing specific noted	Yes • Seniors and adults with complex needs addressed under same strategy • An integrated service delivery model will be selected	Yes • Will address alternatives to LTC placement	• South Western Ontario Geriatric Network	Yes • Transport to and from services and access to services addressed	• Focus on enhancing backroom efficiencies
Waterloo Wellington 3	• Aboriginal community • Francophone community	• Mental Health and Addictions and Seniors addressed under broader strategy of Access	Nothing specific noted	Yes • An evidence-based integrated service delivery model will be selected • Development of a Balance of Care model for integrating Community Support Services with the continuum of care	Yes • Aim to have selected model address LTC demand	• Specialized Geriatric Services Network • Community Support Services • Palliative Hospice Network	Yes •Transportation plan to be included in service delivery model	• Will develop a funding strategy in 2007/2008 • Focus on enhancing backroom efficiencies

Hamilton Niagara Haldimand Brant 4	• Aboriginal community • Francophone community	• Frail seniors • Mental Health and Addictions • Children and Youth	Nothing specific noted	Yes • Specialized services for frail seniors will be developed and coordinated by the Geriatric Access and Integration Network (GAIN)	Yes • Acknowledgement that CSS is linked to a reduction in ALC rates	• End of Life Care Network • CSS/LHIN group (has been meeting for over a year) • Child and Youth Rehab Network	Yes • Intention to provide services as close to home as possible (no specifics)	Nothing specific noted
Central West 5	• People with Mental Health and Addictions • Seniors • New mothers and children • Francophone community • Aboriginal community • Diverse communities	• Mental Health and Addictions • Seniors • New mothers and children • Diversity	Yes • Strategic plan will be developed	Yes • No specific model has been identified (strategic plan will be developed and will include a focus on improved accessibility to CSS, transitional beds, and supportive housing) • "Aging in Place" a priority • Palliative Care and End of Life strategy to be developed • Improving access to services for diverse seniors a priority	Yes • Among the lowest ALC rates in the province (due to new LTC beds over the past 5 years) • Acknowledgement that CSS is linked to a reduction in ALC rates	• Central West Palliative / End of Life Network	Nothing specific noted	• Focus on enhancing backroom efficiencies
Mississauga / Halton 6	• Diverse communities • Francophone community • Aboriginal community	• Mental Health and Addictions • Seniors • New mothers / newborns • Children	Unclear • Diverse communities identified as a priority population • No clear plan or strategy provided	Yes • Specific integrated service delivery model selected: "ASSIST" (All Inclusive Seamless Services for Independence of Seniors for Today and Tomorrow) • Model includes 1-800 call in number, Care Coordinator, centralized screening triage assessment and follow up • Model includes end-of-life strategy • Aging at home identified as outcome indicator	Yes • Focus on reduction of ER, ALC and LTC waits addressed within ASSIST model • Among lowest ALC rates in the province	• Regional Geriatric Program • Seniors Coordinating Council and Project Steering Committee	Nothing specific noted	• Focus on enhancing backroom efficiencies

Toronto Central 7	• Aboriginal community • Francophone community • Ethno-racial communities • Gay , Lesbian, Bisexual, Transsexual and Transgendered community • Homeless	• Mental Health and Addictions • Seniors	Yes • Issues of diversity to be addressed in model	Yes • Integrated service delivery model will be selected	Not explicitly addressed in the plan	• Seniors Advisory Planning Group	Yes • An energy and environmental plan will be developed to address these issues	• Focus on enhancing backroom integration
Central 8	• Diverse communities • Francophone community • Aboriginal community	• Mental health and Addictions • Neurological Services • Cancer Care • Seniors and specialized geriatric services	Yes • Diversity Action Plan to be developed	Yes • Specific integrated service delivery model selected: "Doorways to Care" Model • Model includes a Seniors Central Agency and a 1-800 call-in number	Yes • Not specifically addressed in plan • Acknowledgement that community care is more cost-effective than institutional care	• Seniors Advisory Committee	Nothing specific noted	• Focus on enhancing backroom efficiencies
Central East 9	• Aboriginal community • Francophone community • Diverse communities	• Mental Health and Addictions • Seniors	Yes • Focus on Cultural Competence – Action Plan to be developed	Yes • Seniors strategy includes a sample action plan that addresses key "performance dimensions" • Improved access to CSS is noted in plan	Yes • Third lowest ALC rate among all the LHINs • Acknowledgement that a lack of CSS may lead to higher ALC/LTC rates	• Seamless Care for Seniors Network	Nothing specific noted	• Focus on enhancing backroom efficiencies
South East 10	• Aboriginal community • Francophone community	• Aboriginal strategy • Francophone community • Mental Health and Addictions	Yes • Aboriginal strategy	Yes • Seniors issues addressed under Availability of LTC Services strategy • Will develop a plan to improve availability of services including CSS (in short supply)	Yes • Third highest ALC rate of all the LHINs • Acknowledge the role of CSS in reducing ALC/LTC issues	None named in the plan	• Plan to address issues of access and transportation to and from services	• Focus on enhancing backroom efficiencies

Champlain 11	• Aboriginal community • Francophone community	• Mental Health and Addictions • Elderly with Complex and Chronic Conditions	Yes • Plan to work with health networks to develop objectives aimed at improving access for diverse communities	Yes • An integrated service delivery model will be selected • Plan notes as a next step: "ensure the linkage between the Networks and Coalitions of Community Support Services in Champlain"	Yes • ALC rates higher than the provincial average • Seeking more data to understand LTC trends • Pilot projects to reduce ALC have been implemented • Acknowledgement that CSS play a role in reducing ALC rates	• Regional Geriatric Advisory Committee • Champlain Dementia Network	• Plan will be developed to address transportation to and from services and access to services closer to home	Nothing specific noted
North SImcoe Muskoka 12	• Aboriginal community • Francophone community • Frail Elderly • Women	• Mental Health and Addictions • Aboriginal strategy	Yes • Aboriginal Secretariat to be developed • Aboriginal strategy has been developed • Plan to reduce barriers to access and to launch an educational campaign to raise awareness	Yes • Seniors issues addressed under Access strategy • An integrated service delivery model will be developed to serve people with Mental Health and Addictions problems and will then be extended to other populations	Yes • Longest LTC wait among all the LHINs • CSS acknowledged as being under-funded and difficult to access • Lack of capacity of CSS acknowledged as contributing to ALC/LTC issues	• North Simcoe Muskoka Coalition of Community Support Agencies • Simcoe County Palliative End-of-Life Network • Muskoka East Parry Sound Palliative Care Network • ALC action group (future) • Frail Elderly Regional Action Group (future) • Access to LTC for Sever Behaviors Action Groups	• Issue of transportation not directly addressed	• Capital infrastructure strategy will be developed (for renewing buildings and equipment)

North East 13	• Aboriginal community • Francophone community • Immigrants and visible minorities • Older people • Pre-middle aged people	• Aboriginal strategy • Francophone strategy	Yes • An Access and Equity Model will be developed to evaluate / ensure equitable distribution of resources based on age, gender, race, geographic location, socio-economic status	Yes • Seniors addressed under Access and Equity strategic priority • Seniors health summit will develop a framework and work plan	Nothing specific noted	None named in the plan	Yes • Focus on information and communication technology and e-health strategies as a means for providing services close to home and in rural areas	• Focus on enhancing backroom efficiencies and sharing of IT functions
North West 14	• Aboriginal community • Francophone community	• Aboriginal strategy • Francophone strategy	Yes • Aboriginal strategy to be developed • Francophone strategy to be developed	Yes • Seniors issues addressed under Availability of LTC Services strategy • A plan will be developed that includes a role for "Home Support"	Yes • Second highest ALC rate of all the LHINs • LTC availability is better than provincial average but the Case Mix Measure (intensity of care received) is lower than the rest of the province • CSS acknowledged as playing a role in addressing the LTC issue	None named in the plan	• Distance from care and transportation to and from services addressed within the plan	Nothing specific noted

Appendix B:
LHIN Information Table

LHIN		Geographical Area	Address	Phone	Website
1	**Erie St.Clair**	County of Lambton, Chatham-Kent, Essex County, and the City of Windsor	180 Riverview Drive Chatham, ON N7M 5Z8	519-351-5677 1-866-231-5446	http://www.lhins.on.ca/english/ErieStClair/ErieStClair.asp
2	**South West**	Elgin County, Middlesex County, Oxford County, Perth County, the County of Huron, Bruce County, and the Cities of London and Stratford. Grey County is split with the Waterloo Wellington and North Simcoe Muskoka LHINs	201 Queens Avenue Suite 700 London, ON N6A 1J1	519-672-0445 1-866-294-5446	http://www.southwestlhin.ca/
3	**Waterloo Wellington**	County of Wellington, the Region of Waterloo, and the City of Guelph. Contains part of Grey County, which is split with the South West and the North Simcoe Muskoka LHINs	55 Wyndham Street North Suite 212 Guelph, ON N1H 7T8	519-822-6208 1-866-306-5446	http://www.waterloowellingtonlhin.on.ca/
4	**Hamilton Niagara Haldimand Brant**	Hamilton, Niagara, Haldimand and Brant. Includes part of Halton, (specifically Burlington), and roughly half of Norfolk County, which is shared with the South West LHIN	270 Main Street East Units1-6 Grimsby, ON L3M 1P8	905-945-4930 1-866-363-5446	http://www.hnhblhin.on.ca/

5	**Central West**	Dufferin County, the northern portion of Peel Region, part of York Region, and a small part of the City of Toronto	8 Nelson Street West Suite 300 Brampton, ON L6X 4J2	905-455-1281 1-866-370-5446	http://www.lhins.on.ca/english/CentralWest/CentralWest.asp
6	**Mississauga Halton**	South-west portion of the City of Toronto, the south part of Peel Region, and all of Halton Region except for Burlington, which remains in the Hamilton Niagara Haldimand Brant LHIN	700 Dorval Drive Suite 500 Oakville, ON L6K 3V3	905-337-7131 1-866-371-5446	http://www.lhins.on.ca/english/MississaugaHalton/MississaugaHalton.asp
7	**Toronto Central**	Toronto Central LHIN shares the City of Toronto with the Mississauga Halton, Central West, Central, and Central East LHINs	425 Bloor Street East Suite 201 Toronto, ON M4W 3R5	416-921-7453 1-866-383-5446	http://www.torontocentrallhin.on.ca/index.html
8	**Central**	Northern section of the City of Toronto, most of York Region, and part of Simcoe County	140 Allstate Parkway Suite 210 Markham, ON L3R 5Y8	905-948-1872 1-866-392-5446	http://centrallhin.on.ca/
9	**Central East**	Durham Region, Kawartha Lakes, the Haliburton Highlands, and Peterborough County. Central East also contains part of Northumberland County and the eastern City of Toronto (east of Warden, south of Steeles)	Harwood Plaza 314 Harwood Avenue South Suite 204A Ajax, ON L1S 2J1	905-427-5497 1-866-804-5446	http://www.centraleastlhin.on.ca/

10	**South East**	Hastings County, Lennox & Addington, Prince Edward County, Frontenac County, and the City of Kingston. This LHIN contains most of Northumberland County, as well as Leeds & Grenville - which is split with the Champlain LHIN. Lanark County is also split with the Champlain LHIN to accommodate the moving of the Perth Smith Falls hospital sites to the South East LHIN	48 Dundas Street West Unit 2 Belleville, ON K8P 1A3	613-967-0196 1-866-831-5446	http://www.southeastlhin.on.ca/
11	**Champlain**	Renfrew County, the City of Ottawa, Prescott & Russell, and Stormont, Dundas & Glengarry. Split municipalities include Lanark County (to accommodate the moving of the Perth Smith Falls hospital sites to the South East LHIN) and part of Leeds & Grenville	1900 City Park Drive Suite 204 Ottawa, ON K1J 1A3	613-747-6784 1-866-902-5446	http://www.champlainlhin.on.ca/
12	**North Simcoe Muskoka**	Muskoka, most of Simcoe County, and part of Grey County	210 Memorial Avenue Suites 127-130 Orillia, ON L3V 7V1	705-326-7750 1-866-903-5446	http://www.nsmlhin.on.ca/index.html

13	**North East**	Districts of Nipissing, Parry Sound, Sudbury, Algoma, and Cochrane. The North East LHIN also includes the eastern portion of the District of Kenora, which it shares with the North West LHIN	555 Oak Street East 3rd Floor North Bay, ON P1B 8E3	705-840-2872 1-866-906-5446	http://www.lhins.on.ca/english/NorthEast/NorthEast.asp
14	**North West**	Districts of Thunder Bay, Rainy River and most of Kenora	975 Alloy Drive Suite 201 Thunder Bay, ON P7B 5Z8	807-684-9425 1-866-907-5446	http://www.northwestlhin.on.ca/index.html

Appendix C:

LHIN Chairs and CEOs

(Retrieved from: http://www.health.gov.on.ca/transformation/lhin/lhin_contact.html)

LHIN	Phone Number	Chair and CEO
Central	905-948-1872	Ken Morrison – Chair Hy Eliasoph – CEO
Central East	905-427-5497	Foster Loucks - Chair Marilyn Emery - CEO
Central West	905-455-1281	Joe McReynolds - Chair Mimi Lowi-Young - CEO
Champlain	613-747-6784	Wilmer Matthews (A) - Chair Robert Cushman - CEO
Erie St. Clair	519-351-5677	David Wright (A) - Chair Gary Switzer - CEO
Hamilton Niagara Haldimand Brant	905-945-4930	Juanita Gledhill - Chair Pat Mandy - CEO
Mississauga Halton	905-337-7131	John Magill - Chair Michael Fenn - CEO
North Simcoe Muskoka	705-326-7750	Ruben Rosen - Chair Jean Trimnell - CEO
North East	705-840-2872	Mathilde Gravelle Bazinet - Chair Rémy Beaudoin - CEO
North West	807-684-9425	John Whitfield - Chair Gwen DuBois-Wing - CEO
South East	613-967-0196	Georgina Thompson - Chair Paul Huras - CEO
South West	519-672-0445	Norm Gamble - Chair Tony Woolgar - CEO
Toronto Central	416-921-7453	Michael O'Keefe (A) - Chair Barry Monaghan - CEO
Waterloo Wellington	519-822-6208	Kathy Durst - Chair Sandra Hanmer - CEO

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