

# Highlights of an Invitational Exchange

*Fall 2008*

## THE CHANGE FOUNDATION

Lessons & Confessions from the Regionalized Health-care Front:  
Where can they lead Ontario?

*May 2008*

 **Meeting**  
of the Minds



THE CHANGE FOUNDATION

HEALTH CARE DESERVES  
OUR FINEST THOUGHT

## About The Change Foundation

The Change Foundation is a health policy think tank that generates research, analysis and informed discussion in support of health services and system integration and quality improvement in home and community care for Ontarians.

Established in 1996 through an endowment by the Ontario Hospital Association, The Change Foundation is an independent charitable foundation with a mandate to promote, support and improve health and the delivery of health care in Ontario.

## About the *Meeting of the Minds*

The Change Foundation designed the model for its signature invitational exchange series, *Meeting of the Minds*, true to its tagline—health care deserves our finest thought—and to its commitment to drive informed policy debate. The *Meeting of the Minds* offers select members of Ontario's health-care community a facilitated forum for frank and substantive discussion where they can hear, deliberate—and perhaps heed—the evidence, experience, and insights presented by proven health-care leaders and thinkers across the country and beyond. The Foundation produced an environmental scan of similar exchanges and conducted key informant interviews with senior health leaders in Ontario to help determine the best way to engage stakeholders in purposeful dialogue about health and health care.

## About this report

This summary report is an account of the main ideas and insights that emerged from The Change Foundation's first *Meeting of the Minds* invitational exchange, *Lessons & Confessions from the Regionalized Health-care Front: Where can they lead Ontario?*, held on May 20-21, 2008 in Toronto. Participants were encouraged to speak freely on the understanding that no comments would be attributed.

## Acknowledgements

The Change Foundation would like to acknowledge and thank the following people: Lillian Bayne, who secured a superb lineup of pan-Canadian speakers, developed a meaty and meaningful program, and provided expert facilitation; the Foundation's research advisor Steven Lewis, who helped open and frame the discussion and closed it with a call for 10 changes to give health integration a chance; and a special thank you to all the speakers and participants who helped bring the first *Meeting of the Minds* to life. (See appendix 2 and 3 for participant list and speakers' bios).

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Among the participants of the 1st *Meeting of the Minds* (l to r) Janet Lambert, Tom Ward, Jean Trimnell, Steven Lewis, Luc Boileau, Cory Neudorf, Malcolm Maxwell, Ken Fyke, Stephan Ragaz, Deborah Hammons, Gwen DuBois-Wing, Sue Vanderbilt, John Abbot, Lillian Bayne, Chris Mazurkewich, Hy Eliasoph, Sue Matthews, Kevin Smith, Diane McArthur, Carol Ringer, Anton Hart, Gail Donner, Brian Postl, Tony Dagnone, Cecil Hunt, Sheila Jarvis.

For more photographs from the inaugural *Meeting of the Minds*, go to multimedia gallery at [www.changefoundation.ca/multimedia.html](http://www.changefoundation.ca/multimedia.html).

## WHY THIS TOPIC? WHY NOW?

The Change Foundation dedicated its first *Meeting of the Minds* to examining the lessons learned from more than a decade of regionalized health care across the country—lessons that could be instructive for Ontario during its early days of devolved health-care decision making under Local Health Integration Networks (LHINs). (See appendix 4 for a backgrounder on the LHINs)

To elaborate on those lessons, The Change Foundation lined up some key (and clever) people who led and lived through health-care regionalization across Canada to frankly assess what went right and wrong, and to deliberate with Ontario leaders about what might improve the prospects for success as the province's health integration agenda evolves.

The speakers included former and current CEOs of Regional Health Authorities (RHAs) and hospitals who've had posts that span the country, former deputy ministers under whose watch regionalized health care emerged, a former royal commissioner who authored several reports on regionalization and health reform, and a leading authority on health-care regionalization in Canada.

More than two dozen senior health-care leaders from Ontario (LHIN and hospital CEOs, leaders in the home care, long-term care, mental health, primary health-care sectors, government and community care access centre officials, and Change Foundation board members) engaged with the speakers during the exchange which featured an opening night debate and discussion, followed by a day of panel presentations and dialogue.

The Change Foundation chose to focus on issues it thought would be most useful and illuminating to the Ontario participants. Among them:

- Is it better to focus on local governance structures to improve integration or to concentrate on primary care as a starting point?
- Do or don't RHAs involve clinicians in their planning and decision-making processes? How did physicians fit in?
- What's the impact of bringing the public health sector to the table?
- Did decentralization of health services encourage population-based planning, improve efficiency and quality, or boost accountability and transparency?
- Can we say whether the shift to regional health care has made any discernible difference? Did it hasten the integration of acute and community care, of communication and information technologies?
- What are the barriers to, and facilitators of, health integration? Is it structure, culture, communication, capacity, or clarity of purpose?
- What mistakes did the provinces make during the transition to regional health care? What opportunities were levered or lost? In hindsight, what would have been a better route to creating more coordinated and patient-centred health services?

“... Regionalization is only a structure. All too often it has been a structure without a mission. How could it hope to succeed? Structure must be designed to achieve a strategy that includes a clear mission or purpose. In addition, effective reform requires that the strategy and structure be supported by appropriate culture and skills. Too many governments have made the structure an end onto itself.” — *Ken Fyke*

### Health-care Regionalization: The best route to the right destination or a good idea badly done?

*The Meeting of the Minds* opening night debate featured Kenneth Fyke, a former health commissioner, deputy minister, hospital president and RHA CEO, and Change Foundation research advisor Steven Lewis. Their lively presentations provided important context and background to the country’s experiments with health-care regionalization while delivering incisive assessments of the rationale and results of the reforms and pointing out lost opportunities and unfinished business. (For the full text of their remarks, go to reports & resources/presentations [www.changefoundation.com](http://www.changefoundation.com)).

### Does structure matter?

During their remarks, they both referenced the seemingly relentless reflex in Canada to restructure health care. A case in point: only days before the *Meeting of the Minds*, the Alberta government announced that it was moving from nine health regions to a single health board for the province—in essence abandoning regionalization. Earlier in the spring, New Brunswick collapsed its eight health regions into two. Prince Edward Island abolished its four regions (which spanned health, social services, education and corrections) in November 2005, and other jurisdictions have also altered their structures over time. (See appendix 1, Cross-country checkup: Roundup of health regions.)

Fyke and Lewis agreed that too often discussions about health regionalization get stuck in questions

about structure—what is the right number of regions and how should they be set up, for instance—and fail to move to larger questions about whether the goals of regionalization are well defined, appropriate or achievable, or met.

As Fyke said: “. . . Regionalization is only a structure. All too often it has been a structure without a mission. How could it hope to succeed? Structure must be designed to achieve a strategy that includes a clear mission or purpose. In addition, effective reform requires that the strategy and structure be supported by appropriate culture and skills. Too many governments have made the structure an end onto itself.”

Lewis countered, however, that structure can make a difference to outcome, and made a case for local (regional) governance on two major counts. In his words:

“**First**, regional governance provides a mechanism for engaging people in health and health-care deliberations that cannot adequately be conducted by a single provincial authority. All health, like all politics, is ultimately very local, rooted in the character of neighbourhoods and communities.

“**Second**, population health work is inter-sectoral, and we need leaders willing and able to develop broad-based connections and negotiate innovative approaches to reducing the seemingly intractable disparities in health status. It is difficult to conceive of how this can take place successfully over time in the absence of credible local governance and champions for the cause. A centralized provincial governance model will inevitably be preoccupied with downstream, health-care issues. Inequality, not heart disease or cancer, is the biggest



Ken Fyke.

health problem in the country and the battle against it will be won by a combination of high-level public policy and neighbourhood-by-neighbourhood initiatives.”

Based on their analysis of what has prohibited health-care regionalization from achieving its full potential, Fyke and Lewis offer the following advice to Ontario, including calls for change in policy and political will, as it tries its hand at providing more integrated health services under the LHINs:

### Advice and admonitions for Ontario

1. Clarify the governance roles to ensure government sets policy and province-wide standards while allowing RHAs or LHINs to implement these without interference.
2. Be publicly accountable for the established roles.
3. Be clear that the purpose, the strategic mission, is to improve the health of society and specify a few achievable goals.
4. Under-sell and over deliver regionalization. Don't sell it as more control to the local community except where you state what the RHA or LHIN will control.
5. Embrace transparency. Rather than embarrassing news being reason to prevent public disclosure, public disclosure is the way to deal with embarrassing news.
6. Include physician services in the mandate of the region.
7. Ensure evidence trumps ideology and short-term political expediency.
8. Create a client-centered and quality-focused culture based on current values. Ban out-dated, provider-centered values, norms and practices.
9. Employ strategies to eliminate the overuse, underuse or misuse of resources.
10. Support leaders who stand alone, take the heat, bear the pain, and tell the truth.
11. Insist on a single global budget for the geographic area or integrated health system as well as a single authority and a strategy to eliminate unconstructive competition.\*
12. Develop strategies to align medical culture with the evolving system culture. Given that primary care is formally outside the regional structure, the main road to cultural change and improved quality, outcomes, and efficiency flows through primary health care.
13. Move the LHINs along as quickly as possible, allow them to act decisively, let them deal with their own local skirmishes, and arm them with as much solid information and other intelligence as possible.
14. Remember why others moved to regionalization and try to recapture the ambitions that seem to have expired with the twentieth century. No structure will by itself change a culture; work on changing the culture and on occasion, fighting the cultural battles.

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[\*Note: This presents an obvious challenge for Ontario which has decided, at least for now, to leave local boards in place. The challenge will be whether the LHINs can acquire both the formal and informal authority to act decisively over time, and whether a slow, incremental approach will be sufficient.]



From left: Steven Lewis, Lillian Bayne, Ken Fyke.

## A RECENT REVIEW OF MANITOBA'S HEALTH REGIONS

Following the kick-off discussion, *Meeting of the Minds* participants heard highlights from a recent review of Manitoba's health regions. The review pointed to ways to improve regionalization, including: use of strategic directions, target setting and performance monitoring in a transparent manner; standardizing services and processes across regions; community engagement in health services decisions; avoiding political interference, effective governance, funding incentives, accountability agreements, etc. To read the review, go to Other Resources at [www.changefoundation.com](http://www.changefoundation.com).

access/ volumes of services? Are we more interested in improving quality of services?"

"The biggest question is whether or not authority can really be devolved. In spite of the rhetoric to devolve decision making authority to the local level, there is not much evidence that this has truly happened."

"Put more emphasis on information technology to help with accountability. Information gets better as you use it. Start where you are and move forward."

"We may end up being successful in reforming the primary health-care system simply because of the sheer shortage of people. It is this issue that will force providers to rethink scopes of practice."

**“First,** regional governance provides a mechanism for engaging people in health and health-care deliberations that cannot adequately be conducted by a single provincial authority. All health, like all politics, is ultimately very local, rooted in the character of neighbourhoods and communities.” — *Steven Lewis*

### ✦ From the floor

“Without primary health care and public health, we are operating with one-and-a-half hands tied behind our back.”

“Many of the root causes of the cultural divide need to be addressed. No one seems to be able to effectively address the clash of opinions between medical associations, the government, and other interest groups about what it is we are trying to achieve. Are we trying to achieve better

“Micro management by provincial ministries is the single biggest frustration. . . . If regionalization is going to work we need to let Ministries of Health back off and let LHINs do their things.”

“If health reform in Ontario is only about the LHINs, it will fail. If the LHINs become the vehicles for the pursuit of an inspiring vision, they will have a much greater chance of success in spite of the limitations and complexities of their structures and environment.”

“If health reform in Ontario is only about the LHINs, it will fail. If the LHINs become the vehicles for the pursuit of an inspiring vision, they will have a much greater chance of success in spite of the limitations and complexities of their structures and environment.” — *from the floor*

“Regionalization should be about making the services client focused, about providing effective health services and about value for money. It should be about integrating, reforming and transforming services. And it must be about accountability and transparency. . . . Regionalization was supposed to be about bringing decision making closer to home. . . . In most cases, it appeared to be a strategy for provincial governments to insulate themselves from the fallout of closing hospital beds, and controlling escalating health-care costs.”

## RESULTS AND REFLECTIONS FROM THE REGIONS

Presentations from senior health leaders from across the country focused on four areas: integrating acute and community care; integrating physician resources; integrating public health and health care; and integrating communications and information technologies.

### I. INTEGRATING ACUTE AND COMMUNITY CARE

CEOs from two regional health authorities identified specific accomplishments in integrating acute care and community care services within their regions and suggested in hindsight what issues and priorities they should have heeded.

#### Results (what was done & delivered)

- Adopted single management allowing for a unified voice and facilitating a greater focus on teams (“When everyone’s in charge, no one’s in charge.”).



From left: Steven Lewis, Ken Fyke, Change Foundation Chair Gail Donner.

- Placed community services within acute care institutions.
- Consolidated rehab program that focused on the continuum of services, community to facility and beyond.
- Developed regional programs focused on infection control, quality initiatives and patient safety.
- Improved continuity of care.
- Addressed health needs, not institution needs.
- Gained better economies of scale (purchasing power, human resources expertise).
- Embraced changing technologies that would have been almost impossible to keep up with in smaller organizations.
- Enhanced coordination of services with partners, particularly in population health and health promotion.

“Without primary health care and public health, we are operating with one-and-a-half hands tied behind our back.” — *from the floor*



Ken Fyke, Change Foundation board member and OHA President Tom Closson.

### Hindsight/Lessons learned

- Constantly focus on population, population need, population access, population service.
- Primary care is a critical component to integrated health services—heal the divide between it and other parts of the system.
- Much of the time and energy during the change process focused on reorganization and rebuilding organizational identity. Service provision often ended up taking a back seat with the change being more about the providers than the patients and their families.
- Public engagement not there—how can you do meaningful community engagement? For the most part, the public did not differentiate between the need for service delivery changes (closures, etc.) and regionalization.

- Create a new future, guided by strong governance with a focus on strategic imperatives. Don't rely on 'knitting together' parts of your history.
- Spend more time on region building and knowing who accesses services within your region. Organizational boundaries that can be eliminated will help you get where you want to go faster. Existing travel patterns and service corridors should be the primary influence for regional boundaries.
- Focus more on quality and the patient, less on costs.
- Talk to people, in specifics, about what needs to be done.
- Consider a number of factors including legislation, health regulatory bodies, and union agreements—before regionalizing. Take the time to look more closely at the levers that can help smooth and expedite the change process.
- Be conscious of change fatigue. Health providers and patients need some stability.

### From the floor

“If LHINs obtain sufficient control over the financial envelope they will be able to provide the financial incentives needed to support change.”

“We are still focused on form not function. If we knew more about the outcomes we were after we might be able to move beyond discussions that focus on structure.”

“More acute care is not the answer to meeting our current or future needs. Innovative community care is.”

“You need the resources and the authority to reallocate. There should be a one-way valve: money out of institutions, but not the opposite.”

“Encourage and support physicians to become team players and part of the regional change process.” — *from the floor*

“If I were running a LHIN I’d spend a lot of time thinking about building relationships with Family Health Teams.”

“We need to get past the firewall of the physician funding envelope and look to other services that are needed to operate an effective FHT.”

“We should be asking our political masters to make decisions about what they want of the system now. Are we trying to achieve the greatest good for the greatest number, or offer the best service for the person at the front of the line today?”

## II. INTEGRATING PHYSICIAN RESOURCES

A commonly identified barrier to successful regionalization across the country has been the inability of RHAs to effectively include and/or involve physicians in the new structure. Two experienced CEOs shared their successes in this regard, pointing to practical and effective ways to secure the participation of physicians within regional health systems.

### Results (what was done & delivered)

- Consolidated medical funding within a region—an important precursor to effective change. Done in some jurisdictions through development of a program management model that flows dollars through a ‘matrix model’ to facilitate collaboration and integration.
- Facilitated collaboration by establishing:
  - a single medical staff;
  - regional standards committees;

- regional credentialing processes;
- regional privileges;
- regional medical staff bylaws to help set single standards of care;
- shared leadership with university department heads;
- a physician dataset including physician qualifications, work activity, etc..



Winnipeg RHA CEO Dr. Brian Postl.

- Encouraged and supported physicians to become team players and part of the regional change process.
- Gave physician leaders important regional roles; evidence, opportunity and courage to elicit their support for change.
- Provided high-level performance data to physicians and articulated clear expectations of what is expected.

“If I were running a LHIN I’d spend a lot of time thinking about building relationships with Family Health Teams.” — *from the floor*

### Hindsight/Lessons learned

- Find a critical mass of like-minded leaders who understand and are committed to a shared goal.
- Don’t yield on the issue of competencies and standards of care.
- Communicate, well and often. Use both formal (councils, clinical departments) and informal structures (medical staff organizations) to communicate with and involve physicians.
- Actively seek out physician leaders. Success in developing physician leaders comes from training individuals as heads of certain committees, watching and nurturing them while they grow.



Diane McArthur, Cabinet Office.



Chair of the Peterborough Network of Family Health Teams, Dr. Stephan Ragaz.

### From the floor

“Why can’t we recruit the best and brightest to take on senior medical leadership positions?”

“Primary health care reform (and Family Health Teams, in particular) hold a lot of potential to help LHINs achieve the goals of better health care and a better health system. Many physicians and other health professionals want to practice within a model of health care similar to FHTs.”

“Payment methods for physicians are important but a focus on health outcome indicators is more important. Are people stopping smoking? Are they keeping their blood pressure, cholesterol and weight under control?”

We should take better advantage of non-medical resources—nurse practitioners, for instance—for such priorities as chronic disease management.



Change Foundation board members Glenda Yeates (CIHI CEO), left, Sheila Jarvis (Bloorview Kids Rehab CEO), Steven Lewis, Tom Ward.

We should explore the possibilities of expanding the use of simulation centres, expanding scopes of practice for some professional groups to help fill current gaps.

Why can't we recruit the best and brightest to care for the elderly?

We need to work on educating the public and changing public attitudes. They need the right information to engage in the discussion in a meaningful way. Physician leaders need to get into the community and discuss how the health-care system is organized.

"Physician leaders often end up in a process that they know little about. You need to gradually immerse them in the planning process and provide them with the freedom to explore..."

"... We still allow the media to say that it is about doctors and acute care beds, rather than selling the concept of aging in place as a valued societal goal."

"Professions won't change, professional Colleges won't change, and politicians don't have the courage to ask for quality and insist on credentialing checks. This means we are going to have to look at other outside structures like Quality Councils to monitor quality of care by individual physicians."

"My advice to the LHINs is to start working with medical and nursing schools... doctors and nurses are still educated in silos and they need to learn about health integration."

### III. INTEGRATING PUBLIC HEALTH INTO HEALTH CARE

While participants agreed that changing structure and governance is just a starting point to reforming and transforming health services to improve population health, there were convincing examples and stories of how the shift to a regional health model did in fact help integrate, for instance, public health and health care. Presentations led to discussions about how public health can influence and support system change.

#### Results (What was done & delivered)

- Forged closer links to the rest of the health system (infection control, long-term care, home care, mental health, primary care, chronic disease management, strategic planning, research, etc.).
- Influenced corporate programming.
- Influenced health system restructuring and prioritization.
- Aligned changes in public health programming and management with regional integration efforts at the provincial, regional and local level.
- Saw visible efforts in the development of local capabilities to support the public health agenda.

#### Hindsight/Lessons learned

- See public health as both a service department and a support department.
- Ensure strong, clear legislation exists for your programming and authority and reporting relationships.

“If you are going to regionalize health services, public health services need to be a part of it. This is only part of the challenge. The bigger challenge is raising understanding of the important role public health has in leading system change.” — *from the floor*

- Focus on the opportunities, not the potential problems.
- Ask for more staff to fulfill broader mandate.
- Harder to maintain relationships with municipalities in regions.
- The fears about regionalization from public health were unwarranted (To read an account of what actually happened in one region versus what was feared, go to [www.changefoundation.com](http://www.changefoundation.com)).
- Involve public health leaders. Having credibility and impact requires that public health be represented as an integral part of the senior team.
- Need to develop competencies, knowledge and skills of public health leaders to set priorities and mobilize resources.

### ✦ From the floor

“Public health still grapples with a number of challenges including the constant struggle to maintain focus on upstream issues of prevention and health promotion given the tyranny of the urgent inherent in the day-to-day crises of acute care issues, and the fact that the proportion of the budget devoted to population and public health has not changed significantly.”

“Don’t let hysteria drive public health efforts. The public’s expectations of what public health should be delivering has been increased by issues like SARS, West Nile Virus, Walkerton, etc. The challenge is for public health to respond to the growing public demand in a manner that will respond to the need for upstream planning, not constantly preparing to respond to a ‘crisis.’”



Malcolm Maxwell, Steven Lewis.

“How do you address the public health mandate given the difficulty of cause and effect proof of its effectiveness? What is measured matters—national/provincial indicators in support of a goal to reduce health disparities would strengthen arguments for action.”

“If you are going to regionalize health services, public health services need to be a part of it. This is only part of the challenge. The bigger challenge is raising understanding of the important role public health has in leading system change.”

“The biggest challenge confronting public health is to grow the pool of qualified people who can fill the current gaps and take on leadership positions.”

**Be bolder** at the beginning; go fast and far enough before the elastic band starts to retract, especially on provincial front.

#### IV. INTEGRATING INFORMATION AND COMMUNICATION TECHNOLOGIES

The potential for hastening the integration of information and communication technologies (ICT) under regionalized health care is great. Examples in two jurisdictions show what progress is possible, and what problems may be encountered.

##### Results (What was done & delivered)

- Regionalization has provided the catalyst for provincial leadership and action to integrate information and communication technologies. In many jurisdictions, a provincial-regional shared vision of ICT reform has started to emerge.
- One business system for the region.
- Almost one clinical system.
- Celebrated patient stories, quality improvement and financial savings.
- Increased demand by clinicians as a result of successes.
- The focus on ICT has allowed regions to:
  - adapt new systems, solutions and approaches;
  - increase government investment in infrastructure;
  - concentrate expertise regionally (and provincially);
  - standardize good clinical practice and monitor and track performance;
  - successfully leverage Canada Health Infoway funding, expertise and projects.

##### Hindsight/Lessons learned

- Don't take on too many projects in too many areas at once—manage expectations & frustrations.
- Be bolder at the beginning; go fast and far enough before the elastic band starts to retract, especially on provincial front.
- Work with a vision and a plan—both provincial and regional.
- Decisions need to be made early about migration - what platform, what application, etc..
- Select leaders and champions carefully; take early action; nurture a vision; develop strategy; engage internal & external stakeholders.

##### From the floor

“This involves major change, and we have an aging workforce and inadequate change management skills.”

“Service providers working in community care in Ontario are not connected to ICT systems and are struggling with inadequate systems. This poses significant barriers to achieving an integrated health system for Ontarians.”

“How do we measure avoidable adverse events/errors in the home?”

“In addressing ICT challenges and finding solutions to overcome them you need to constantly remind yourself that the purpose of what you are doing is to make the patient's life better and to improve the quality of their care.”

“Consolidate, standardize and use IT to exploit the opportunities for the patient's (and taxpayer's) sake.”

“We need process redesign before investing in IT.”

“Remember— for whom all of this matters: the public. Articulate the public interest and assess all preferences and arguments on the basis of how well they advance it.”

### TEN CHANGES TO GIVE HEALTH INTEGRATION A CHANCE

Steven Lewis consolidated the counsel that had been shared during the symposium’s discussions, issuing a call for action and 10 verbs to live by:

1. **CLARIFY**—authority, accountability, rules, and roles. Devolving authority is sensitive and difficult. As regionalized jurisdictions have confirmed, functional devolution without political devolution is unsustainable. Governments must be prepared for occasional discomfort and allow the new entities to misstep, and answer for their actions.
2. **SPECIFY**—goals, targets, and the consequences of success and failure. High-level language and lofty but vague goals do not get the job done. Hard numbers matter. Set ambitious targets, and when achieved, set them higher. Reward success and rather than penalize failure, develop the skills to isolate its causes and supply the tools to get better.
3. **ELIMINATE**—perverse incentives and unconstructive competition. If volumes are no longer the litmus test for success, quit paying for volumes and stop penalizing those who reduce volumes for good reasons. It is good to compete against standards and reward excellence. It is impractical and damaging to have programs and institutions wasting energy competing against each other.
4. **CONFRONT**—narrow interests and power that no longer serves the public interest. Priority setting for local fundraising efforts must complement a coherent and creative plan that addresses identified community needs. Regionalized provinces by and large recognized that the consolidation of power at the local level was at least as important as devolution from the capital. Speaking truth both to and about power matters.
5. **MODERNIZE**—information systems and their use. No amount of effort and individual ingenuity can compensate for the absence of comprehensive, real-time, appropriately accessible information. Everyone in the system, from front-line practitioners to managers to board members, must become as addicted to high-quality information and analysis as they are to their Blackberries.
6. **ENGAGE**—doctors, associations, and organizations. If full integration of these parallel groups remains a distant dream, the fallback strategy should be greater participation, supported by effective collective agreement bargaining aimed at greater alignment.
7. **EXPERIMENT**—with new approaches, incentives, division of labour, and with the permission, if not the active blessing, of government. Take the chains off innovation and let organizations learn by doing, with clear goals and accountability. Government should tell the system what to accomplish but not how to accomplish it.
8. **MEASURE**—the right things, and well. In the absence of measurement and transparency, there is a Babel of opinions, and the presumption of excellence. Good measurement ends a lot of arguments and provides a solid foundation for progress. It is the bedrock of sound decision-making and the key to quality improvement.



Photo left: Change Foundation board member Tony Dagnone, RHA CEO Cecile Hunt, Central LHIN CEO Hy Eliasoph.  
Photo right: Change Foundation board member Kevin Smith.

9. **COMMUNICATE**—vision, goals, and performance, honestly and bravely. The policy community, practitioners and interest groups, and the general public all have different visions of where the system should go and different perspectives on what needs fixing and what doesn't. If the public is persuaded by one vision and policy-makers adhere to another, conflict prevails and transformative ambitions falter.
10. **REMEMBER**—for whom all of this matters: the public. Articulate the public interest and assess all preferences and arguments on the basis of how well they advance it.

## CONCLUSION/LOOKING AHEAD

We hope this report provokes good discussion and deliberation, putting on the table ideas for action and change as you work within and across organizations and with all stakeholders towards a common goal: more coordinated and seamless health services organized efficiently and fairly around the identified needs of Ontarians in communities across the province.

What options and actions would be advisable and possible at this point for those entrusted with Ontario's mandate to integrate health services? How can we in Ontario make the most of the opportunity that the commitment to integrate health services offers?

The lessons from the regions must of course be adapted to Ontario's unique model of regional health care and take into account the differences between LHINS and RHAs—LHINS are not employers responsible for delivering services, for instance, and they operate in tandem with local boards, which were largely abolished in the regional structures in other provinces. (The Change Foundation released a review Oct. 14/2008 of the structure, powers and accountability of the LHINS. Download it at [www.changefoundation.com](http://www.changefoundation.com))

Despite those differences, several critical lessons emerge from the cross-country examples and experiences that Ontario would do well to turn its collective mind to: the need to bring primary care and public health under the integration umbrella, and the need to boost public engagement efforts. These are areas that The Change Foundation may concentrate on in the future as essential components to the integration of health services in Ontario.

## APPENDIX 1: CROSS-COUNTRY CHECKUP: ROUNDUP OF HEALTH REGIONS

Regional Health Authorities by province and territory May 2008		
Jurisdiction	# of Regions/Evolution	Total Population (2007)
British Columbia	5 regional 1 provincial  Pre 2001: 52 regional health authorities 2001: 5 RHAs, covering 16 health service delivery areas; 1 provincial health services authority	4,352,800
Alberta	1 provincial health services board  1994: 17 health regions; appointed boards 2001: 17 regions; 2/3 board members elected; 1/3 appointed 2003: 9 boards; appointed boards May 2008: 1 Provincial Board, replacing 9 RHAs, Alberta Mental Health Board, Alberta Cancer Board, and Alberta Alcohol & Drug Abuse Commission	3,455,060
Saskatchewan	12 regions provincial cancer agency  1992: 30 District Health Boards established, replacing 400 health care boards 1998: 2 northern districts added (32); 8 elected board members (of 12 total) 2001: 12 RHAs, reorganized from 32; Board wholly appointed by provincial government	990,210
Manitoba	11 regions provincial cancer agency  1997: 12 RHAs, populations from 24,000 to 667,000(exception—Churchill: 931 2001: 11 RHAs (2 RHAs amalgamated to form new RHA of Assiniboine) 2007: External review of the RHAs	1,182,920
Ontario	14 Local Health Integration Networks (LHINs) provincial cancer agency, cardiac care network  2006: 14 LHINs created 2007: LHINs assume responsibility for planning, funding and integrating health services	12,753,700

Quebec	<p>18 regional authorities 95 local service networks</p> <p>1973: Creation of Community Health Departments, Regional Health &amp; Social Services Counsels 1992: Creation of Regional Health and Social Services boards 2004: Transformation of the regional boards into Agencies for the Development of Local Health and Social Services Networks 2006: Transformation into Health and Social Services Agencies</p>	7,687,060
Nova Scotia	<p>9 districts(from 4 regional boards) 37 community health boards within the districts IWK Health Centre (provincial children's hospital)—forms a separate district health authority</p> <p>1996: 36 local hospital boards amalgamated into 4 regional health boards 2001: 4 regions expanded into 9 district health authorities</p>	932,970
New Brunswick	<p>2 regions &amp; a New Brunswick Health Council</p> <p>2008: 8 regions consolidated into 2</p>	748,880
Newfoundland & Labrador	<p>4 regional integrated health authorities</p> <p>1990s: 14 Health Boards (reduced from over 50) 2004: 4 regional integrated health authorities</p>	506,550
Prince Edward Island	<p>No regions – 5 community hospital boards</p> <p>2005: All regional boards dissolved</p>	138,800
North West Territories	8 health & social service regions	41,800
Nunavut	No regions	31,220
The Yukon	No regions	30,880

## APPENDIX 2: PARTICIPANT LIST

### Speakers

John Abbott, former Health & Community Services DM, NL  
Lillian Bayne, facilitator and former ADM, BC  
Dr. Luc Boileau, CEO, Health and Social Services Agency for Montérégie, QC  
Tom Closson, President & CEO, OHA, & co-author, Report of the Manitoba Regional Health Authority External Review  
Gail Donner, Chair, The Change Foundation  
Kenneth Fyke, former Health DM, SK & BC, author of the Fyke Report (Report of the Commission on Medicare in Saskatchewan), founding Chair of Canadian Blood Services  
Cecile Hunt, CEO, Prince Albert Parkland Health Region, SK  
Steven Lewis, Research Advisor, The Change Foundation  
Malcolm Maxwell, CEO, Grand River Hospital, former health authority CEO  
Chris Mazurkewich, COO, Strategic & Corporate Officer, Interior Health, BC  
Dr. Cory Neudorf, Chief Medical Health Officer, Saskatoon Health Region, SK  
Dr. Brian Postl, CEO, Winnipeg Health Authority, MB  
Dr. Tom Ward, former hospital CEO and former DM of Health, NS

### Other

Theresa Agnew, Nurse Practitioner, East End Community Health Centre  
Pat Campbell, President & CEO, Grey Bruce Health Services  
Anton Hart, Publisher, Longwoods Publishing  
Janet Lambert, Executive Director, Ontario Long-term Care Association  
Sue Matthews, VON, VP, Ontario, East & North and Chief of Practice—ON  
Diane McArthur, Exec.Coordinator, Health & Social Policy, Cabinet Office, ON  
Margaret Mottershead, Exec.Dir., ON Assoc. of Community Care Access Centres  
Susan Pigott, VP, Communications & Community Engagement, CAMH  
Maureen Quigley, Consultant  
Dr. Stephan Ragaz, Chair of the Peterborough Network of Family Health Teams  
Carol Ringer, consultant and former Regional Health Authority executive  
Sue Vanderbent, Executive Director, Ontario Home Care Association

### Change Foundation Board Members

Tony Dagnone, Chair, OHAfrica  
Sheila Jarvis, President & CEO, Bloorview Kids Rehab  
Kevin Smith, Pres. & CEO, St. Joseph's Healthcare Hamilton  
Glenda Yeates, President & CEO, CIHI

### Local Health Integration Networks

Gwen DuBois-Wing, North West LHIN CEO  
Hy Eliasoph, Central LHIN CEO  
Deborah Hammons, Central East LHIN CEO  
Mimi Lowi-Young, Central West CEO  
Jean Trimnell, North Simcoe Muskoka CEO

### APPENDIX 3. Biographies of speakers, *Meeting of the Minds*

#### JOHN ABBOTT

John G. Abbott is a former deputy minister of Health & Community Services with the Government of Newfoundland and Labrador as well as former board chair of the Health Care Corporation of St. John's. During John's tenure as deputy minister, he oversaw the integration of the province's 14 health boards into four regional integrated health authorities, and the development of enabling legislation to guide their service delivery mandates. As part of his approach, John ensured that plans and budgets to support regionalization were designed and implemented in full collaboration with each of the new health authorities.

John is a graduate of Memorial University of Newfoundland and Carleton University, and a past recipient of the Lieutenant Governor's IPAC Award for Excellence in Public Administration. Currently, John is a management consultant with *The Institute for the Advancement of Public Policy, Inc.*, a private consulting firm specializing in public policy analysis development, located in St. John's.

#### LILLIAN BAYNE—moderator

Lillian Bayne is an independent consultant working in health policy, planning and research. In 2001/2002, Lillian served as associate executive director and special advisor to the Royal Commission on the Future of Health Care, the Romanow Commission. Lillian was regional director general for Health Canada's BC/Yukon Region from 1999 until she joined the Commission. Prior to that, Lillian was an assistant deputy minister with the BC Ministry of Health where she has held portfolios including public health, Aboriginal health, mental health and forensic psychiatric services, legislation and professional regulation, and intergovernmental health relations. Lillian is the BC Regional Officer for the Canadian Health Services Research Foundation and President-Elect of the Canadian Association for Health Services and Policy Research.

#### DR. LUC BOILEAU

Dr. Luc Boileau has been a physician for more than twenty years. He is specialised in public health and has a master's degree in health administration. Over the years, he has acquired remarkable experience in hospital and public health organisations and management while being involved in many regional, national and international projects, particularly in Africa.

For more than eight years, he was director of public health at the Régie régionale de la santé et des services sociaux de la Montérégie (RRSSM). In 2002, the government of Quebec nominated him president and chief executive officer of the RRSSM—now the Agence de la santé et des services sociaux in the same region.

Luc is an associate professor with the faculty of medicine at Sherbrooke University, where he served as vice dean for more than ten years. He has delivered almost 100 national and international lectures.

#### TOM CLOSSON

Tom Closson was appointed President and CEO of the Ontario Hospital Association in January 2008. He stepped down from the position of President and Chief Executive Officer of University Health Network (UHN) in 2005 and subsequently practiced as a health-care management consultant. As a consultant, Tom's projects included a review of the effectiveness of regionalization in Manitoba. Before joining UHN, Tom worked in Victoria BC as President and CEO of the Capital Health Region. Prior to that, he spent nine years at Sunnybrook Health Sciences Centre in Toronto and rose from the position of Chief Financial Officer to Chief Operating Officer and ultimately to President and CEO.

Tom obtained previous experience in health-care consulting as an owner of Medicus Canada and as a Partner with KPMG. He has extensive government experience including with the Ontario Ministry of Health, the Ministry of Community and Social Services and Management Board.

Tom has volunteered on many panels and Boards, including Cancer Care Ontario, Canadian Organization for Advancement of Computers in Health (COACH), Institute for Clinical Evaluative Sciences (ICES), Institute for Work and Health, and Canadian Institute for Health Information (CIHI). Tom is currently on the Boards of Canada Health Infoway, Wellspring and LifeLabs. He earned an MBA from York University in Toronto and graduated from U of T with a Bachelor of Applied Science in Industrial Engineering. He is a Professional Engineer.

### GAIL DONNER

Chair of The Change Foundation since June 2007, Gail is a professor and dean emeritus in the Lawrence S. Bloomberg Faculty of Nursing, University of Toronto and a partner in donnerwheeler, Career Planning Consultants. Internationally recognized for her contributions to the nursing community, Gail has published extensively and is a popular speaker and presenter on health care and professional nursing issues. Her academic research and consulting interests range from health policy and nursing administration to career planning and development in Canada, the United States, Europe and South Africa.

Gail has also worked in leadership roles at Ryerson Polytechnic Institute (now Ryerson University), the Registered Nurses' Association of Ontario, and the Hospital for Sick Children. She chaired the Air Ambulance Review in Ontario and served on the Metro District Health Council Hospital Restructuring Committee as well as on the Academic Education and Research Committee of the Sunnybrook and Women's College Hospital de-merger project.

Gail serves on the Board of Trustees of the Hospital for Sick Children where she is Chair of the Quality Council, and is Book Editor for the Canadian Journal of Nursing Leadership. In addition to the numerous professional awards she has received over the years, Gail is also a member of the Order of Ontario. In 2007, she received an honorary doctorate from Ryerson University for her contributions to the nursing community.

### KENNETH FYKE

Kenneth Fyke has 45 years of experience in Canadian health services. In 2001, he was Commissioner and author of *Caring for Medicare-Sustaining a Quality System*, the Report of the Commission on Medicare in the Province of Saskatchewan.

He served as a member of the British Columbia Royal Commission on Health Care and Costs, *Closer to Home*, 1990-91, as the founding Chair of the Board of Directors, Canadian Blood Services (CBS), 1998, and as a Deputy Minister of Health in the provinces of Saskatchewan and British Columbia, working with governments led by several political parties.

In 1984, Ken was the first President and Chief Executive Officer of the Greater Victoria Hospital Society, one of Canada's first amalgamated hospital systems. He was also the first Chief Executive Officer of the Capital Health Region in Victoria, where he developed an integrated, regional health service, 1996. Ken led the Victoria Health Project, which received national recognition and an international award for its innovations in community-based care. He currently serves as *Chair*, Canadian Stroke Strategy Steering Committee and *Chair*, Advisory Committee, Centre for Health Leadership and Research, Royal Roads University.

Ken Fyke is a member of the Order of Canada and holds an honorary Doctor of Laws from Royal Roads University. He also holds a Master of Health Sciences Administration from the University of Alberta and a Bachelor of Science in Pharmacy from the University of Saskatchewan.

### CECILE HUNT

Cecile Hunt became the President and Chief Executive Officer of the Prince Albert Parkland Health Region on March 1, 2006. Prior to joining Prince Albert Parkland, Cecile was the Vice-President of Integrated Health Services for the Prairie North Health Region, which includes North Battleford, Lloydminster and Meadow Lake and surrounding areas.

She lives in the Region, and her husband farms in the Kinistino area. Cecile started her career in health care 30 years ago as a registered nurse. Prior to working in Prairie North, she was the Director of Health Services for the North Central Health District in Melfort. She also worked in Prince Albert from 1988-96. She was Director of Nursing at Victoria Union Hospital and also served as the Prince Albert Health District's Director of Patient Care.

### STEVEN LEWIS

Steven Lewis joined The Change Foundation as Research Advisor in the summer of 2007. As a well-respected health policy consultant with Access Consulting, Steven's knowledge and analysis of health integration issues across Canada make him a valuable resource for the Foundation and the province. Based in Saskatoon, Steven is an Adjunct Professor of Health Policy at the University of Calgary, and was recently Visiting Scholar at Vancouver's Simon Fraser University, where he is also works as an adjunct professor. He has headed a health research granting agency and spent seven years as CEO of the Health Services Utilization and Research Commission in Saskatchewan. He has served on various boards and committees, including the Governing Council of the Canadian Institutes of Health Research, the Saskatchewan Health Quality Council, the Health Council of Canada, and the editorial boards of several journals, including the newly launched Open Medicine. His published work covers topics such as reforming and strengthening medicare, improving health-care quality, primary health care, regionalization and integration, and the management of wait times.

### MALCOLM MAXWELL

Malcolm Maxwell is President and CEO of Grand River Hospital in Kitchener. His career has included leadership roles within regional health systems, hospitals and health ministries in four provinces. From 2003 to 2007, he was the first CEO of Northern Health, one of British Columbia's six Health Authorities. Malcolm has participated in the boards of CIHI, CCHSA, and currently serves as a Board member in the Canadian Health Services Research Foundation.

### CHRIS MAZURKEWICH

Chris Mazurkewich came to Kelowna in 1992 as Vice-President of Finance and Support Services for Kelowna General Hospital. In 1997 when the Okanagan Similkameen Health Region was formed, he was appointed Corporate Finance and Operations Officer. He held that position until Interior Health was formed in 2001, when he became the Chief Operating Officer, Strategic and Corporate Services for all of Interior Health. Chris has been a member of various provincial committees such as Chief Financial Officers, Electronic Health Record, Telehealth, Physician Contract Administration, and a board member of the Healthcare Benefit Trust. He holds a Bachelor of Commerce (Accounting), Master of Administration (Health) and a BC Chartered Accountant designation.

### DR. CORDELL NEUDORF

Dr. Neudorf is the Chief Medical Health Officer for the Saskatoon Health Region. He received his medical degree from the University of Saskatchewan, a Master's of Health Science degree in Community Health and Epidemiology from the University of Toronto, and is a fellow of the Royal College of Physicians and Surgeons of Canada with Certification in the specialty of Community Medicine. He is the past president of the National Specialty Society for Community Medicine, Chair-elect of the Canadian Public Health Association, and Chair of the Canadian Population Health Initiative Council.

Cory is a Clinical Associate Professor in the Department of Community Health and Epidemiology at the University of Saskatchewan, College of Medicine. His research interests include health inequalities, health status indicators and surveys, health status monitoring and reporting, and integrating population health data and geographic information systems into public health and health planning.

He has been with the Saskatoon Health Region (SHR) for 14 years, and has been a part of the SHR Senior Leadership Team since 2000, where he provides a population health physician's perspective to health

system planning issues. During this time, he has worked at integrating Public Health Services into the RHA environment, which has involved looking for ways Public Health can act as both a service provider of public health programs as well as a support department to other parts of the health system, especially in the areas of population health promotion leadership and population health planning, evaluation and research. He has spoken to many groups in Canada about the benefits and challenges of integrating public health into an RHA environment.

### DR. BRIAN POSTL

Dr. Brian Postl is the President and CEO of the Winnipeg Regional Health Authority, a position he has held since 1999. A graduate of the University of Manitoba where he achieved Royal College Fellowships in community medicine and pediatrics, Brian has practiced these specialties in rural and northern areas of Manitoba and the Northwest Territories.

Brian has been head of the departments of Pediatrics and Community Health Sciences at the University of Manitoba. He has served on a number of national boards and committees including: the Canadian Patient Safety Institute; the Canadian Health Research Foundation; the Canadian Institute for Health Information; Canada Health Infoway; the Health Council of Canada; the Canadian Society of Circumpolar Health; and the Canadian Pediatric Society (Indian and Inuit Health Committee).

He has published widely on a variety of topics, but with a special focus on the health of residents in rural and isolated northern native communities and circumpolar health. He continues to practice pediatrics out of Winnipeg's Health Sciences Centre.

### DR. TOM WARD

Dr. Ward is an internationally respected health systems planner and a former paediatrician with a 30-year track record in frontline medical practice, hospital administration, research and government. A former deputy minister of Health in Nova Scotia, Tom was also Vice President, Medicine, at St. Paul's Hospital

in Vancouver and CEO of Scarborough Hospital. On the national stage, Tom led key initiatives in health reform, particularly in health human resources and national health system performance reporting. He was Chair of the National Deputy Ministers' Advisory Committee on Health Human Resources and a Director of CIHI. He also practiced and taught neonatology and pediatric intensive care at the University Hospitals of Saskatchewan and Alberta.

## APPENDIX 4. Backgrounder: Ontario's Local Health Integration Networks (LHINs)

The Ontario government introduced the Local Health System Integration Bill in November 2005. The government created 14 Local Health Integration Networks—or LHINs—in March 2006 with passage of the legislation. The LHINs are to:

- Promote the integration of the local health system.
- Ensure community engagement in health reform.
- Allocate funding to health service providers.
- Evaluate the performance of the local health system.
- Efficiently manage health system resources.

They are responsible for planning, integrating and funding local health services, including: hospitals, community care access centres (CCACs), community support services, long-term care, mental health and addictions services, and community health centres (CHCs). However, a number of key health services are not under the auspices of the LHINs: physicians; public health; ambulance services; laboratories; provincial networks and priority programs; and pharmaceuticals.

LHINs do not directly provide services, but they oversee approximately one-half of the \$40 billion provincial health budget. The funding allocation is currently based on historical allocations, service volumes, operating plans, etc., rather than on more sophisticated formula reflecting population size, estimated health needs (related to demographics, local morbidity and mortality patterns) and adjustments for variation in cost of living. They work with local health providers and community members to determine the health service priorities of geographic regions ranging from 234,000 to 1,357,000 populations. (LHIN boundaries are for management and administrative purposes only—people are not restricted to receiving services within their LHIN.)

LHINs operate as not-for-profit crown corporations governed by boards of directors appointed by the province following a merit-based selection process. Each LHIN has no more than nine board members. The board of directors is responsible for the management and operation of the LHIN and is the key point of interaction with the ministry. CEOs were selected after an extensive

search and selection process and report directly to the LHIN boards.

### Local Health System Integration Act, 2006:

LHINs can issue Integration Decisions to health-service providers (HSP) to:

1. Stop, start, merge, adjust or transfer services.
2. Permit voluntary integration by HSP(s) (unlike #1, this Integration Decision could involve a merger or amalgamation of HSPs or other health-care providers, or closure of HSP(s) if it is voluntarily agreed to by the HSPs and not opposed to by the LHIN).
3. Stop a voluntary integration of services or programs. A LHIN may also integrate the local system by changing funding to HSP(s).

The Minister retains certain integration powers that have not been devolved to LHINs which may be exercised by issuing an Integration Order (e.g., to require a HSP to amalgamate with another HSP, cease operating or wind up operations, or transfer all its operations to another entity).

### LHIN Integrated Service Plans:

LHINs are based on a principle that community-based care is best planned, coordinated and funded in an integrated manner within the local community because local people are best able to determine their health service needs and priorities. LHINs are specifically mandated to engage people and providers about health needs and priorities. All LHINs were required to create a three-year Integrated Health Service Plan; they were completed in the fall of 2006.

### LHIN Accountability Agreement with MOHLTC:

Accountability agreements have been signed between the 14 LHINs and the Ministry of Health and Long-Term Care. The Agreement gives the following decision-making authority to the LHIN:

- Which health services will be provided by the health service providers in or for the local health system, and where the health services will be provided.
- Which health service providers will be funded to deliver those services and the amount of funding.
- Service volumes and performance requirements of the health service providers.
- The Agreement notes that:
  - in 2007/08, the LHIN will consult with the MOHLTC prior to issuing a decision to integrate or to stop an integration;
  - the LHIN should include a report on its integration activities in its annual report.

(A definition of integration is not included in the Agreement.)

The Agreement contains specific performance indicators which the LHIN must report publicly along with performance targets. Benchmarks are noted in some instances but many are still to be developed by the Spring of 2008. Integration indicators included in the Agreements were restricted to:

- Rate of emergency department visits that could be managed elsewhere.
- Hospitalization rate for ambulatory care sensitive conditions.
- Wait time to long-term care home placement.

The LHINs have created a Director-level working group to develop performance indicators.

### **LHIN Accountability Agreements with Hospitals:**

Hospitals previously signed accountability agreements with the Ministry of Health and Long-Term Care. The Ministry has transferred the authority to oversee these agreements to the LHINs. The 2008-2010 Hospital Service Accountability Agreement (H-SAA) process marks the first hospital budget negotiation between the 14 LHINs and hospitals. Signed by the boards of directors of both hospitals and their LHIN, H-SAAs hold hospitals accountable for operating within a balanced budget and maintaining agreed-upon service levels. Hospitals are required to balance their budgets under the Local

Health System Integration Act, 2006. However, an Ontario Hospital Association survey concluded that 75 hospitals across the province are in deficit. It is still not clear how much authority the LHINs really have in pressuring hospitals to balance their budgets.

### **LHIN Accountability Agreements with Other Providers:**

The expectation is that LHINs will sign accountability agreements by March 31, 2009 with mental health and addictions agencies, community support services agencies, community health centres, and community care access centres. LHINs are expected to sign accountability agreements with Long-Term Care Homes by March 31, 2010.

### **Ministry/LHIN Effectiveness Review:**

After two years of operations, external consultants (KPMG) have been contracted to conduct a review to examine the effectiveness and capacity of both the Ministry and the LHINs to adequately fulfill their roles. It is scheduled to be released in the fall of 2008.

## Vision

To be Ontario's trusted advisor advancing innovative health policy and practice.

## Mandate

To promote, support and improve health and the delivery of health care in Ontario.

## Mission

To promote independent analysis and informed debate of current and emerging health issues.

To support outstanding research and policy analysis about health system integration.

To improve patient outcomes through innovative approaches to quality improvement and knowledge transfer.

## Values

### *Excellence*

We strive for excellence in all that we do.

### *Innovation*

We take innovative approaches in developing new ideas.

### *Collaboration*

We work in partnership with others to achieve success.

## President & CEO, Cathy Fooks

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