DRAFT

Appendix D

Waterloo Wellington LHIN Integrated Health Service Plan Literature Reviews

2006 Integrated Health Services Plan
Environmental Scanning Process

Framework for the Review of Health Services and Health Policy Reports

<table>
<tr><td>Overall Mandate of the Integrated Health Service Plan</td><td>The IHSP will describe the Waterloo Wellington LHIN initial priorities for the three year period beginning April 2007.
The IHSP will include a vision, priorities and strategic directions for the local health care system.
The IHSP will be developed in accordance with principles outlined in the WWLHIN Community Engagement Framework.</td></tr>
<tr><td>Environmental Scan Process</td><td>The environmental scanning process will be comprised of a number of activities designed to capture key stakeholder (citizen and provider) input. These activities include both primary data collection and secondary data analysis.
Primary data collection includes:
Introductory meetings with provider agencies and networks (2005/06);
Participative Community Engagement Town Hall Meetings (March 06);
Provider and Citizen Surveys (May 06), and
Focus groups with special populations.
Sources of secondary data to be included in the IHSP review includes:
Statistical population demographic and services data;
Review and analysis of key health services and health policy reports.</td></tr>
<tr><td>Health Services/Policy Reports:
Review Principles</td><td>Transparency – Documents are readily available to the public through reliable sources;
Respect – Inclusion of local health service reports recognizes the input of local stakeholders and ensures that recommendations are considered as part of the input required for future health care planning;
Accountability – The WWLHIN is committed to affirming and building upon the identified system integration opportunities;
Development of a Shared Vision – Recommendations for integration opportunities and key system gaps help to shape the strategic plan for WWLHIN health care system;
Commitment – The WWLHIN is committed to a citizen-centred sustainable health care system. Recommendations will be reviewed within that</td></tr>
</table>

	context.
Health Services/Policy Reports: Review Objective	The review of selected health services and policy reports will be used to: • **highlight recommendations regarding service gaps and opportunities for service coordination and integration;** • build on previously identified local priorities; • provide background documentation that will inform and confirm the issues raised by the other IHSP environmental scanning activities.
Health Services/Policy Reports: Identification of Reports for Review	Applying the principles for the review of health services documents, criteria for inclusion of reports include: • **Public documents**: Past Waterloo Region – Wellington-Dufferin District Health Council reports that are archived with the Government of Ontario; • Local reports that include **recommendations regarding sectors within the health care system,** with recommendations regarding **horizontal** integration and/or service gaps and future directions; • Local reports that include **recommendations for health systems integration,** addressing more than one sector from which a given individual may be receiving care. Reports to be reviewed contain recommendations regarding **vertical** integration, system gaps and system directions. • Local and Provincial reports that **align with the priorities** identified by WWLHIN Community Engagement strategies; • Local and Provincial Reports that **focus on population need** • Recent provincial and federal documents that **address health care system policy and directions.**
Health Services/Policy Reports: Framework for Review	Using a template, each identified report will be reviewed for: • Purpose, objective of report; • Report Highlights; • Integration Recommendations: Identify recommendations referring to health services collaboration, partnerships and care coordination; • System Gaps: Identify recommendations referring to service system needs and gaps or recommendations regarding service system requirements; • System Directions: For provincial and federal health policy reports, identify policy recommendations that will have an impact on the

	local health care delivery.
Health Services/Policy Reports: Cautions	• Comprehensiveness of review: identification of reports may not include all systems level reports available from sectoral networks and other sources not currently or readily available to WWLHIN.

Report Identification: Horizontal and Vertical Integration

Reports that are to be included in the review are reports that contain recommendations regarding either vertical or horizontal integration.

Vertical Integration is "networking of organizations or creating an organization to provide or arrange to provide a continuum of services to a defined population and with a willingness to be held clinically and fiscally accountable for the outcomes and health status of the population served". (Health Systems Integration Framework, Ministry of Health and Long Term Care, 2005)

Horizontal Integration involves establishing relationships among like organizations for the organization, coordination, management and/or delivery of services. (Health Systems Integration Framework, Ministry of Health and Long Term Care, 2005)

Traditionally within the health care system, planning reports have addressed specific sectors or sub-systems, such as acute care, long term care, and mental health. It is important to identify historically significant documents that address health needs and priorities within each sector, recognizing that some of the recommendations coming from a sectoral report also address systemic issues, or issues that cross the continuum of care.

While many reports identified for review reflect the geography of the LHIN, some of the reports address a specific geographic region of the LHIN, such as Wellington County or Waterloo Region.

Many reports are directed at the health service needs and system requirements for specific age groups, and others reflect service system requirements to meet the needs of the general population.

The Environmental Scanning process has included identifying networks within each traditional health care delivery sector to assist in the collection of data. Using a similar framework, **key reports from within each sector** can be identified to ensure that historical reports from across the sectors are captured in the inventory of reports to be reviewed. **Additionally, key reports that address multiple sectors will be identified and included in this review of background documentation.**

Applying geographic, population age group and sectoral lenses, reports can be identified from within:

- Primary Care
- Community Support

- LTC (facilities, CCAC)
- Mental Health/Addictions
- Acute Care and
- Rehabilitation.

Additionally, **reports that cross the traditional sectors** will also be highlighted for inclusion in the review, especially those that address the determinants of health. Sources for the reports include:

- WRWD DHC Reports that are archived with the Government of Ontario
- Social Planning Council of Cambridge and North Dumfries
- Social Planning Council of Kitchener-Waterloo
- United Way of Guelph Wellington
- Hospital System Sizing reports (Health Services Restructuring Commission, Wellington County Hospitals Network)
- Reports released by provider networks regarding system directions and system gaps/requirements
- Recent provincial and national documents that address health care system policy and/or directions.

Inventory of Documents for Review

Local Population Health and Health Service Documents:

Cross-Sectoral Reports:

- A Snapshot of Children, Youth, Individuals and Families Living in Guelph-Wellington. Part 1: Pre-Forum Report (United Way of Guelph-Wellington, August 2004).
- An Overview of Palliative Care Issues in Waterloo Region and Wellington and Dufferin Counties (June 2003 Ontario District Health Council Archives).
- Community Forum Report: Addressing the Needs of Children, Youth, Individuals and Families Living in Guelph-Wellington, (United Way of Guelph-Wellington, 2004).
- Community Trends in Cambridge and North Dumfries (Social Planning Council of Cambridge and North Dumfries, 2006).
- Community Needs and Capacity Assessment (Woolwich Community Health Centre, 2004).
- Health Human Resources Capacity and Utilization (May 2003, Ontario District Health Council Archives).
- Implementation of the Model of Specialized Geriatric Services in Waterloo Region (2003 Ontario District Health Council Archives).
- Rural Health Study in Waterloo Region (Waterloo Region Public Health, 2004).
- Wellington Dufferin Expert Geriatric Service Project (May 2005, Ontario District Health Council Archives).
- Where Urban and Rural Meet: Looking at Quality of Life in the Township of North Dumfries (Social Planning Council of Cambridge and North Dumfries, 2006).

Sectoral Reports:
Primary Care:

- Facilitating the Primary Care Reform Agenda: A Proposed Role for the Community Care Access Centre of Wellington Dufferin and the CCAC of Waterloo Region, (CCAC of Waterloo Region and CCAC of Wellington Dufferin, 2005).

Long Term Care and Community Support Services:

- A Day in the Life of Community LTC Services: Results of a One-Day Census in the Waterloo Region and Wellington-Dufferin Counties (March 2004 Ontario DHC Archives).
- A Needs Analysis for Supportive Housing for the Elderly in Waterloo Region, Wellington and Dufferin Counties (January 2003 Ontario DHC Archives).
- Overview of Long Term Care Facilities in Waterloo Region and Wellington – Dufferin Counties (December 2001 DHC Archives.
- Strengthening Services for People with Alzheimer Disease and Related Dementias in Waterloo Region and Wellington and Dufferin Counties (January 2004 Ontario DHC Archives).
- Toward 2006 – Directions for Community Long Term Care Services in Waterloo Region and Wellington and Dufferin Counties (July 2003 Ontario DHC Archives).

Mental Health

- Health Services Restructuring Commission Report to Waterloo Region (August 1998, HSRC Archives).

- **Acute Care**
- Health Services Restructuring Commission Report to Waterloo Region (August, 1998, HSRC Archives).
- Wellington County Hospitals Network Report to the Health Services Restructuring Commission, (Wellington County Hospitals Network, 1999).

Rehabilitation

- Report of the Waterloo Region Wellington Dufferin Acquired Brain Injury Model Development Project (2004, Ontario District Health Council Archives).
- Wellington County Hospitals Network Report to the Health Services Restructuring Commission, (Wellington County Hospitals Network, 1999).
- Wellington-Dufferin Children's Rehabilitation Implementation Plan (04/05 Ontario DHC Archives).

Provincial Policy Reports on the Ontario Health Care System:

- Building the Foundation of a Strong Public Health System for Ontarians (MOHLTC 2005).
- Every Door Leads to Service: Enhancing Access and Building a Culture of Service Integration for a Made in Ontario Health System (Association of Ontario Health Centres, Ontario Community Support Association, Ontario Federation of Mental Health and Addiction Programs 2006).
- Final Report of the Ontario Critical Care Steering Committee, 2005
- Improving the Quality of Palliative Care Services in Ontario, Cancer Care Ontario, 2006.
- Laying the Foundation for Change: A Progress Report on Ontario's Health Human Resource Initiatives (MOHLTC, 2005).
- Noojimawin Health Authority: Aboriginal Community Profile for Waterloo Wellington LHIN, June 2006.
- Ontario Cancer Plan 2005-2008, (Cancer Care Ontario 2005).
- Optimizing the Role of Complex Continuing Care and Rehabilitation in the Transformation of the Health Delivery System (Ontario Hospital Association, 2006.
- Primary Health Care Strategy (Health Services Restructuring Commission, 1999).
- Provincial Status Report: Ontario Stroke System, (Provincial Steering Committee, Ontario Stroke System, 2006).
- Realizing the Potential of Homecare: Competing for Excellence by Rewarding Results (Caplan, 2005.)
- The Metis Nation of Ontario: Metis Nation Specific Provisions in the Transformation Agenda, Submission to the Ministry of Health and Long Term Care, November 2005.
- The Time is Now: Themes and Recommendations for Mental health Reform in Ontario, (Final Report of the Mental Health Implementation Task Force Chairs, 2002).
- The Wait Time Strategy, Ministry of Health and Long Term Care, 2004
- Transition Planning in Health Care Systems: Key Quality Processes and Outcome Measures, (The Ontario Home and Community Care Council, 2004).

National Reports on the Canadian Health Care System:

- Building a National Diabetes Strategy: A Strategic Framework (Public Health Agency of Ontario, 2005).
- Building on Values: The Future of Healthcare in Canada (Romanow, November 2002.)
- Emergency Department Overcrowding in Canada: What are the Issues and What Can be Done? (Canadian Agency for Drugs and Technologies in Health, 2006)
- Improving the Health of Young Canadians, Canadian Population Health Initiative (Canadian Institute for Health Information, 2005).
- National Profile of Family Caregivers in Canada – 2002: Final Report, (Health Canada, 2002).
- Partnership in Practice: Two Key Strategies Involving Home Care Yield High Impact Benefits for Primary Health Care In Canada, (Canadian Homecare Association, 2006)
- The Health of Canadians – The Federal Role – (Kirby, October 2002).

Local Population Health and Health Services Documents

Cross-sectoral Reports:

A Snapshot of Children, Youth, Individuals and Families Living in Guelph-Wellington. Part 1: Pre-Forum Report (United Way of Guelph Wellington August 2004)	
Guelph-Wellington community indicators	
Purpose/Objectives	The report tracks information on key community indicators, identifies gaps in service and serves as a planning tool for service providers, the United Way and others making decisions about allocating resources.
Report Highlights	Provides information on population projections, population aging, population diversity and key social conditions such as poverty, family structure (costs, childcare, child health, family violence), school life, performance and dropping out, youth issues (school to work, literacy) adult well-being (health status) community well being (housing).
Population needs highlighted in report	• Spending rising faster than incomes, therefore personal debt rising • Use of food banks is increasing • Financial gap between the rich and poor is widening • Obesity is rising and physical activity levels are decreasing • Shortage of affordable and social housing • Shortage of regulated child care programs • No alternative education system • Demand for neighbourhood space for recreation activities, specifically for youth • Transportation identified as a pressure point in Wellington County
Integration Recommendations	N/A
System Gaps/system requirements	8 issues emerged for follow-up: • Special education in the school system • Literacy programs for adults • Cultural interpreters and related services • Child care spaces for infants and toddlers • Early Childhood Education – school preparedness • Alternative education programs for disengaged youth • Affordable housing • Social supports (e.g., counselling, recreation)
Alignment with themes identified through LHIN IHSP consultation	
Alignment with Provincial Priorities	

Source: United Way of Guelph-Wellington, August 2004

An Overview of Palliative Care Issues in Waterloo Region and Wellington and Dufferin Counties, Waterloo Region Wellington Dufferin District Health Council, 2003	
Palliative care services sector in Waterloo Region and Wellington and Dufferin	
Purpose/Objectives	To identify the planning needs for palliative care services; To identify issues and challenges that need to be addressed in order to provide a comprehensive, quality, integrated palliative care system
Report Highlights	Identifies issues and challenges across the planning district and suggests potential solutions to respond to the identified service issues.
Population needs highlighted in report	
Integration Recommendations	Coordination and organization of the palliative care system Information to support system development (data collection and analysis, quality management and evaluation, research;
System Gaps/system requirements	Identified need for: • Pain and symptom management resources • Information sharing and referral • Palliative care beds • Palliative care physicians • Palliative care education and training • System coordination • Dedicated funding support Recommend that the MOHLTC undertake a comprehensive policy framework describing how palliative care services will be organized and delivered in Ontario.
Alignment with themes identified through LHIN IHSP consultation	Palliative Care
Alignment with Provincial Priorities	

Source: Waterloo Region Wellington Dufferin District Health Council, 2003

<table>
<tr><th colspan="2">Community Forum Report: Addressing the Needs of Children, Youth, Individuals and Families Living in Guelph-Wellington, 2004</th></tr>
<tr><td colspan="2">Guelph-Wellington community action plan</td></tr>
<tr><td>Purpose/Objectives</td><td>Summary of the United Way of Guelph-Wellington’s Social Planning Committee annual community forum, with Community Action Plan</td></tr>
<tr><td>Report Highlights</td><td>Includes recommendations for action by both the United Way and by other organizations and planning groups, based on community needs identified in “A Snapshot of Children, Youth, Individuals and Families Living in Guelph-Wellington. Part 1: Pre-Forum Report”</td></tr>
<tr><td>Population needs highlighted in report</td><td></td></tr>
<tr><td>Integration Recommendations</td><td>Identify transportation needs and develop a coordinated response</td></tr>
<tr><td>System Gaps/system requirements</td><td>Improve access to information by:
Exploring the establishment of a 211 community information service for Guelph-Wellington
Updating the Blue Book and Community Links Website
Developing a Community Data Warehouse
Establishment of a Data Consortium
Produce a list of local cultural interpreters and related services
Establish “Welcome Centres” that would house a variety of social resources (e.g., social service agencies, housing, justice, employment, cultural interpretation etc.)
Establish a vision for Alternative Education in Guelph Wellington
Implement the Rent Supplement and affordable housing supply initiative, as documented in the County of Wellington Affordable Housing Strategy
Establish a Housing Resource Centre
Update the Community Housing Plan
Provide forums to address children’s issues</td></tr>
<tr><td>Alignment with themes identified through LHIN IHSP consultation</td><td></td></tr>
<tr><td>Alignment with Provincial Priorities</td><td></td></tr>
</table>

Source: United Way of Guelph-Wellington, 2004

Community Trends in Cambridge and North Dumfries, 2006	
Local Trends and Issues in Cambridge and North Dumfries	
Purpose/Objectives	The report identifies local trends and issues so that funders, policy makers and planners can make informed choices and address the needs of Cambridge and North Dumfries.
Report Highlights	Community Profile, including demographic characteristics Community Trends, providing information on service levels and needs
Population needs highlighted in report	• Supports and Services for Youth • Supports and Services for Older Adults • Supports and Services for those with Disabilities • Rural Supports and Service • Transportation Services • Access to Emergency Food Supports • Access to Housing • Health Services and Supports • Community Safety and Supports
Integration Recommendations	N/A
System Gaps/system requirements	Health related trends: • More people without a family physician due to continued shortage of family physicians • More people waiting in the community for placement in a long term care home due to shortage of long term care beds • Decrease in hospital inpatient days due to a shift toward day surgery and decreasing wait times for long term care placement from the hospital • More youth participation in community recreational activities • Increase in outreach services to people with disabilities • Increase in Meals on Wheels and home maintenance services, with a decrease in number accessing home help.
Alignment with themes identified through LHIN IHSP consultation	Primary care Services for seniors Community Services Services for Specific populations (people with disabilities)
Alignment with Provincial Priorities	

Source: Social Planning Council of Cambridge and North Dumfries, 2006

<table>
<tr><th colspan="2">Community Needs and Capacity Assessment, Woolwich Community Health Centre, May 2005</th></tr>
<tr><td colspan="2">People living within the catchment area of Woolwich Community Health Centre (Woolwich township and a portion of Wellesley township</td></tr>
<tr><td>Purpose/Objectives</td><td>To learn about the factors that affect health, the health status and the strengths that exist within the catchment area.
To identify specific needs of vulnerable populations within the community to inform future planning for access to the services and supports that would improve community health status and capacity.</td></tr>
<tr><td>Report Highlights</td><td>Significant determinants of health that affect the population include family income, education and literacy, transportation, farm safety and security, senior housing, and the environment.</td></tr>
<tr><td>Population needs highlighted in report</td><td>People living in the community reported that they are generally healthy. However, vulnerable populations were identified including low income seniors, low income families, Low German speaking Mennonites from Mexico, and people with significant mental health problems. Issues identified that impact on health include:
moderate to high stress levels across all age groups and income levels.
mental health and the lack of accessibility of services and supports,
deteriorating lifestyle habits related to diet and exercise</td></tr>
<tr><td>Integration Recommendations</td><td></td></tr>
<tr><td>System Gaps/system requirements</td><td>Strategic Planning document for Woolwich Community Health Centre, to be use to inform future planning for access to services that would improve population health status.</td></tr>
<tr><td>Alignment with themes identified through LHIN IHSP consultation</td><td>Prevention/Promotion: determinants of health
Mental Health: access to services
Special Populations: Mennonite
Accessibility: transportation</td></tr>
<tr><td>Alignment with Provincial Priorities</td><td>Making Ontarians Healthier</td></tr>
</table>

Source: Woolwich Community Health Centre, 2005

Health Human Resources Capacity and Utilization, Waterloo Region Wellington Dufferin District Health Council, 2003	
Health care system-wide report focussing on Health Human Resources	
Purpose/Objectives	To develop a knowledge base regarding staff redeployment strategies that have been implemented to address health human resource issues, and to what extent they have been successful or unsuccessful. The Ministry of Health and Long Term Care requested this advice to help inform policy development.
Report Highlights	Results of a one day forum indicate that: • HHR efforts continue to focus on recruitment and retention strategies; • Staff redeployment efforts focus on maximizing skills within the scope of practice, moving to team-based care, training initiatives re: skill mix, 'borrowing' skills from other agencies, and shifting to generic workers whose responsibilities are more flexible.
Population needs highlighted in report	
Integration Recommendations	• System-wide HHR planning requires up-front costs to realize long-term efficiencies.
System Gaps/system requirements	• System-wide HHR planning requires up-front costs to realize long-term efficiencies. • HHR planning requires support from policy and planning positions developed at the provincial and national levels • Ministry of Health and Long Term Care HHR planning has focussed on physician supply, and needs to expand to include other HHR professionals
Alignment with themes identified through LHIN IHSP consultation	Health Human Resources/Personnel Planning and Resources
Alignment with Provincial Priorities	

Source: Waterloo Region Wellington Dufferin District Health Council, 2003

Implementation of the Model of Specialized Geriatric Services in Waterloo Region, Waterloo Region Wellington Dufferin District Health Council, 2002-03	
Elderly persons with complex geriatric needs living in Waterloo Region	
Purpose/Objectives	To determine next steps for implementing the previously developed model for geriatric/psychogeriatric service delivery in Waterloo Region, which will increase geriatric service capacity in Waterloo Region.
Report Highlights	• Examines service linkages between hospital inpatient units, emergency departments, community CCAC services and LTC Facilities. • Program logic model (blueprint) of ideal Specialized Geriatric Service System developed, including required components of the model, outcomes of improving the service delivery system, and activities required to implement the desired model.
Population needs highlighted in report	Elderly persons with complex geriatric needs
Integration Recommendations	• Need for area-wide, cross-sectoral planning for a coordinated model of geriatric/psychogeriatric services. • Need for a Waterloo Region education and training program for Specialized Geriatric Services.
System Gaps/system requirements	
Alignment with themes identified through LHIN IHSP consultation	• Senior Care: community, LTC Facility, psychogeriatrics • System Efficiency: Coordination of services
Alignment with Provincial Priorities	

Source: Waterloo Region Wellington Dufferin District Health Council, 2002-03

Rural Health Study In Waterloo Region, Waterloo Region Public Health, 2004	
Seniors, youth, conservative Mennonites, families and farmers living in the rural areas of Waterloo Region. Examines rural culture, community, demographics, economy, physical environment, and supports, services and access.	
Purpose/Objectives	To gain a better understanding of the factors that affect the health of residents in the rural area of Waterloo region in order to identify ways to improve and maintain health
Report Highlights	• Rural-based organizations struggle to keep up with demand for service. • Lack of physicians results in health system accessibility difficulties including the need to travel outside of the area, using urgent care facilities and not receiving health care. • Increase public awareness regarding available resources • Impact of the lack of affordable housing, transportation and employment opportunities, especially on seniors, young people, single-parent families and other people living on low incomes. • Lack of social, recreational and employment opportunities for youth.
Population needs highlighted in report	Seniors, youth, conservative Mennonites, families and farmers living in the rural areas of Waterloo Region. Examines rural culture, community, demographics, economy, physical environment, and supports, services and access.
Integration Recommendations	• Identifies the need for more health, community and social service integration. • Collaborate with rural community agencies to investigate effective ways to get information to rural residents • Ensure access to information is more available, more coordinated. • Increase investment in outreach programming, e.g. mobile services
System Gaps/system requirements	Recognize "rural" as a vulnerable population in Waterloo Region, Use information from the Rural Health Study to plan and deliver Public Health Services to the townships in Waterloo Region.
Alignment with themes identified through LHIN IHSP consultation	• Accessibility: Primary Care • Transportation • Geography
Alignment with Provincial Priorities	

Source: Waterloo Region Public Health, 2004

Wellington Dufferin Expert Geriatric Service Project, Final Report, Waterloo Region Wellington Dufferin District Health Council, 2005	
Elderly persons with complex geriatric needs living in Wellington and Dufferin Counties	
Purpose/Objectives	To develop a model for the delivery of expert (specialized) geriatric service delivery in Wellington Dufferin, which will increase geriatric service capacity.
Report Highlights	• Examines service linkages between hospital inpatient units, emergency departments, community CCAC services and LTC Facilities. • Model for Expert (specialized) Geriatric Service System developed, including required service components of the model, outcomes of improving the service delivery system, and activities required to implement the desired model.
Population needs highlighted in report	Elderly persons with complex geriatric needs
Integration Recommendations	Recommended model includes a focus on psychogeriatric/geriatric system integration, including: • Central/joint intake • Common assessment tool • Shared protocols • Shared case conferencing and education, and • Joint management committee Single database for the integrated service to support evaluation and reporting
System Gaps/system requirements	• Need for an Expert Geriatric Service with two arms,: geriatric medicine and geriatric psychiatry;
Alignment with themes identified through LHIN IHSP consultation	• Senior Care: community, LTC Facility, psychogeriatrics • System Efficiency: Coordination of services
Alignment with Provincial Priorities	

Source: Waterloo Region Wellington Dufferin District Health Council, 2005

Where Urban and Rural Meet: Looking at Quality of Life in the Township of North Dumfries, March, 2006	
Community priorities facing the Township of North Dumfries	
Purpose/Objectives	The paper examines assets and challenges in the Township of North Dumfries, and identifies community priorities.
Report Highlights	Community Profile including: • Population demographics and characteristics; • Community Supports and Basic Services, and • Personal and Community Health.
Population needs highlighted in report	Healthcare was identified as the top issue presently facing the township, specifically regarding: • Shortage of doctors; • Access to health facilities • Substance abuse identified as a moderate issue; • Lack of supports for aging population (e.g., no LTC home in township). Issues related to Community Supports and Basic Services • Lack of services and supports for youth identified as important issue facing the township; • Need for day-care to support the many commuting parents living in the township • Create a drop-in centre for youth • Expand recreation and leisure programs to meet needs of families, seniors and youth; • Make recreational facilities wheelchair accessible.
Integration Recommendations	**N/A**
System Gaps/system requirements	Shortage of doctors; Limited access to health facilities; Need for Substance Abuse services and supports; Lack of supports for aging population (e.g., no LTC home in township).
Alignment with themes identified through LHIN IHSP consultation	
Alignment with Provincial Priorities	

Source: Social Planning Council of Cambridge and North Dumfries, March 2006

Sectoral Reports:

Primary Care:

Facilitating the Primary Care Reform Agenda: A Proposed Role for the Community Care Access Centre of Wellington-Dufferin and the Community Care Access Centre of Waterloo Region, CCAC of Wellington-Dufferin and CCAC of Waterloo Region, 2005	
Primary Care, Community Care Access Centres	
Purpose/Objectives	Identifies opportunities for CCAC involvement in support of transforming the primary care services system in Waterloo Region and Wellington County.
Report Highlights	In addition to identifying opportunities for CCAC involvement in primary care service delivery, the report suggests that the CCAC could play a lead role in supporting system development, by leading the development of a single mechanism that will enable the primary care sector in Waterloo Region and Wellington County to speak with one voice on issues pertaining to the organization, management and delivery of primary care services.
Population needs highlighted in report	
Integration Recommendations	CCACs can support the primary care reform agenda by: • Working with Family Health Teams, specifically assuming the role of system navigator • Expanding the Community Health Information Network to serve as an enabler for the development of an integrated health record, • Partnering with Family Health Teams in the management of chronic diseases and partnering with hospitals in the management of chronic diseases • Playing a leadership role in organizing the primary care sector to speak with one voice regarding the organization, management and delivery of primary care services.
System Gaps/system requirements	
Alignment with themes identified through LHIN IHSP consultation	• Health System Navigation • Access to Health Records/Information • System Efficiency
Alignment with Provincial Priorities	

Source: CCAC of Wellington-Dufferin and CCAC of Waterloo Region, 2005

Long Term Care and Community Supports Services:

<table>
<tr><th colspan="2">A Day in the Life of Community Based Long Term Care Services: Results of a one-day census in Waterloo Region and Wellington and Dufferin Counties, Waterloo Region Wellington Dufferin District Health Council, 2004</th></tr>
<tr><td colspan="2">Community long term care service system, including community support services, community care access centre services and long term care facility services in Waterloo Region and Wellington and Dufferin Counties.</td></tr>
<tr><td>Purpose/Objectives</td><td>The Central West Health Planning Information Network and the DHCs collaborated on a one-day census survey to collect information regarding community long term care services for the purposes of health planning</td></tr>
<tr><td>Report Highlights</td><td>All MOHLTC funded community support agencies, long term care facilities, community care access centres, and Children's Treatment Centres participated in the survey. The survey measured units of service provided in the planning district, and the findings compare service volumes between Waterloo and Wellington-Dufferin.</td></tr>
<tr><td>Population needs highlighted in report</td><td>Key population needs highlighted by the census:
The majority of recipients of long term care services are older adults and the frail elderly, particularly women.
Projections from this census indicate that the number of LTC facility beds operating in the district will be insufficient to meet demand as early as 2006.
Additional community-based resources will be required to prevent and delay institutionalization.
The level of community support services delivered on census day was noticeably lower in Wellington Dufferin than in Waterloo Region. There was also a higher rate of LTC Facility use in WD, potentially explained by the inadequate number of community resources.</td></tr>
<tr><td>Integration Recommendations</td><td>N/A</td></tr>
<tr><td>System Gaps/system requirements</td><td></td></tr>
<tr><td>Alignment with themes identified through LHIN IHSP consultation</td><td>Senior Care: community and LTC Facilities
Community Support Services: access and availability</td></tr>
<tr><td>Alignment with Provincial Priorities</td><td></td></tr>
<tr><td>Implementation Status</td><td>N/A</td></tr>
</table>

Source: Waterloo Region Wellington Dufferin District Health Council, 2004

A Needs Analysis for Supportive Housing for the Elderly in Waterloo Region, Wellington County and Dufferin County, Waterloo Region Wellington Dufferin District Health Council, 2003	
Frail and or cognitively impaired elderly persons living in WRWD whose service requirements justify the need for availability of 24 hour on-site assistance.	
Purpose/Objectives	MOHLTC requested report to analyze and review the need for supportive housing for the elderly in the district.
Report Highlights	• Identification of the need for supportive housing for the elderly in the district • Description of best practice models of supportive housing both in rural and urban locations
Population needs highlighted in report	At time of report, no supportive housing services for the elderly existed in the district.
Integration Recommendations	Increase public and stakeholder awareness of the need for this service, and of the opportunities for partnerships and steps toward implementation
System Gaps/system requirements	There are no supportive housing services for the elderly in the district. Recommend the endorsement by the WRWDDHC of a 4% benchmark for phasing in supportive housing (i.e. 4%of the population aged 75+ by 2006, or 1,598 living units.
Alignment with themes identified through LHIN IHSP consultation	Senior Care: Community care
Alignment with Provincial Priorities	

Source: Waterloo Region Wellington Dufferin District Health Council, 2003

Overview of Long Term Care Facilities in Waterloo Region and Wellington and Dufferin Counties, Waterloo Region Wellington Dufferin District Health Council, 2001	
Waterloo region and Wellington and Dufferin Counties; frail seniors and adults with physical disabilities living in LTC facilities;	
Purpose/Objectives	Examination of LTC facilities in order to better understand the impact of changes that are occurring in the LTC facility sector.
Report Highlights	Resident characteristics noted in the report include: • Over half of residents have both physical disabilities/frailty and cognitive disorders; • Almost a quarter of residents are physically frail; • A significant proportion of residents have cognitive impairments but are not physically frail; • Approximately 10% of residents have mental health needs, behavioural problems and/or developmental disabilities.
Population needs highlighted in report	Report examines needs of LTC residents including adults under age 65, and elderly with physical and/or cognitive impairments
Integration Recommendations	Monitor the extent to which LTC service systems are able to work together to meet the needs of area residents requiring LTC services and supports.
System Gaps/system requirements	• Specialized programming is required for the increasing number of younger residents (under 65) with physical disabilities; • Occupancy rates have been between 95% and 100% throughout the area, with growing CCAC waiting lists for placement. • CCAC budgets may not be sufficient to support the high needs of clients living in the community, resulting in earlier moves form the community to LTC Facilities.
Alignment with themes identified through LHIN IHSP consultation	• Senior Care: LTC Facilities; Psychogeriatrics • Special Population: Disabled
Alignment with Provincial Priorities	

Source: Waterloo Region Wellington Dufferin District Health Council, 2001

<table>
<tr><th colspan="2">Strengthening Services for People with Alzheimer Disease and Related Dementias in Waterloo Region, Wellington County and Dufferin County, Waterloo Region Wellington Dufferin District Health Council, 2004</th></tr>
<tr><td colspan="2">Persons, families and caregivers living with dementia in Waterloo Region and Wellington and Dufferin Counties.</td></tr>
<tr><td>Purpose/Objectives</td><td>To strengthen the service system for people, families and caregivers living with dementia, the MOHLTC requested the establishment of Dementia Networks.</td></tr>
<tr><td>Report Highlights</td><td>Dementia Networks are designed to:
Facilitate people and resources coming together, and enhance partnerships and linkages between sectors
Provide a mechanism to increase the impact of other relevant provincial Alzheimer Strategy Initiatives
Improve responsiveness and accessibility of organizations to provide coordinated care for people living with dementia
Ensure knowledge is shared between service providers, professionals, caregivers, agencies and organizations in regards to services and effective best practices.</td></tr>
<tr><td>Population needs highlighted in report</td><td></td></tr>
<tr><td>Integration Recommendations</td><td></td></tr>
<tr><td>System Gaps/system requirements</td><td>Sustainability of the Networks is an issue as seed money for their establishment ended in 2004.</td></tr>
<tr><td>Alignment with themes identified through LHIN IHSP consultation</td><td>Senior Care: psychogeriatrics</td></tr>
<tr><td>Alignment with Provincial Priorities</td><td></td></tr>
</table>

Source: Waterloo Region Wellington Dufferin District Health Council, 2004

Toward 2006: Directions for Community Long Term Care Services in Waterloo Region and in Wellington and Dufferin Counties, Waterloo Region Wellington Dufferin District Health Council, 2002	
Community-based long term care services in Waterloo Region and Wellington and Dufferin Counties, serving people of all ages who require health care at home, the elderly, people with physical disabilities, and children with special needs.	
Purpose/Objectives	Toward 2006 is a consolidation report on the service needs and issues of the community long term care service sectors, including Community Care Access Centres, community support services, and Children's Treatment Centres.
Report Highlights	The report recommends strengthening the capacity of community-based long term care services, preventing or delaying the need for higher levels of institutional care.
Population needs highlighted in report	Profiles consumer trends in needs for services, highlighting the needs of older adults, people with physical disabilities and children with special needs. Caregiver issues are also highlighted, noting the need for additional caregiver support as they endeavour to maintain their family members in their homes in the community.
Integration Recommendations	Monitor and document changes across the health system to examine the outcomes of initiatives that have been implemented to fill identified gaps in community-based long term care services.
System Gaps/system requirements	Identified needs/gaps in service that require follow-up implementation planning: • Development of a program proposal to address identified service needs for people with acquired brain injury; • Planning for a coordinated children's rehabilitation system in WRWD; • Planning for a Specialized Geriatric Service model in Waterloo Region; • Planning for the development of Home Help Community Support Services in Wellington County • A review of services for people with HIV/AIDS • A needs assessment for Supportive Housing for the Elderly • A review of palliative care planning needs • An analysis of Community Support utilization by population • An assessment of the needs of complex clients with long term care and mental health needs
Alignment with themes identified through LHIN IHSP consultation	• Senior care – community and LTC Facility • Psychogeriatrics • Palliative care • Community Support Organizations – access and availability
Alignment with Provincial Priorities	
Implementation Status	Based on the system gaps identified in the community-based LTC sector, WRWDDHC undertook further planning in the areas of ABI, Children's Rehabilitation, Specialized Geriatric Services, Supportive Housing for the Elderly, Palliative Care and Community Support Service utilization. These planning reports are included in the literature review.

Source: Waterloo Region Wellington Dufferin District Health Council, 2002

Acute Care:

<table>
<tr><td colspan="2">Waterloo Region Health Services Restructuring Report, Health Services Restructuring Commission, August 1998</td></tr>
<tr><td colspan="2">Acute Care, Complex Continuing Care (CCC) and hospital-based mental health and rehabilitation services in Waterloo Region</td></tr>
<tr><td>Purpose/Objectives</td><td>Final Directions and Advice regarding health services restructuring to Waterloo Region hospitals</td></tr>
<tr><td>Report Highlights</td><td>The HSRC Directives included hospital system sizing, directives regarding new services, directives regarding hospital governance and directives regarding program transfers.</td></tr>
<tr><td>Population needs highlighted in report</td><td></td></tr>
<tr><td>Integration Recommendations</td><td>HSRC directed bed allocation for Waterloo Region:
Application of the HSRC efficiency methodology provides an estimation of the required number of beds for 2003:
Acute 537
Rehabilitation 117 (local – 93, regional – 19, transitional to independent living – 5)
CCC 198
Mental Health 134 (acute adult – 76, child and adolescent – 8, longer term – 50)

(note: HSRC also recommended a level of care termed sub-acute, with 61 beds recommended by 2003)</td></tr>
<tr><td>System Gaps/system requirements</td><td>HSRC directives for the sizing of Waterloo Region hospital system are made with the caveat that reinvestment in community-based services is required before the closure of any acute or chronic care beds.
Directives include:
• a Regional Cancer Centre, Cardiac Centre, and MRI.
• Retain separate governance structures for the three hospitals in Waterloo region
• Establish of a Joint Executive Committee which will develop a joint strategic plan for hospital services in Waterloo Region
• Program transfers to support Cancer Centre at GRH (oncology, neurosurgery, trauma)</td></tr>
<tr><td>Alignment with themes identified through LHIN IHSP consultation</td><td></td></tr>
<tr><td>Alignment with Provincial Priorities</td><td></td></tr>
</table>

Source: Health Services Restructuring Commission, August 1998

Wellington County Hospitals Network Report to the Health Services Restructuring Commission Re: Rural/Northern Hospital Restructuring, September, 1999	
Acute Care, Complex Continuing Care (CCC) and hospital-based mental health and rehabilitation services in Wellington County	
Purpose/Objectives	The Report contains recommendations to the Health Services Restructuring Commission on the sizing and siting of hospital-based services for Wellington County. These recommendations were determined by the Wellington County Hospitals Network (WHCN) by analyzing CIHI data and applying the HSRC benchmarks.
Report Highlights	WCHN recommends the sizing and siting of acute care, rehabilitation, complex continuing care and mental health services for Wellington County for 2003
Population needs highlighted in report	
Integration Recommendations	WCHN recommended bed allocation by type of service: Application of the HSRC efficiency methodology provides an estimation of the required number of beds for 2003: Acute – 273 Rehabilitation – 41 (short term – 11, long term – 30) CCC – 95 Mental Health 67 (Acute Adult - 42, Severe and Persistent Mentally Ill – 17, Psycho- geriatric - 8. (note: HSRC also recommended a level of care termed sub-acute, with 30 beds recommended by 2003) Note: The WCHN also recommended regional mental health services for Wellington County residents, including 4 beds for children and adolescent mental health and 3 beds for dual diagnosis services)
System Gaps/system requirements	N/A
Alignment with themes identified through LHIN IHSP consultation	
Alignment with Provincial Priorities	

Source: Wellington County Hospitals Network, 1999

Rehabilitation:

Report of the Waterloo Region Wellington Dufferin ABI Model Development Project, Waterloo Region Wellington Dufferin District Health Council, 2004	
Post-Acute services for persons with Acquired Brain Injury and their families living in Waterloo Region and Wellington and Dufferin Counties	
Purpose/Objectives	To develop a community-based service model for the provision of post-acute rehabilitation and functional skill development for adult residents of the district with an acquired brain injury.
Report Highlights	Proposed model is comprised of: • Features or functions that are needed to support persons with an ABI and their families • Descriptions of what each of the features should ideally include
Population needs highlighted in report	Recognizes that there are significant limitations in the services available for persons with an ABI and their families.
Integration Recommendations	Recommendations include: • Service components, which include direct, clinically focussed services to individuals and their families and caregivers, • System components, which include indirect services that assist the service system to function in a more coordinated, accessible way.
System Gaps/system requirements	
Alignment with themes identified through LHIN IHSP consultation	• Special Populations: Disabled • System Efficiency: Coordination of services
Alignment with Provincial Priorities	

Source: Waterloo Region Wellington Dufferin District Health Council, 2004

Wellington Dufferin Children's Rehabilitation Implementation Plan, Waterloo Region Wellington Dufferin District Health Council, 2004	
Children with rehabilitation needs living in Wellington and Dufferin Counties.	
Purpose/Objectives	The Ministry of Health acknowledged in 2001 the need to ensure that all children with rehabilitation needs have access to children's treatment centre based rehabilitation services. The purpose of the plan is to address the limited access of children in Wellington and Dufferin counties to these services.
Report Highlights	The Children's Treatment Centres whose catchment areas include Wellington and Dufferin Counties traditionally have not provided services to these areas due to distance, and the historical provision of these services by Community Care Access Centres.
Population Health Needs	Rehabilitation services for children and youth with multiple special needs
Integration Recommendations	• KidsAbility, the Children's Treatment Centre based in Waterloo Region is to expand it centre-based services in Guelph Wellington. • CCAC, Wee Talk, Early Childhood Development Program and other service providers to develop stronger linkages with the KidsAbility. • All partners to work together to deliver a more integrated and comprehensive system of children's rehabilitation services.
System Gaps/system requirements	Children and youth in Guelph Wellington have limited access to centre based children's rehabilitation services. Access to services should become less complex as a result of the clarification among service providers of the most appropriate first point of contact, which is determined by the needs of the child.
Alignment with themes identified through LHIN IHSP consultation	System Efficiency: coordination of services
Alignment with Provincial Priorities	

Source: Waterloo Region Wellington Dufferin District Health Council, 2004

Provincial Policy Reports on the Ontario Health Care System:

<table>
<tr><th colspan="2">Building the Foundation of a Strong Public Health System for Ontarians: 2005 Annual report of the Chief Medical Officer of Health, Ministry of Health and Long Term Care, 2005</th></tr>
<tr><td colspan="2">Public health</td></tr>
<tr><td>Purpose/Objectives</td><td>2005 Annual Report of the Chief Medical Officer of Health</td></tr>
<tr><td>Report Highlights</td><td>Emphasises Public Health system focus on:
• Health protection
• Chronic disease and injury prevention
• Healthy child development
• Family and community health
• Environmental health</td></tr>
<tr><td>Population needs Highlighted in Report</td><td></td></tr>
<tr><td>Recommendations with policy implications related to health system integration</td><td></td></tr>
<tr><td>Recommendations with policy implications related to health system gaps, system requirements or future directions</td><td>Strengthen capacity of public health system
Strengthen capacity of provincial Public Health lab
Strengthen capacity of Ontario’s public health units</td></tr>
<tr><td>Alignment with themes identified through LHIN IHSP consultation</td><td>Promotion/Prevention</td></tr>
<tr><td>Alignment with provincial priorities</td><td>Making Ontarians Healthy</td></tr>
</table>

Source: Ministry of Health and Long Term Care, 2005

Every Door Leads to Service: Enhancing Access and Building a Culture of Service Integration for a Made in Ontario Health System: A Discussion paper, August 2006	
Community-based services and supports for at-risk populations	
Purpose/Objectives	The report envisions a provincial health system that addresses the determinants of health as key to a healthy society, makes individuals and groups who are marginalized, isolated and at high risk of poor health outcomes a priority in each Local Health Integration Network (LHIN) and makes every door the right door to enter the health care system.
Report Highlights	Identifies system requirements to meet the vision, including: • A province-wide culture of service integration across healthcare sectors and providers, where client transitioning is understood as a commitment to ensuring that linkages across sectors and between providers support clients to successfully transition; • Local best practice initiatives and existing partnerships that aim to better integrate client care must be supported and adequately funded; • Current long-standing community governed services must be adequately resourced in order to build capacity to link clients to required services; • As part of the culture of service integration, local communities must have information on local health and community services easily available.
Population needs Highlighted in Report	At-risk populations and those who face barriers in accessing care and support are individuals who are socially isolated and marginalized in the community. Lengthy Waiting lists for services and supports increase the risk of poor health status for these individuals. In particular, low-income seniors with mental health issues are seriously under-served and in need of specialized support.
Policy directions related to health system integration	Build on existing community-based primary care, mental health and addiction and community support services to address integration and service collaboration in communities. Recommendations: • That the MOHLTC develop policy directives for LHINS and health service agencies outlining the responsibility of all health service organizations to put in place processes for transition planning for clients as they move through the system in their health care journey; • That LHINS undertake regular audits of existing partnerships and collaborations in each community and recognize these partnerships at the community level as the basis for LHIN local system planning; • That the MOHLTC and LHINS support and review the outcomes of collaborative best-practice initiatives across the province, champion successes and encourage duplication in other parts of the province; • That the MOHLTC and LHINS ensure that health human resources planning takes place across all health sectors and is not solely acute-care focused.
Policy directions related to health system gaps/system requirements or future directions	Build on existing community-based primary care, mental health and addiction and community support services to enhance services to populations in need.
Alignment with	Community services

themes identified through LHIN IHSP consultation	Mental health and addiction Primary care Services for specific populations

Source: Association of Ontario Health Centres, Ontario Community Support Association, Ontario Federation of Community Mental Health and Addiction Programs, August, 2006

Final Report of the Ontario Critical Care Steering Committee, 2005	
Critical Care	
Purpose/Objectives	To provide comprehensive recommendations to improve the quality and efficiency of Ontario's adult critical care services
Report Highlights	Recommendations focus on improving access to safe critical care by organizing services better, providing critical care supports, reducing the need for critical care through early interventions by intensivists, targeting efficiencies through better management and advancing best practices and knowledge transfer.
Population needs Highlighted in Report	
Recommendations with policy implications related to health system integration	Access to critical care through greater efficiencies and effectiveness that include system level and organization level solutions to meet minor, moderate and major surges in demand; Improvement of the Adult Critical Care patient's journey from Pre Critical Care (Transfer and Admission through Critical Care Unit (Diagnosis and Treatment) through to Post Critical Care (Discharge); Establishment of Critical Care Networks;
Recommendations with policy implications related to health system gaps, system requirements or future directions	Sufficient and appropriate human resources to meet the future need for critical care; Improved Critical Care technologies; Critical Care funding issues.
Alignment with themes identified through LHIN IHSP consultation	Accessibility Quality of Care Health Human Resources
Alignment with provincial priorities	Reduce Wait Times

Source: Ontario Critic al Care Steering Committee, 2005

Improving the Quality of Palliative Care Services for Cancer Patients in Ontario Cancer Care Ontario, 2006	
Palliative Care Services for cancer patients	
Purpose/Objectives	Working paper to advance dialogue on CCO's role in improving the quality of palliative care services. Presents the core components of CCO's palliative care strategy.
Report Highlights	Promotes a comprehensive model of care that is both disease/cure oriented and palliative/symptom oriented. The three components of the strategy are: • Improving measurement through development of quality indicators' • Increasing the use of evidence-based guidelines and standards, and • Fostering the development and uptake of tools to increase efficiency and access to care.
Population needs Highlighted in Report	Services for people with advanced or terminal illness and their families
Recommendations with policy implications related to health system integration	Promotes a system of care that meets patients needs and is focussed on: • System integration • Service integration • Improves the palliative client experience
Recommendations with policy implications related to health system gaps, system requirements or future directions	• Improve measurement • Increase the use of evidence • Increase access to services
Alignment with themes identified through LHIN IHSP consultation	• Palliative Care • System Efficiency
Alignment with provincial priorities	

Source: Cancer Care Ontario, 2006

Laying the Foundation for Change: A Progress Report on Ontario's Health Human Resource Initiatives, Ministry of Health and Long Term Care, 2005	
Health Human Resources	
Purpose/Objectives	Progress report on the province's health human resource initiatives that will support the transformation of the health care system
Report Highlights	Initiatives are categorized into six themes: Coordinating the education system with the health system; Gathering better data about current and future need; Improving access to doctors, nurses and other health care providers; Supporting providers to work collaboratively; Using innovative technologies, and Supporting providers in the workplace.
Population needs Highlighted in Report	
Recommendations with policy implications related to health system integration	
Recommendations with policy implications related to health system gaps, system requirements or future directions	In 2006, the health system and education system are to develop a comprehensive HHR strategy that will address short, medium and long term HHR needs.
Alignment with themes identified through LHIN IHSP consultation	Health Human Resources Planning
Alignment with provincial priorities	Improve access to doctors, nurses and health professionals

Source: Ministry of Health and Long Term Care, 2005

Noojimawin Health Authority: Aboriginal Community Profile for Waterloo Wellington LHIN, June 2006	
Aboriginal population living in urban centres of Waterloo Wellington	
Purpose/Objectives	Demographic profile and recommendations for health planning regarding needs of Aboriginal people living in Waterloo Wellington
Report Highlights	3900 people in Waterloo Wellington urban centres identified themselves as Aboriginal in the 2001 Canada census
Population needs highlighted in report	No Aboriginal health services available in Waterloo Wellington – population accesses mainstream health services
Integration Recommendations	• Recommends Aboriginal involvement in health planning processes, representation and public appointments
System Gaps/system requirements	• Recommend assessing Aboriginal disease patterns and health status, specifically related to health promotion/wellness, mental health and addiction, disease and illness prevention and long term care and disability • Recommend examining how Aboriginal people access health services in including issues related to languages and communication, patient advocacy, transportation, health facilities, training and coordination of traditional healing
Alignment with themes identified through LHIN IHSP consultation	
Alignment with Provincial Priorities	

Source: Noojimawin Health Authority, June 2006

Ontario Cancer Plan 2005-2008, Cancer Care Ontario	
Cancer Care	
Purpose/Objectives	The plan outlines a provincial strategy for improving the quality of cancer care throughout Ontario
Report Highlights	The Plan proposes targeted investments in three areas: • Treating more people to improve wait times • Transformational initiatives to enhance quality accessibility, and accountability, and • Capital development to cope with growth in cancer cases.
Population needs Highlighted in Report	The quality of cancer services across Ontario is uneven, as some people don't have access to consistent quality cancer services
Recommendations with policy implications related to health system integration	• Implement regional cancer programs
Recommendations with policy implications related to health system gaps, system requirements or future directions	• Close the gap by reducing demand for cancer services and increasing capacity • Implement rapid access strategies • Broaden the development and use of provincial standards and guidelines • Invest in performance measurement and accountability • Advance the coordination and focus of cancer research efforts in Ontario
Alignment with themes identified through LHIN IHSP consultation	Accessibility: specialist care
Alignment with provincial priorities	Wait times, improved accountability, and regional service integration

Source: Cancer Care Ontario, 2005

Optimizing the Role of Complex Continuing Care and Rehabilitation in the Transformation of the Health Care Delivery System, Ontario Hospital Association, 2006	
Complex Continuing Care and Rehabilitation	
Purpose/Objectives	Report aims to provide a broader understanding about the potential role the province's complex continuing care (ccc) and rehabilitation sectors play in integrating care along the care continuum.
Report Highlights	Potential to relieve health system pressures and strengthen health system capacity by optimizing the use of complex continuing care and rehabilitation.
Population needs Highlighted in Report	
Recommendations with policy implications related to health system integration	Further examination of the role of complex continuing care and rehabilitation is required so that system planners and decision makers can leverage the ccc and rehabilitation system to promote health system integration.
Recommendations with policy implications related to health system gaps, system requirements or future directions	Recommends increasing the capacity of the ccc and rehabilitation sectors to alleviate pressures on acute care, long term care and community-based care.
Alignment with themes identified through LHIN IHSP consultation	System Efficiency – coordination of services
Alignment with provincial priorities	

Source: Ontario Hospital Association, 2006

Primary Care Health Strategy Health Services Restructuring Commission, 1999	
Primary Health Care in Ontario	
Purpose/Objectives	To provide a detailed action plan to create a true system of primary health care in Ontario
Report Highlights	This plan identifies the resources and professional teams needed to serve patients in a reorganized primary health care system, focussing on the principles of Enhanced Quality, Accessibility and Affordability.
Population needs Highlighted in Report	The aging population, the changing health care consumer, and hospital restructuring emphasize the need to have a comprehensive primary health care system for all Ontarians.
Recommendations with policy implications related to health system integration	Recommends primary health care group practices (operationalized within Ontario as Family Health Teams and the expansion of Community Health Centres). Waterloo Wellington has been awarded 9 Family Health Teams, and has 4 Community Health Centres with 3 satellite CHCs.
Recommendations with policy implications related to health system gaps, system requirements or future directions	The inappropriate use of emergency departments for primary care is taxing hospital resources. The shortage of physicians can be addressed by creating teams of primary care providers (physicians, nurse practitioners and others) who can work within their full scope of practice to maximize primary health care resources. **Recommendation: Primary Health Care Group Practices** (operationalized within Ontario as Family Health Teams and the expansion of Community Health Centres)
Alignment with themes identified through LHIN IHSP consultation	Accessibility: primary Care
Alignment with provincial priorities	Improve Access to doctors, nurses and health professionals

Source: Health Services Restructuring Commission, Advice and Recommendations to the Honourable Elizabeth Witmer, December, 1999

Provincial Status Report: Ontario Stroke System, Provincial Steering Committee, Ontario Stroke System, 2006	
Stroke system including services and supports provided across the continuum of care	
Purpose/Objectives	To draw attention to the opportunities for continued stroke care integration, building on the success of regional stroke development
Report Highlights	Outlines the Ontario Stroke Strategy stroke system development with regard to system components: primary prevention; secondary prevention; stroke recognition and emergency response; acute care; rehabilitation; community re-engagement; and transitions between sectors
Population needs Highlighted in Report	More equitable access to stroke system components across the continuum of care is required; Further designation of district stroke centres is required; Need for an appropriate array of rehabilitation services; and Need for more secondary prevention services.
Recommendations with policy implications related to health system integration	OSS has determined that a coordinated system for stroke relies on the patient's smooth and timely transition across the continuum of care. Facilitated by the appropriate flow of information for clinical management.
Recommendations with policy implications related to health system gaps, system requirements or future directions	
Alignment with themes identified through LHIN IHSP consultation	• System efficiency: coordination of services • Access to Health Records/Information
Alignment with provincial priorities	

Source: Provincial Stroke System Steering Committee, Ontario Stroke System, 2006

Realizing the Potential of Home Care: Competing for Excellence by Rewarding Results, CCAC Procurement Review, Caplan, 2005	
Home Care, including post-acute care, rehabilitation, end-of-life care, and ongoing care for people with chronic illnesses.	
Purpose/Objectives	To determine the impact of the procurement process to acquire client services on quality, price and workforce stability, including determining if the ministry policy is achieving the intended outcomes and if CCAC's are adhering to the policy; and To make recommendations for potential improvements to the procurement process for client services.
Report Highlights	The report makes 70 recommendations in three key areas: • Sustaining client-focussed Quality home care services; • Stabilizing the Home Care Workforce; • Improving Procurement Practices.
Population needs Highlighted in Report	
Recommendations with policy implications related to health system integration	• Reduce the number of CCACs from 42 to 14, aligning with the Local Health Integration Networks; • Improve continuity of care by having CCACs partner with hospitals to coordinate inpatient, emergency and outpatient discharge planning; • Improve continuity of care by ensuring better communication between all workers providing care to individual clients; •
Recommendations with policy implications related to health system gaps, system requirements or future directions	• Promote workforce stability through longer term contracts and additional funding and supports for providers and additional support for people who provide home care services (personal support workers, nurses, therapists). • Ensure stability and continuity of care for clients during contract changes, especially for vulnerable clients, children and those receiving end-of-life care
Alignment with themes identified through LHIN IHSP consultation	• Health Human Resources Planning • Quality • Coordination
Alignment with provincial priorities	Improve the planning, management and coordination of services throughout the health care system

Source: CCAC Procurement Review, 2005

The Métis **Nation of Ontario: Metis Nation Specific Provisions in the Transformation Agenda, Submission to the Ministry of Health and Long Term Care, November 2005**	
Health and demographic profile of Metis Nation of Ontario	
Purpose/Objectives	Métis Nation of Ontario submission to the Ministry of Health and Long Term Care on Implications of LHINs on Métis people.
Report Highlights	• Demographic profile – younger median age (27 vs. 38 for general population) • Socio demographic profile – disadvantaged re: employment and income • Definition of health to Métis Nation • Population health needs – Chronic conditions, other determinants of health
Population needs Highlighted in Report	• Arthritis and rheumatism: more than double the rate of the general population • High blood pressure: 14% of urban Métis and 12% of rural Métis compared to 9% of general population • Asthma: 13% prevalence rate for Metis vs. 10% in the general population • Diabetes: three times higher in the Métis population than the general population • Heart problems: 1 in 15 reporting heart disease • Mental health: high incidence of depression and attempted/completed suicide
Policy directions related to health system integration	• Recommend establishment of a Métis Nation of Ontario Health Authority • Recommendations include provisions for Métis Nation involvement in LHIN governance
Policy directions related to health system gaps/system requirements or future directions	
Alignment with themes identified through LHIN IHSP consultation	Chronic disease management
Alignment with provincial priorities	

Source: Métis Nation of Ontario, November, 2005

<table>
<tr><th colspan="2">The Time is Now: Themes and Recommendations for Mental Health Reform in Ontario, Final report of the Provincial Forum of Mental Health Implementation Task Force Chairs, 2002</th></tr>
<tr><td colspan="2">Mental health system including services and supports provided across the continuum of care</td></tr>
<tr><td>Purpose/Objectives</td><td>Sets out recommendations for mental health system reform in Ontario</td></tr>
<tr><td>Report Highlights</td><td>• Recommends regional systems of mental health care that will be responsible for the delivery of a core basket of services and supports
• Identifies issues that are provincial in scope</td></tr>
<tr><td>Population needs Highlighted in Report</td><td>Gaps were identified in the service and support continuum throughout the province. Identified services for expansion include peer support, housing, education, employment and income supports.</td></tr>
<tr><td>Recommendations with policy implications related to health system integration</td><td>Streamline access to services for people living with mental illness and their families.</td></tr>
<tr><td>Recommendations with policy implications related to health system gaps, system requirements or future directions</td><td>Development of a system that delivers a continuum of care, with programs, services and supports available at every stage of life and as close to home as possible;
Provide caregiver services and supports;</td></tr>
<tr><td>Alignment with themes identified through LHIN IHSP consultation</td><td>Mental Health: access to services
Caregiver Support</td></tr>
<tr><td>Alignment with provincial priorities</td><td></td></tr>
</table>

Source: Provincial Forum of Mental Health Implementation Task Force Chairs, 2002

The Wait Time Strategy, Ministry of Health and Long Term Care, 2004	
Cancer surgery, cardiac care, cataract surgery, hip and knee replacements, and MRI/CT scans	
Purpose/Objectives	To provide background information on Ontario's Wait Time Strategy, which is intended to reduce the time that people wait for cancer surgery, selected cardiac procedures, hip and knee total joint replacements, cataract surgery and MRI/CT scans.
Report Highlights	Describes the reasons for Ontario Wait Time Strategy, the focus of the wait (between seeing a specialist and receiving the prescribed surgery of diagnostic intervention), describes a "blueprint" for achieving the wait time targets
Population needs Highlighted in Report	
Recommendations with policy implications related to health system integration	
Recommendations with policy implications related to health system gaps, system requirements or future directions	Hospitals are responsible for achieving wait time targets through a "blueprint" containing five elements: • Accountability • Access Management • Capacity • Evaluation • Communication
Alignment with themes identified through LHIN IHSP consultation	Accessibility: Surgical Care Accessibility: Facilities (diagnostic)
Alignment with provincial priorities	Reduce Wait Times

Source: Ministry of Health and Long Term Care, 2004

Transition Planning in Health Care Systems, The Ontario Home and Community Care Council, 2004	
Community care, acute care	
Purpose/Objectives	To describe key quality processes for transition planning between acute care and community care
Report Highlights	Defines transition planning as an expanded discharge planning process focussing on the management of a complex two-way interface between and among institutions and community-based service providers.
Population needs Highlighted in Report	Transition planning is particularly important for those people with long term mental or physical illnesses who require on-going system support and move back and forth between the institutional and community sector.
Recommendations with policy implications related to health system integration	Recommends key quality processes (those activities which assist organizations in effectively meeting customer demands and are the basic building blocks of communication between health care providers within the system. Recommends a focus on: • Primary care and community services to emergency care and care within the acute sector, • From within acute care to the community, and • Within the community.
Recommendations with policy implications related to health system gaps, system requirements or future directions	
Alignment with themes identified through LHIN IHSP consultation	• System Efficiency: Coordination of transitions between health care providers/services; • Access to Health Records/Information
Alignment with provincial priorities	

Source: The Ontario Home and Community Care Council, 2004

National Reports on the Canadian Health Care System:

<table>
<tr><th colspan="2">Building a National Diabetes Strategy: A Strategic Framework volume 2, 2005</th></tr>
<tr><td colspan="2">Diabetes services and supports for Canadians</td></tr>
<tr><td>Purpose/Objectives</td><td>A comprehensive framework to mobilize all sectors in developing, implementing and evaluating an integrated and coordinated approach for reducing the social, human and economic impact of diabetes in Canada</td></tr>
<tr><td>Report Highlights</td><td>• Strategic approach to the prevention, early detection and management of diabetes
• Profile of Canadians with diabetes
• Associated risks from complications arising from diabetes
• Costs of diabetes
• Risk factors for diabetes
• Framework includes strategies for working with Aboriginal communities and populations to address diabetes.</td></tr>
<tr><td>Population needs Highlighted in Report</td><td>Recognizes the role of the broad determinants of health and the importance of addressing the needs of all members of the population in a variety of ways. For example, language and culture need to be considered when delivering programs.</td></tr>
<tr><td>Policy directions related to health system integration</td><td>Goal is to mobilize all sectors to develop an integrated, coordinated approach for reducing the social, human, and economic impact of all types of diabetes

Partnering with other sectors (than health) is recommended as factors influencing the onset of diabetes extend into the workplace, schools, recreation programs, transportation, industry, and the economic and political environments</td></tr>
<tr><td>Policy directions related to health system gaps/system requirements or future directions</td><td>Strategic directions:
• Support the development of healthy public policy
• Provide community based health promotion and prevention programs
• Provide accessible health services for prevention of diabetes in high-risk individuals and optimal diabetes education and management
• Develop human resource capacity and enhance the education of those who provide diabetes prevention and management programs and services
• Conduct research and evaluation, and support knowledge exchange
• Enhance surveillance</td></tr>
<tr><td>Alignment with themes identified through LHIN IHSP consultation</td><td>Chronic disease management</td></tr>
<tr><td>Alignment with provincial priorities</td><td></td></tr>
</table>

Source: Public Health Agency of Canada, 2005

Building on Values: The Future of Health Care in Canada, 2002	
Policy directions regarding the future of Medicare in Canada	
Purpose/Objectives	Report of the Commission on the Future of Medicare in Canada, intended as a roadmap to renewed and reformed health care system
Report Highlights	47 recommendations provided outlining actions that should be taken in 10 critical areas. In order to sustain Medicare.
Population needs Highlighted in Report	• Disparities in both access to care and health outcomes in some parts of the country, particularly for Aboriginal peoples and in the north • Healthcare needs are currently being met, but the system will require some adjusting to continue to meet the needs of an aging population
Policy directions related to health system integration	• Building Canada's health information technology infrastructure • Investing in health care providers • Primary health care renewal • Improving access to services and ensuring quality of care • Improving rural access • Home care as the next essential service • Establishing a catastrophic drug transfer • Addressing Aboriginal Health
Policy directions related to health system gaps/system requirements or future directions	N/A
Alignment with themes identified through LHIN IHSP consultation	N/A
Alignment with provincial priorities	

Source**: Building on Values: The Future of Health Care in Canada, Roy Romanow, 2002**

Emergency Department Overcrowding in Canada: What are the issues and What can be Done? Canadian Agency for Drugs and Technologies 2006	
Emergency Department Services	
Purpose/Objectives	To examine the issues and explore solutions to the overcrowding of emergency departments in Canada
Report Highlights	Reports on frequency and severity of ED overcrowding, some of the reasons for overcrowding, and suggests some potential solutions. The report also notes that there is no evidence of effectiveness for many of the broadly adopted interventions in Canada, and limited evidence of other strategies that are in place to address the issue.
Population needs Highlighted in Report	
Recommendations with policy implications related to health system integration	
Recommendations with policy implications related to health system gaps, system requirements or future directions	Emphasises the need for consistent and measurable information related to overcrowding, the need for electronic collection of data, a national data system, and consideration of fast tracking patients with minor injuries or illnesses.
Alignment with themes identified through LHIN IHSP consultation	Accessibility – Emergency Services
Alignment with provincial priorities	

Source: Canadian Agency for Drugs and Technologies 2006

Improving the Health of Young Canadians: Canadian Population Health Initiative, 2005	
Population health report on Canadian youth aged 12 -19	
Purpose/Objectives	Report explores the link between adolescents' social environments (families, schools, peers and communities) and their health.
Report Highlights	Highlights the association between positive assets in social environments and teens health behaviours and health status (for example, tobacco, alcohol drug use, self-worth) Focuses on healthy adolescent development models
Population needs Highlighted in Report	Looks at impacts of population health indicators (determinants of health) such as income, socioeconomic status, education, social support and social environments, employment and working conditions, early child development, physical environment, personal health and coping skills, biological and genetic factors, health services, gender, culture and media on teen health behaviours and health status
Policy directions related to health system integration	N/A
Policy directions related to health system gaps/system requirements or future directions	N/A
Alignment with themes identified through LHIN IHSP consultation	
Alignment with provincial priorities	

Source: Canadian Institute for Health Information, 2005

National Profile of Family Caregivers in Canada, Final Report, Health Canada, 2002	
Caregiver Support	
Purpose/Objectives	Provides a profile of caregivers in Canada, with information regarding type of care provided, coping with caregiver responsibilities, and employment impacts.
Report Highlights	Family caregivers in Canada as a group appear to be coping well with little formal support, although this role is creating stresses and personal difficulties, particularly among those caregivers who are employed
Population needs Highlighted in Report	Caregivers provide support to family members with a physical or mental disability, chronic illness or physical frailty. Other than respite care, caregiver service and support needs are not well documented, although they do report feeling stressed emotionally, financially and physically.
Recommendations with policy implications related to health system integration	
Recommendations with policy implications related to health system gaps, system requirements or future directions	Results of the study should inform policy makers regarding service and support development.
Alignment with themes identified through LHIN IHSP consultation	Caregiver Support
Alignment with provincial priorities	

Source: Health Canada, 2002

Partnership in Practice: Two Key Strategies Involving Home Care Yield High Impact Benefits for Primary Health Care In Canada, 2006	
Chronic disease management through collaboration between home care and primary care	
Purpose/Objectives	Describes the National Home Care and Primary Care Partnership Project
Report Highlights	Explores an augmented role for Homecare in partnering with family physicians in the management of chronic disease.
Population needs Highlighted in Report	
Policy directions related to health system integration	• Suggests alignment of home care case management with primary care physicians in order to strengthen primary care connections with the health care system • Suggests expanding the role of home care in chronic disease management • Continued investment and emphasis on the importance of electronic health records to ease transitions
Policy directions related to health system gaps/system requirements or future directions	
Alignment with themes identified through LHIN IHSP consultation	coordination
Alignment with provincial priorities	

Source: Canadian Homecare Association, 2006

<table>
<tr><th colspan="2">The Health of Canadians – the Federal Role, The Standing Senate Committee on Social Affairs, Science and Technology, 2002</th></tr>
<tr><td colspan="2">Health policy report recommending reform in hospital funding, governance, primary health care, post-acute home care, palliative home care, health care technology, measuring system performance, health human resource planning.</td></tr>
<tr><td>Purpose/Objectives</td><td>This report provides recommendations for reform and renewal of the Canadian health care system</td></tr>
<tr><td>Report Highlights</td><td></td></tr>
<tr><td>Population needs Highlighted in Report</td><td></td></tr>
<tr><td>Recommendations with policy implications related to health system integration</td><td>Includes recommendations on restructuring the current hospital and doctor system to make it more efficient and more effective in providing timely and quality patient care;</td></tr>
<tr><td>Recommendations with policy implications related to health system gaps, system requirements or future directions</td><td>• Recommends a health care guarantee that would ensure that patients receive treatment within a specified maximum amount of time for major hospital or diagnostic procedures;
• Recommends expanding public health care insurance to include coverage for catastrophic prescription drug costs, immediate post-hospital home care costs, and costs of providing palliative care for patients who choose to spend the last weeks of their lives at home;
• Recommendations that strengthen the federal contribution to, and role in, developing health care infrastructure, including health information systems, health care technology, the evaluation of health care system performance and outcomes, the supply of health human resources, health research, wellness promotion and illness prevention,</td></tr>
<tr><td>Alignment with themes identified through LHIN IHSP consultation</td><td>Palliative Care
Health Human Resources
Accessibility</td></tr>
<tr><td>Alignment with provincial priorities</td><td>Wait Time Strategy
Improves access to doctors, nurses and health professionals</td></tr>
</table>

Source: The Standing Senate Committee on Social Affairs, Science and Technology, 2002