Integration Framework

Community Health Ontario

Addictions and Mental Health Ontario
Association of Ontario Health Centres
Canadian Mental Health Association -- Ontario
Ontario Community Support Association

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INTEGRATION FRAMEWORK

About Community Health Ontario (CHO)

Community Health Ontario (CHO) is the voice of the LHIN-funded community sector, a strategic partnership between Addictions and Mental Health Ontario (AMHO), the Association of Ontario Health Centres (AOHC), the Canadian Mental Health Association - Ontario Division (CMHA ON) and the Ontario Community Support Association (OCSA). Together, CHO represents the majority of the non-profit home care, community support, mental health, addictions and community-governed primary health care organizations in Ontario.

CHO knows the sustainability of Ontario's health system depends on the ability to keep people healthy, avoiding the need for more costly care.[1] We envision healthy communities served by a vibrant network of community-governed, community-based, people-centred health services that are seamlessly coordinated with the full spectrum of care, including services that address the determinants of health. We envision 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, and makes every door the right door to enter the health care system.

CHO agrees with the World Health Organization that **health** is the ability to live to one's fullest potential. **Health care** treats and supports the whole person. It empowers people to make decisions and supports a healthy community. It removes systemic barriers to full and equal participation of people and their families or loved ones in maintaining or recovering their health.

The people our members serve face diverse and intersecting barriers such as age, chronic disease, disability, race, racialization, language, culture, geography, sexual and gender identities, mental health conditions, addictions, homelessness, food insecurity, poverty, among others. Our members' services aim to overcome these barriers through front-line, community-centred, consumer-driven and people-centred service delivery that is continuously improving. Our members are focused not only on treatment and support, but also on health promotion and prevention, including the determinants of health, in order to maintain people's health so they can live to their full capacity in our communities.

Integration: Ontario's Context

With the passage of the *Local Health System Integration Act* in 2006, the government of Ontario signalled its commitment to providing 'high quality, coordinated health care', planned and delivered at the local level.[2] The legislation articulated a vision of "an integrated health system

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[1]This fact is found in many sources, including the 2012 Commission to Reform the OPS, http://www.fin.gov.on.ca/en/reformcommission/chapters/ch5.html#ch5-e

[2] *McGuinty Government Strengthens Role of Local Communities in Health Care Decision.* Government of Ontario, Ministry of Health and Long-Term Care, March 1, 2006

that delivers the health services that people need, now and in the future."[3] Since then, the province's 14 Local Health Integration Networks (LHINs), whose powers were defined under the *Act,* have pursued that objective.

Community Health Ontario is supportive of efforts to integrate the manner in which health care is planned, organized and delivered. From our perspective, the true test of any integration initiative is whether or not it enhances the care provided to those the system was designed to serve. Integration must result in the improvement of the quality of life of people who use the system. We also believe that the health system – no matter how well designed, or how well resourced, cannot accomplish that task on its own. Truly integrated care can only be delivered when the health sector engages effectively with the broader social service sector and both systems work together in the interest of the client.

Our member agencies live the reality of integration – through their organizational values, their commitment to partnerships, and their approaches to service provision. Their clients face barriers to care – sometimes multiple and complex barriers. Meeting their needs often requires a coordinated response – one that integrates an array of community-based health services with acute, specialized and long-term care services, and, more broadly, with services that address the determinants of health. In our view, enhancing the system's capacity to deliver that type of integrated care must be the primary objective of all integration efforts.

With the amendments to the *Local Health System Integration Act* under Bill 210, the LHINs mandates expand to include responsibility for health equity, the reduction of health disparities, the determinants of health and health promotion. These new objects will be extremely supportive in enabling the LHINs to better bolster our members' efforts to deliver comprehensive, integrated, community-based services to support everyone's ability to attain health, including Ontario's most complex, vulnerable and marginalized residents.

Integration Definitions

Integration is defined as "services, providers, and organizations from across the continuum working together so that services are complementary, coordinated, in a seamless unified system, with continuity for the client."[4] The same source adds that "[i]ntegration is an ongoing process which must be developed and implemented within the context of population needs and focused on the goals of improved health outcomes and higher quality of care." Other definitions bring in the additional integration goals of improved access, client satisfaction, health system efficiencies and, importantly, the ability to better meet the needs of complex clients.[5]

The Local Health System Integration Act charged the LHINs with "promoting the integration of the local health system to provide appropriate, coordinated, effective and efficient health services".[6] In defining 'integration', the legislation identified five strategies:

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[3] Preamble – *Local Health System Integration Act,* 2006

[4] Suter, Oelke, Adair, et al, "Health Systems Integration", October 2007

[5] Compiled from Gröne & Garcia-Barbero (2001), Kodner & Spreeuwenberg (2002)

[6] *Local Health System Integration Act, 2006, S.O., 2006, C.4* available at: http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_06l04_e.htm

(a) to co-ordinate services and interactions between different persons and entities,

(b) to partner with another person or entity in providing services or in operating,

(c) to transfer, merge or amalgamate services, operations, persons or entities,

(d) to start or cease providing services,

(e) to cease to operate or to dissolve or wind up the operations of a person or entity.

As detailed in the section on integration enablers, evidence clearly demonstrates that by focusing the majority of their energies and resources on enabling the first and second strategies (i.e. service coordination and organizational partnerships), the LHINs will produce a health care system that delivers more integrated care from the perspective of people who use the system.

The power granted to the LHINs to order mergers, amalgamations and the dissolution of organizations must be used sparingly, and with great caution. There is little empirical evidence, from any jurisdiction or from any sector, that this type of restructuring is an effective strategy for achieving effective, sustainable integration. In fact, a significant body of literature[7] suggests that reliance on structural approaches has the opposite effect. That disappointing outcome results from a tendency to focus on the legal, structural and technical aspects of inter-organizational relationships and to neglect the 'softer' side – the 'people processes'.[8] No matter how well-intentioned, or how compelling they appear on paper, system change efforts that fail to respect the values, beliefs and principles of the individuals charged with implementing them will almost certainly not succeed. We will look at this more closely in a moment.

Integration Enablers

How, then, do we create a sustainable, integrated health system that operates effectively and efficiently and, above all else, meets the complex needs of diverse people in Ontario? Studies have consistently emphasized the importance of employing a wide range of flexible models, 'tailor-made' to fit each community and each set of circumstances, rather than a single 'one size fits all' solution.[9] In addition to that overarching principle, researchers have found that successful efforts to integrate health systems share the following features:

- They are person-centred, including client and caregivers' engagement and participation.[10]
- The integration process is driven from the bottom up, including:
    - Being based on trust and effective collaboration, including enabling consensus amongst all stakeholders on defining and working toward common goals, and shared sense-making;

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[7] See, for example: Grubb, Thomas M. and Robert Lamb (2000), Zimmerman, Brenda and Kevin Dooley (2001) and LaPiana (2009)

[8] Cartwright, Susan and Cary L. Cooper (1993), Dooley, Kevin and Brenda Zimmerman (2003)

[9] See, for example: Suter et al (2007), Shaw and Rumbold (2010), Kodner (2010) Pong, Sanders, Church et al (1995), Hughs and Weiss (2007), McEwan and Goldberg (2001)

[10] Kodner (2009, 2011), Suter et al (2009), Williams et al (2009)

    - Focusing on shared needs identified by those involved; and
    - Being voluntary not mandated.[11]
- They enable the cultural fit of all participants.[12]
- System leaders have a clear, compelling vision.
- The system's culture is congruent with this vision.
- Governance bodies are strong, varied and focused.
- The system employs a mix of strategies in pursuit of integration; the synergy between strategies can be as important as the individual strategies themselves.

More specifically,

- Successful integration initiatives are comprehensive in scope (i.e. cross-sectoral).
- Initiatives acknowledge and enhance pre-existing relationships among agencies.
- The patient/client/person is at the centre of the system and contributes, in a meaningful way, to the decision-making processes.
- Interprofessional teams deliver standardized care that is continuously improving.
- Service providers' roles and responsibilities are clearly defined.
- The human resource implications of all integration efforts are thoroughly examined and addressed with sensitivity.
- State-of-the-art information systems allow for secure, efficient communication among providers.
- System goals are clear and evaluation protocols are consistently implemented.
- Well developed performance management systems are in place.[13]

The research offers a few caveats - that integrated care is difficult to achieve, takes careful planning and adaptation, demands long-term commitment and requires significant investment of time and resources.[14]

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[11] Compiled from characteristics identified by Kodner (2011), Suter et al (2007), Goodwin et al (2004), Goodwin (2006), McEwan and Goldner (2001), Gray (1989)

[12] Hughs and Weiss (2007)

[13] Compiled from characteristics identified by Suter et al (2007), Kodner (2009 (2010), Kodner and Spreeuwenberg (2002) Shaw (2009), Shaw and Rumbold (2010)

[14] Shaw (2009), Shaw and Rumbold (2010), Kodner (2011), Suter et al (2007), Graham et al (2010)

Finally, effective reform of the provincial health system requires planning and coordination of services at three levels: the system level, community (or subregion) level, and individual level.

System level coordination and planning refers to the overall planning and management of the health system by the Ontario Ministry of Health and Long-Term Care. At this level, effective stewardship is required in order to ensure that the administration of the broad system sets in place the vision, values, standards, resources, policies and effective implementation mechanisms —in this case the LHINs— that will enable appropriate and equitable local health care planning and service coordination.

Community (or subregion) level coordination and planning refers to the manner in which the system-wide vision and standards are realized and implemented based on the individual texture of communities and neighbourhoods. Community level coordination and planning is critical so that health care services address diverse client needs and community priorities building from existing strengths and assets. Since these are unique to each community, solutions to local community challenges cannot be effectively determined at the level of system planning whether at provincial level or regional/LHIN level. These solutions are best achieved through the engagement of health service provider agencies, and clients, caregivers and consumer groups at the community level. Together they will determine what mechanisms are required to support each other and clients across the full continuum of care and to ensure that a vision of seamless client experience can be achieved.

Individual level coordination and planning refers to the function of client care and service coordination that is the responsibility of all health service provider agencies. Just as communities have unique needs requiring community-level coordination, diverse clients must be able to benefit from health services that use interprofessional teams, designed to respond and adapt to their individual needs, including through the development of culturally safe practices.

With the introduction of Bill 210, including the additional Ministerial powers to create consistency across the LHINs and LHIN subregional planning, Ontario is well-prepared to implement integration enablers at all three levels for effective reform.

Integration Disablers

As one might guess, according to evidence, many approaches that inhibit integration are the opposite of what was described above:

- Power imbalances, lack of trust
- Provider-centricity
- Cultural incompatibility
- Misaligned goals and/or incentives
- Lack of transparency
- Poor communication

- Unreasonable time, inadequate resources.[15]

Large scale structural changes in the form of mergers or amalgamations, particularly mandated ones, often fail. They experience "disintegration"; do not improve service delivery; do not improve clinical health outcomes; and/or reduce services or the uptake of services.[16] In the private sector, "merger alternatives" like joint ventures, strategic alliances, franchising and licensing agreements are often preferred or viewed as the options of first choice because they "multiply [the] potential universe of resources by leveraging those of all [the] partners...[with] benefits from such partnerships often derived much faster, cheaper, easier, more profitably, and without the debilitating conflict and turmoil when compared to a typical merger or acquisition."[17]

CHO's Integration Framework

Given the evidence across jurisdictions and sectors, Community Health Ontario supports the following principles of integration:

- **Person-centred**
- **Voluntary**
- **Adaptive** to local needs and assets
- Based on **trust**
- Supportive of effective **collaboration** that meaningfully engages and builds consensus amongst all health and social service stakeholders, including people who use the system, and supporting existing collaborative relationships and partnerships
- Supported by **system leaders**
- Supported by necessary **resources** for all participants, including time
- Supported by **data, performance management and evaluation** systems to ensure ongoing **learning and improvement** by all participants
- Embedding **equity** deeply into every aspect of the initiative at all stages to ensure health disparities are reduced
- Applying **governance and operationalization** approaches that support the other principles.

These principles apply to all three levels of planning and coordination: individual, community (sub-regional) and provincial.

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[15] Kodner (2011), Cartwright and Cooper (1993), Calgary Chamber of Voluntary Organizations (2010), Toronto District Health Council (2000)

[16] Fyke (2007), (Zimmerman and Dooley 2001), Grubb and Lamb (2000), Lurie (2009)

[17] Grubb and Lamb (2000)

Concluding Remarks

Given the complexity of the undertaking, it might be tempting to abandon the notion of integrating Ontario's health system. Neither the system nor its users can afford for that to happen. We must, in the interest of system sustainability and the delivery of integrated care to the almost 14 million people who depend on the province's health services, stay the course. CHO's Integration Principles help all participants -- from the Minister of Health and Long-Term Care to people who use the system and their loved ones -- better address the complexity of the undertaking by working well together. At the same time, given their alignment with the evidence on what supports successful integration of any form, we must protect the values and principles on which Ontario's community health services were founded: connection with community, connectedness among services, respect for the unique needs and resources of each individual, and a fundamental commitment to the provision of integrated care.

Only then will we have a sustainable health system in which quality care is delivered efficiently and evidence-based practices are balanced with innovation.

Only then will we have the health care system that everyone in Ontario deserves.

Case Studies

(include Quadruple Aim Impacts, as available)

Because barriers to care and complex care needs come heavily into play, the member organizations of the AOHC, OCSA, and OFCMHAP have learned that only community- level planning, with ongoing mechanisms geared toward community-level decision making can appropriately gauge and respond to these realities. AOHC, OCSA, and OFCMHAP member agencies and centres have achieved a great deal of this local accountability, adapting to change in the community over time, through the leadership of volunteer community boards of directors and the active involvement of interdisciplinary teams of health professionals, program staff and volunteers in the day-to-day activities of these services.

At the same time, the complexity of individual client needs requires that at the level of individual planning, not only must appropriate 'in-house' systems be developed to ensure appropriate client care and support, but that all health care provider organizations must have an equal responsibility and obligation to coordinate care for clients as they move through the health system and other, related systems. "Every Door Leads to Service", means that client care needs to be understood as a set of processes, rather than a task, with all access points on the health care continuum being supported to assist a client in entering and navigating their way through the systems.

Members of the AOHC, OCSA, and OFCMHAP are committed to working collaboratively in each community throughout Ontario to ensure that all Ontarians, and particularly those facing barriers to care, and who are at higher risk of being marginalized by 'mainstream' services, receive coordinated care to achieve positive health outcomes + other triple aims

Urgent Services Access Team - service integration initiative between Quest CHC, CMHA Niagara, CASON, hospital, Segue methadone clinic: https://www.aohc.org/USAT

Rural Hastings Health Link - subregional planning and system navigation between Gateway CHC, multiple FHTs, home and community support services, hospital, mental health, including patient representation on steering committee and working groups: https://www.aohc.org/RHHL

Connectivity Situation Tables - https://www.usask.ca/cfbsjs/research/pdf/research_reports/AnEvaluationoftheConnectivitySituationTablesinWaterlooRegion.pdf