

EVERY DOOR LEADS TO SERVICE...

Enhancing Access and Building a Culture of Service Integration for a **Made in Ontario** Health System

A Discussion Paper

July 2006



Association of Ontario Health Centres



Ontario Community Support Association

OFCMHAP

Ontario Federation of Community
Mental Health and Addiction Programs

These three provincial associations, representing a myriad of health professionals, with over 120,000 volunteers, and serving over 1,250,000 people annually, have come together to articulate a vision of community-based, client-centred health services integration. We offer our experience and recommendations to help work towards effective, evidence-based models of service-level collaboration in each of Ontario's 14 Local Health Integration Networks (LHINs).

Prepared by:

Association of Ontario Health Centres (AOHC)

AOHC provides leadership for the promotion of community health centres, Aboriginal health access centres and other non-profit community-governed multidisciplinary primary health care organizations, with a view to ensuring that all Ontarians have access to non-profit community-governed multidisciplinary primary health care.

www.aohc.org

Ontario Community Support Association (OCSA)

OCSA is a provincial association that supports, promotes and represents the common goals of its members, which are providers of community-based not-for-profit health and social services, so that they are better able to support people to live at home in their own communities.

www.ocsa.on.ca

Ontario Federation of Community Mental Health and Addiction Programs (OFCMHAP)

OFCMHAP brings together community mental health and addiction services in the province of Ontario to help members provide effective, high-quality services through information sharing, education, advocacy and unified effort.

www.ofcmhap.on.ca

See page 12 for more information on these associations.

EVERY DOOR IS THE RIGHT DOOR TO SERVICE: CHAMPIONING A CULTURE OF SERVICE INTEGRATION

The Association of Health Centres (AOHC), the Ontario Community Support Association (OCSA) and the Ontario Federation of Community Mental Health & Addiction Programs (OFCMHAP) 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 in each local health integration network, and makes every door the right door to enter the health care system.

We strongly endorse a health care system for Ontario where every door leads to appropriate and effective services, focused on the client and coordinated at the local community level. In order to support this system, the following are required:

- A province-wide culture of service integration across health sectors and providers**, championed and supported by the Ministry of Health and Long-Term Care (MOHLTC) and the Local Health Integration Networks (LHINs). This would require all health service provider organizations, regardless of their location on the continuum of care and within the overall system, to commit to client-centred, effectively coordinated care and seamless transitioning of clients to other services that may be needed or more appropriate.

A true culture of integration means a health system where client transitioning is understood as more than mere referral or “hand off” mechanisms, but rather commitments to ensuring that linkages across sectors and between providers support clients to successfully transition, with due respect for the barriers that they may face and the complexity of their care issues.

Each health service provider agency must support clients to move through the system smoothly, following the most direct route, reducing duplication of service.¹ This will result in the optimum outcomes for all clients, who will receive the right care, at the right time, and in the right place. It will also lead to positive outcomes in the broader system and more efficient use of resources to help the health care system live within Ontario’s means.

¹ *Transition Planning in Health Care Systems: Key Quality Processes and Outcome Measures, a Discussion Paper*, the Ontario Home & Community Care Council, S. VanderBent, Chair, Ontario Home and Community Care Council, October, 2004. This paper is available at www.ohccc.ca under the Position Papers section.

- Local best practice initiatives and existing partnerships that aim to better integrate client care must be supported and adequately funded** by MOHLTC and LHINs. There are many local initiatives underway currently that should be show-cased and replicated provincially across LHINs.
- Current long-standing community governed services must be adequately resourced** in order to build capacity to link clients to required services. The infrastructure and expertise exist, however, additional resources are needed to expand on current programming, enhance current care coordination and reduce wait lists for service.
- As part of the culture of service integration, local communities must have information on local health and community services readily available²** at health service provider agencies and physician’s offices for easy referral. There must be a mix of access points that are culturally competent, reflect the most urgent care needs, and that allow for client choice. Once referred, the service provider is responsible to ensure the other health care needs are addressed through community collaborations and networks. (Note: in the future, physician portals will have local provider services information readily available.)

FROM SYSTEM, TO COMMUNITY, TO INDIVIDUAL AND BACK – PLACING THE QUESTION OF SERVICE INTEGRATION IN CONTEXT

Effective reform of the provincial health system will require planning and coordination of services at three levels: the system level, community level, and individual level.

System level coordination and planning refers to the overall planning and management of the health system, a process that the Ontario Ministry of Health and Long-Term Care has undertaken through its bold “Made in Ontario” health transformation agenda. 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 and implementation mechanisms—in this case the LHINs—that will enable appropriate and equitable local health care planning and service coordination.

² Services such as the United Way’s 2-1-1 line – the first multilingual, 24-hour information and referral line in Canada for health and social services, operated by Findhelp Information Services – is an excellent and cost-effective model for referrals to the available services and should be expanded across the province. Telehealth can also refer people, as can Connex Ontario which links people to available mental health and addictions services.

Community 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. Since these needs and priorities 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 client/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 transitioning 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 are designed to respond and adapt to their individual needs, and with due cultural competence.

LESSONS FROM COMMUNITY HEALTH CENTRES, ABORIGINAL HEALTH ACCESS CENTRES, COMMUNITY SUPPORT SERVICES AND COMMUNITY MENTAL HEALTH AND ADDICTION PROGRAMS – THE NEED FOR COMMITMENT TO EFFECTIVE COMMUNITY AND INDIVIDUAL LEVEL PLANNING AND INTEGRATION OF SERVICES

The services delivered by members of the AOHC, OCSA, and OFCMHAP have grown up out of communities across the province over the past number of decades in response to locally identified gaps in services, and to address the diverse and complex barriers to care faced by individuals and groups due to factors such as age, race, language, culture, age, mental health, addictions, homelessness, poverty, disabilities, chronic diseases, and others. The services offered are front-line, community-based, consumer-driven, and client-centred.

Numerous studies over the past few years have pointed to the complexity of providing care and support for various populations with high needs and who face increased barriers in accessing ‘mainstream’ services. A few examples include:

- 3 "The Middlesex-London Health Unit's Task Force on barriers to care for frail elderly persons found that at-risk seniors have multiple, complex issues and challenges including social isolation/withdrawal, extreme self-neglect, domestic squalor, and a strong refusal of help, which often leads to eviction. To address the needs of these individuals, community strategies are needed, including collaboration amongst service providers and the establishment of clear processes for coordinated care."³
- 4 A recent CIHI Survey, "Alternatives to Acute Care?", found that 19% of all Alternative Level of Care (ALC) patients are discharged from hospital without any supports whatsoever back to their communities and homes. There is an urgent need to develop pilot projects linking hospitals with community support services, community mental health and addiction services and CHCs, to develop best practices in supportive hospital discharge teams. This would include a CSS lead representative for home transport, to make sure that adequate food is in the home, and that the client is safe, receives mental health or addiction support if needed, and facilitates ongoing medical care through a CHC or other appropriate primary health care organization. This would help prevent clients from having to return to the hospital again, using costly and avoidable hospital services, to remedy unattended-to complications.⁴
- 5 A survey of learning needs for shelter staff in Toronto ranked cognitive impairment, medications and aging, addictions and aging, and elder abuse in the top 10 learning needs.⁵
- 6 The Canadian Institutes for Health Research (CIHR) reports that for First Nations communities the tuberculosis rate is 6.2 times higher than the general population, the rate of heart diseases is 16% higher than the general population, the rate of diabetes is 2.7 times higher than in the general population, and Aboriginal people living off-reserve have lower levels of formal education and income, and higher rates of smoking, drinking and obesity compared to the general Canadian population.⁶
- 7 A study exploring the link between mental health and homelessness estimated that 66% of homeless seniors have a mental illness.⁷ Another task force found that people with addictions are at higher risk of homelessness as well.⁸

3 Task Force on Senile Squalor, Final Report, April 2000, Middlesex-London Health Unit.

4 Jokovic, A., Baubergenova, A. Baldota, K., Leeb, K., "Alternatives to Acute Care?", Healthcare Quarterly, Vol. 9 No. 2, 2006, pp. 22-24.

5 Learning Needs Study for Shelter Staff, The Aging and Homelessness Project, Regional Geriatric Program of Ontario, www.rgp.toronto.on.ca.

6 Aboriginal Health Overview. Canadian Institutes for Health Research. 2005.

7 Homelessness and Mental Illness in the Hamilton-Wentworth Region, Cook,p., Schofield R., pages iii, iv, 1995.

8 The Hamilton Mayor's Action Task Force on Homelessness (1999).

- ▶ An ecological approach to assessing health risk was undertaken that applied it to a sample of elderly homeless people within the context of a single day in a single urban setting revealing a number of risk factors specific to older persons.⁹
- ▶ It has been well documented that one of the strongest determinants of health is poverty.¹⁰ With this in mind, it is critical to note that census data, nationally and for the city of Toronto point to strong correlations between poverty and ethno-racial and immigrant status. Nationally, 39% of children from two-parent, recent immigrant families were living in poverty in 2001, up from 33% in 1990.¹¹ In Toronto, where the city average for families living in poverty is 22.7%, the total rates for a number of ethno-racial groups are starkly above the average: African, Black and Caribbean (44.6%); Arab and West Asian (45.2%); Latin American (41.4%), and South Asian (34.6%).¹²
- ▶ Research findings have pointed out that homelessness is significantly associated with factors common to low-income seniors, including low income, dementia, living alone, and an unstable residential history.¹³

Bearing in mind these complexities, it is critical to recognize that people enter the health care and social service system from many (often multiple) points of entry, for diverse reasons related to personal identity, and a search for safety and comfort within the social setting.

Where 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

9 Reilly, F. (1994) An ecological approach to health risk: A case study of urban elderly homeless people. *Public Health Nursing*, 11, 305-314.

10 Auger, N. et al. (2004) “Income and Health in Canada” in D. Raphael (Ed.), *Social Determinants of Health: Canadian Perspectives*. Toronto: Canadian Scholars Press (2004).

11 Canadian Council on Social Development (2003). *Census Shows Growing Polarization of Income in Canada: Analysis of Canada Census 2001*.

12 Ornstein, M (2000). *Ethno-Racial Inequality in the City of Toronto: An Analysis of the 1996 Census*. City of Toronto.

13 Keigher, S. & Greenblatt, S. (1992) Housing emergencies and the etiology of homelessness among the urban elderly. *The Gerontologist*, 32, 457-465.

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 system in their health care journey. **“Every Door Leads to Service”**, meaning 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 his/her way through the overall system, based on needs.

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.

WHEN SERVICES DON'T REACH OUR CLIENTS

The most at-risk populations, and those who face greatest barriers in accessing care and support, are individuals who are socially isolated and marginalized in the community. Although a referral for supportive services or treatment may actually be made, if the wait list is six months to two years, these individuals can become “lost between the cracks”. This is why it is so important to adequately fund the necessary services for people who are on long waits for the services they need. In many instances these wait lists exist to access the first point of care, even before appropriate referrals can be made. A recent report in London, Ontario¹⁴ suggests that individuals such as this are more likely to access emergency services (police, paramedics, and ultimately emergency rooms). Of particular note, evidence suggests that low-income seniors with mental health issues are seriously under-served and in need of specialized support.

Some of the outcomes when services are not available in the right place for local populations facing barriers in accessing care include:

- Longer waiting lists for necessary services
- Increased use of other, more expensive institutional services
- Increased pressure on emergency rooms
- Inappropriate use of prescriptions, leading to health complications
- Increased pressure on health and social services, and most notably, ambulatory, police and correctional services
- Increased stress on consumers/clients, families and communities
- Loss of human resource capacity and productivity for Ontario businesses
- Increased costs to the health care system as a whole

¹⁴ Key Informant Interviews, then Executive Director of Mission Services, London, Ontario, May 2004

Community Health Centres, Aboriginal Health Access Centres, Community Mental Health and Addiction Programs, and Community Support Services, when adequately funded, achieve positive client outcomes, particularly when they link with each other to provide a comprehensive array of services in a coordinated way.

In addition to the need for adequate funding, it is important to note that for decades, countless programs at AOHC, OCSA, and OFCMHAP member agencies have been supported by large numbers of volunteers. This contribution of volunteerism is estimated to give back close to \$1.35 for every dollar that is invested in these services by taxpayers. These programs have and will continue to be shining examples of leveraging resources and support in the community. A true government/LHIN/community partnership will pay dividends in the community.

EFFECTIVE AND PROVEN CARE MODELS FOR POPULATIONS FACING BARRIERS TO CARE AND WITH COMPLEX CARE NEEDS

The not-for-profit providers of Community Health Centres (CHCs), Aboriginal Health Access Centres (AHACs), Community Mental Health and Addiction Programs, (CMH&APs) and Community Support Services, (CSS), in Ontario are uniquely positioned to help each local community collaborate to better meet the needs of clients, consumers and their families.

In addition to assessment/diagnostic, routine medical services, counselling, assistance with the activities of daily living, homemaking, personal care and nutrition components of the services provided, the following are also among the key services provided by some or all of the three groups of members represented by AOHC, OCSA, and OFCMHAP:

- Local advocacy to remove barriers to care, including locating and arranging community and health-related services
- Programming geared to health promotion, nutrition counselling, chronic disease management, community information, education and referral
- Adult/Alzheimer day programs
- Social/recreational programming
- Caregiver respite
- Early Years child care programming
- In-home respite and caregiver support groups
- Intensive Case Management for at risk clients
- Attendant care

- ▶ Assisted living in supportive housing
- ▶ Transportation to medical appointment or grocery shopping
- ▶ Meals-on-Wheels,[®] food box and other food security programs
- ▶ Service planning: problem identification and service coordination
- ▶ Crisis prevention and intervention
- ▶ Immigrant/settlement counselling and support
- ▶ Multi-language translation of services
- ▶ Home visits with clients who are unable to access office sites
- ▶ Access to agency resources for homeless persons
- ▶ Ongoing outreach and long-term monitoring
- ▶ Support and assistance in coping
- ▶ Security checks and reassurance
- ▶ Daily living skills and lifestyle planning
- ▶ Court diversion services
- ▶ Mobile crisis teams
- ▶ Assertive Community Treatment Teams
- ▶ Addiction treatment programs, including withdrawal management services
- ▶ Peer-based supportive counselling and educational workshops
- ▶ Locating and arranging community and health-related resources
- ▶ Training, supervising and supporting volunteers to deliver services
- ▶ Working in partnership with a wide range of providers of community services and funding bodies to best respond to need
- ▶ Volunteer hospice

THE EVIDENCE

As a result of the local leadership of community governance Boards, comprehensive programs delivered through a social determinants of health framework, and innovative interdisciplinary care services, CHCs, AHACs, CSSs, and CMH&APs have achieved remarkable results across the province. A few examples include:

- ▶ Frontenac Community Mental Health Services in Kingston reports that as a result of their supportive housing program, there has been a 60% reduction over 8 years in the total length of time clients spend in hospital. ¹⁵

¹⁵ “The Benefits of Funding Addiction and Mental Health Services”, Ontario Federation of Community Mental Health and Addiction Programs, 02/04, p.11.

- While the southwestern Ontario average for diabetes testing in blood pressure, dietary fats, weight, feet and hand/foot nerve exam varies from 15-88 percent of ideal, a London InterCommunity CHC Latin American diabetes program has hit 100 percent of the ideal in every one of these categories. Additionally, by effectively utilizing nurses, community workers, and volunteers to support diabetes care, a yearly cost of only \$216/patient was achieved by the CHC vs. \$278/patient in private practice. The health centre has also been able to reduce costs by 22 percent before case complexity is included while increasing visits from 5 per year to 12 per year.¹⁶
- A recent study examining the use and outcomes of Community Support Services for at risk seniors in an assisted living in supportive housing complex in Toronto found that with the programs's intensive case management, only 34% of seniors use costly 911 and hospital emergency departments, compared to 64% of seniors in other settings. Instead, the seniors in the supportive housing setting make use of their emergency response buttons to reach on-site staff.¹⁷

A culture of health service integration will achieve positive results for our mutual clients, as we enhance linkages with each other and with our other partners in the community, across sectors, including the CCACs, FHTs, pharmacists, hospitals, long-term care facilities, and chronic disease health charities.

Already at the local level, a myriad of community-centred partnerships exists among agencies and centres belonging to the AOHC, OCSA, and OFCHAP. A few shining examples of local collaboration include:

Kingston Area: Team Work in Action

1. The Kingston Community Health Centre, which offers a team of doctors, nurse practitioners, nurses, dietitians, social workers and occupational therapists, is part of a partnership with Frontenac Community Mental Health Services, Street Health, a harm reduction centre,¹⁸ and Better Beginnings, which offers programs and supports for families and children. These centres work collaboratively with community partners, making client referrals to other community services, including obtaining affordable housing, securing assistance with mental health and addiction issues, and a variety of other community support services.¹⁹ Community providers also work closely with Providence Continuing Care Centre that offers specialized care for seniors with complex health needs, and expert resources for professionals and caregivers.

¹⁶ Performance Assessment Group Inc., Community-Based Diabetes Program: Diabetes Management Questionnaire, 3-Month Follow-Up Overall Assessment Results, April 2003.

¹⁷ "When Home is Community", a research initiative of Ryerson University, Neighbourhood Link/Senior Link and the University of Toronto (funded by the United Way) March 2005.

¹⁸ Among its services are disease prevention, needle exchange program, primary care and treatment services

¹⁹ For details of the programs and linkages with the Kingston Community Health Centres go to www.kchc.ca

Mid-Toronto Area: Food for Life Coalition

2. By sharing resources, a coalition of six agencies and organizations has been very successful in providing a critical service to lower income and marginalized members of a mid-Toronto community. The Food For Life Coalition is a group of organizations working together to provide an affordable, nutritious meal delivery program for homebound men, women and their children living with HIV in Metro Toronto. This partnership includes Mid-Toronto Community Services (MTCS), The Toronto People with AIDS Foundation (PWA), The AIDS Committee of Toronto (ACT), Casey House, FoodShare Metro Toronto, and the Sherbourne Health Centre.

As MTCS has the infrastructure to support a food delivery program, including the volunteer base, vehicle capability and experience in providing a large-scale Meals on Wheels service, it is responsible for delivering the meals. PWA has expertise working with persons with HIV/AIDS (PHA's), so the Food For Life staff are housed at PWA and are responsible for intake, assessment, client follow up and monitoring, ordering food, and securing additional funding for the program through fundraising efforts. PWA pays the food costs. The Food for Life program has received accolades for its work with a marginalized group and the United Way has applauded the program for its cultural competence and attention to diversity. Most importantly, individuals who face significant medical needs and face critical barriers to care and support, receive at least one good meal per day and a supportive environment.

Northwest Ontario: A Model of Collaborative Care

3. The Kenora Rainy River Mental Health and Addictions Network is comprised of hospital-sponsored and free-standing mental health programs/agencies. This Network is reaching out to other community and health care services to better coordinate care for clients/consumers.

In Thunder Bay, providers have a long history of collaborative networks. One community mental health and addictions group is comprised of the Anishnawbe Mushkiki Aboriginal Health Access Centre, Sister Margaret Smith Centre (an addiction services centre), and Brain Injury Services of Northern Ontario – BISNO (a community support services agency), all working together to better integrate services for individuals in the Thunder Bay area. There is also a network of community service providers that meet regularly to better plan care for older adults in the Thunder Bay area.

OUR RECOMMENDATIONS

Building on existing partnerships and the power of community-based care, the AOHC, OCSA, and OFCMHAP envision a ‘Made in Ontario’ health system that is based on a true provincial culture of health service integration. This will require effective planning and coordination of services at system, community, and individual levels. In order to achieve this, the three provincial associations recommend the following:

- ▶ That the Ministry of Health and Long-Term Care 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. Existing community-based agencies and centres should have funding levels enhanced to build capacity to coordinate and transition clients to the next service provider in a seamless way: “Every Door Leads to Service”;
- ▶ That LHINs undertake regular audits of existing partnerships and collaborations in each community across the province, and recognize these partnerships at 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 replication in other parts of the province;
- ▶ That the MOHLTC and LHINs ensure that health human resources planning takes place across all health care sectors, and across LHINs, ensuring that HR system planning is not solely acute care-focused.

These are measures required in order to achieve a “Made in Ontario” solution. Collectively, we look forward to working with our health care provider partners, the MOHLTC and the LHINs to achieve positive local health outcomes across the province.

ALL PROVIDERS HAVE A ROLE IN CARE COORDINATION AND CLIENT TRANSITIONING

Association of Ontario Health Centres (AOHC) is the policy and advocacy organization for non-profit, community governed, interdisciplinary primary health care. Our members include 54 Community Health Centres, 10 Satellite CHCs, 9 Aboriginal Health Access Centres, and other non-profit community governed multidisciplinary primary health care organizations. Between 2006 and 2008, 22 new CHCs, 17 new Satellite CHCs, and 17 new Community Family Health Teams will also be established. The AOHC's research and policy development focuses on community-centred primary health care models using a community development and social determinants of health approach. www.aohc.org

Ontario Federation of Community Mental Health and Addiction Programs (OFCMHAP), which includes 220 community-based member organizations, conducts educational and other activities that contribute to the advancement of the capacity of community mental health and addiction organizations to deliver quality services. The Federation envisions a community mental health and addiction system which is accessible, flexible, comprehensive and responsive to the needs of individuals, families, and communities, shaped by many partnerships, respectful of human dignity and rights, and accountable to those its serves. www.ofcmhap.on.ca

Ontario Community Support Association (OCSA) represents the not-for-profit agencies with CCAC contracts to deliver home care services such as nursing, personal support, and therapies. The Association's also represents 360 community support agencies that provide a broad basket of services such as attendant care, adult/Alzheimer day programs, Meals on Wheels, homemaking services, transportation and supportive housing programs. Member agencies have 25,000 staff and 100,000 volunteers. 750,000 people of all ages across Ontario receive community support services each year. www.ocsa.on.ca